A SINGLE QUALITATIVE CASE STUDY OF HOW THE INTRODUCTION OF AN AEC UNIT INFLUENCED THE EXPERIENCES OF PATIENTS, CARERS AND NHS STAFF

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D Prof Thesis

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Submitted in Partial Fulfilment of the Requirements of the

Degree of Professional Doctorate, 2021

“Stories have to be told or they die, and when they die, we can’t remember who we are or why we are here” (Kidd, 2002, p. 107)

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LIST OF ABBREVIATIONS

Acute Assessment Unit (ACU)

Academy of Medical Royal Colleges (AMRC)

Accident and Emergency (A&E)

Acute Internal Medicine (AIM)

Acute medical unit (AMU)

Advance Nurse Practitioners (ANPs)

Ambulatory Care-Sensitive Conditions (ACSCs)

Ambulatory care score (AMB)

Ambulatory Emergency Care (AEC)

British Association for Ambulatory Emergency Care (BAAEC)

Care Quality Commission (CQC)

Clinical Resource Efficiency Support Team (CREST)

Commission for Health Improvement (CHI)

Computerised Tomography (CT)

Deep Vein Thrombosis (DVT)

Department of Health (DH)

GP Assessment Unit (GPAU)

General Practitioners (GPs)

Healthcare assistant (HCA)

International Association for Practice Doctorates (IAPD)

Internal Evaluation (IE)

Key Performance Indicators (KPIs)

Medical Admissions Unit (MAU)

National Centre for Health and Clinical Excellence (NICE)

National Health Service (NHS)

Public Service Agreement (PSA)

National Research Ethics Service (NRES)

National Service Frameworks (NSFs)

Participatory Action Research (PAR)

Performance Assessment Framework (PAF)

Pulmonary Embolism (PE)

Doctoral Programme (DProf)

Registered nurse (RN)

Research and Development (R&D)

Royal College of Emergency Medicine (RCEM)

Royal College of Physicians (RCP)

Scottish Intercollegiate Guidelines Network (SIGN)

Standard Operating Procedure (SOP)

Thematic analysis (TA)

United Kingdom (UK)

United States of America (USA)

GLOSSARY

AMB score - a scoring system to determine the suitability for management in an AEC unit

Emergency admissions - refers to any urgent, unplanned visits to the hospital which required hospital-based care.

Cellulitis - Refers to a bacterial infection of the skin

Consultant - a senior doctor who accepts ultimate responsibility for the care of patients referred to them and oversees the rest of the medical team

DVT - Refers to the formation of a blood clot in the limbs

HCA - a non-qualified nurse who works under the direction of a staff nurse

Junior doctors - Refers to a graduate doctors-in-training in the UK and includes Foundation Year FY1 and FY2 doctors

NEWS score - a scoring system to standardise the assessment and response to acute illness

PE - Refers to the formation of a blood clot in the lungs

Registrars - are fully qualified and registered doctors who have passed medical school and completed their two years of pre-registration in a hospital and been admitted as fully registered doctors to the GMC list

Registered Nurse - a qualified nurse, registered with the NMC

Short-stay admission - refers to hospital admissions for forty-eight hours or less.

MAIN DEFINITIONS IN EMERGENCY MEDICAL CARE

Concept	Definition	Reference
Acute illness	Refers to any illnesses that are of short duration.	Jones, White, Armstrong, Ashworth, and Peters (2010)
Acute medicine	"Acute medicine is that part of general (internal) medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies"	RCP (2007, p. xxi)
Acute Medical Unit (AMU)	AMU: "a specialised area of an acute hospital where patients suffering from acute medical illness can be assessed and *initially admitted*". Opening hours: 24/7 for 7/7	RCP (2007, p. xxi)
Acute Medical Unit (AMU)	"The Acute Medical Unit (AMU) (also often called the acute assessment unit (AAU) or medical admissions unit (MAU)) is the first point of entry for patients referred to hospital as an acute medical emergency (AME) by their GP and those requiring admission from the Emergency Department. Its primary role is to provide rapid definitive *assessment,* investigation and treatment for patients".	NICE (2018, p.5)
GP Assessment/Admission Unit (GPAU)	GP patients are accepted for assessment and investigations with an agreed arrival time. Opening hours: Monday-Friday with limited opening hours	DH (2005)

ACKNOWLEDGEMENTS

- I thank God for His mercy and grace.
- My supervisors Elaine Ball, Tracey Williamson and Karen Higginbotham, thank you for your patience and belief in me. Elaine, you are indeed a special lady!
- My children Geandre, Ewan and Jayden and my grandchildren Destianah, Marcus, and Nala, whose mere presence in my life gives me the strength and willpower to continue even when I feel like giving up. Love lives here!
- My dad and my siblings who are my biggest cheerleaders. Your belief in me continues to motivate me. Thank you for always being there.
- My critical friend Maureen for listening without judgement or interruption.
- Jack Whitehead, Marie Huxtable and the Living Theory SKYPE Group members for being critical yet compassionate and kind and for welcoming me into their safe space. You are a fantastic group of individuals!
- Lastly, but not least, thank you to the participants of this study who shared their stories with me.

DEDICATION

I dedicate this thesis to my two mothers who are departed from this world but whom I carry in my heart forever. My mother, Kathleen Demingo and my grandmother Merriam Anthony who both shaped me into the woman I am today. Your teachings about the importance of family, living our values and working hard are engraved into my soul. I am who I am today because of both of you! But mostly, thank you for teaching me about the power within me and reminding me constantly that if I do not use my power, someone else will. Mammie Kathy, thank you for sacrificing your dreams so we can have ours. I hope we make you proud every day! Finally, in memory of my beloved brother Myron John Demingo, who taught me how to be a mother long before I had my children. Gone too soon, little brother. I miss you.

To Live in the Borderlands

In the Borderlands

you are the battleground

where enemies are kin to each other;

you are at home, a stranger,

the border disputes have been settled

the volley of shots have scattered the truce

you are wounded, lost in action

dead, fighting back…

To survive the Borderlands

you must live **sin fronteras**

be a crossroads.

Extract by GLORIA ANZALDUA

ABSTRACT

Background

The urgent and emergency care spectrum in the National Health Service (NHS) in the United Kingdom (UK) has changed over the last few years in response to the population's changing needs. In response, Ambulatory emergency care (AEC), which offered a different way of providing medical daycare, was introduced (Department of Health [DH], 2010c). The introduction of AEC was based on the supposition that it can prevent short-stay admissions and improve patients' experiences. There are currently several AEC units across the UK, but up to date, there are no published studies of the impact of these units on the experiences of patients, carers and NHS staff.

Statement of intent

This interpretive case study aimed to answer the research questions about how introducing an AEC unit influenced patients, carers and NHS staff's experiences and what factors affected their experiences.

Research design and methods

The experiences of patients, carers, and NHS staff in an AEC unit were explored through a single, qualitative, intrinsic case study. The intrinsic case study was conducted over fourteen months at an NHS Trust in the North West of England. Qualitative data were collected through participant observations, a staff focus group and semi-structured interviews with patients, carers and NHS staff. A purposeful sample of six patients, four carers, six AEC staff members, four senior NHS managers, two GPs and two ANP's were recruited for semi-structured interviews. Participant observations were undertaken on the unit over four weeks. One focus group with six members of the AEC team occurred. Data was analysed through thematic analysis (Braun & Clarke, 2006) and using the analytical techniques (direct interpretation, categorical aggregation and naturalistic generalisation) proposed by Stake (1995).

Findings

Four major themes emerged from the data collected: discourse, misalignment, safety and power. Through a sense-making lens, the influences of power differentials, discourse communities, misalignment of values and concerns regarding psychological safety on participants perceptions of experiences were brought to the fore. The framework provided insight into how they dealt with the challenges and how misalignment between power, discourse and values can create psychologically unsafe environments which negatively impact experiences and hamper transformation efforts.

Conclusion

The study findings demonstrated that AEC's introduction positively impacted the experiences of participants. However, meanings and interpretations about experiences are simultaneously context-dependent and context-renewing, thus formed and sustained by the broader social, political and organisational context. Furthermore, the study findings highlighted the importance of intersubjectivity in the mutual shaping, reciprocity and bi-directionality of viewpoints about the experience.

CHAPTER ONE INTRODUCTION TO STUDY

1.1 INTRODUCTION

This thesis aimed to explore the experiences of patients, carers, and NHS staff in an AEC unit. In this chapter, the study's aims, the research questions, and the objectives are clarified. The purpose of this chapter was twofold. Firstly, to give the reader an insight into current issues in emergency medical care, which necessitated the study and why NHS organisations were directed to establish this type of services. Furthermore, to provide a brief overview of the study organisation and an explanation of what AEC encompassed. The second intent was to acknowledge the roles personal and philosophical viewpoints played in the research process from the onset.

Thus, chapter one simultaneously acts as a backdrop for the study and a quick reference guide aimed at steering the readers from the national to the local and then the personal context. The study's contextual situating aimed to clarify study boundaries to the reader, which is imperative when doing case study research.

1.2 BACKGROUND TO THE STUDY

The number of people seen in accident and emergency (A&E) departments across the UK increased over the last few decades. A strong evidence base showed that A&E had become a substitution for access to non-urgent and emergency care services (Manley et al., 2014; National Audit Office, 2013; Picker Institute Adult Inpatient Survey, 2018; Poteliakhoff & Thompson, 2011). The increase in the demand for A&E services has been partially linked to changes to the GP's out-of-hours contract in 2004 (Purdy, 2010). One of the contractual change outcomes was the establishment of a multiplicity of urgent and emergency care providers. In turn, this array of service providers appeared to confuse service users and providers about appropriate service utilisation (Manley et al., 2014; O'Cathain, Colman & Nicoll, 2008; Purdy, 2010). However, due to the lack of research into how these services impacted emergency presentations to the A&E departments, the link remains a point of controversy (Knowles, O'Cathain & Nicholl, 2012).

Most NHS organisations have high bed turnover and hospital admission rates, further exacerbating the long waits in A&E and claims of dissatisfaction with care by patients, carers, and NHS staff. Studies also cited a lack of early senior review, risk-averse triaging, and the A&E 4-hours waiting-time standard pressures as reasons for increased admissions (Blunt, 2010; Calnan et al. 2007; NHS England, 2013e; Royal College of Physicians, 2013). However, the evidence to support these suppositions is anecdotal (Blunt, 2010). Despite ongoing controversies about the reasons for increased presentations to A&E departments, the resultant impact on NHS Trusts' ability to deliver safe services remained a cause for concern (Glynn, Bennett & Silke, 2011; Ogilvie, 2005; Sibley, Wiskin, Holder & Cook, 2007).

Nevertheless, despite the stated concerns over patient safety, up to this point, the UK appeared to have higher hospital admissions, lower average lengths of stay and higher bed turnover rates (Smee, 2005). Thus, it was widely believed by officials in Whitehall that the UK was doing very well in these areas in comparison to other European countries and reducing beds would be a viable option. However, those initial comparisons were ultimately deemed flawed because it was based on inconsistent data (the different ways acute hospital admissions were reported in different countries). In the UK, both short-stay and overnight admissions were recorded in the admissions data, whilst most other countries recorded overnight admissions only as part of their admissions data.

Government officials used the flawed data to substantiate reducing in-patient beds, which accelerated between 2004-2005 after legislators reviewed the traditional delivery of in-patient care. They concluded that a large proportion of the elderly population could be managed in the community, resulting in the closure of most wards where long-term care was delivered (Ewbank et al., 2017; Poteliakhoff & Thompson, 2011; Saxena et al., 2009; Smee, 2005). The subsequent shift of the policy towards community-based care left the UK health system with fewer in-patient facilities than populations with similar healthcare systems across the globe (Ewbank et al., 2017).

New measures were introduced to address the concerns that the reduced capacity in NHS Trusts will negatively affect patients' safety (as the community services in its current form would be unable to meet the needs of all the additional patients). One of these measures was to support patients' transition back into the community by introducing 'new' nursing roles like community matrons and discharge coordinators (DH, 2003). Additionally, NHS Trusts were instructed to review their discharge procedures to ensure discharge planning starts upon admission and not just before the patient is discharged. (DH, 2003; Ewbank et al., 2017). These measures aimed to ensure appropriate utilisation of the available community services and to encourage a culture where the discharge planning started on admission and not upon discharge.

Nevertheless, the evidence of these measures' successful impact on the NHS or community services' pressures, patients' safety, or experiences was minimal (Ewbank et al., 2017). Instead, the ‘gap’ between in-hospital and community care created by the wards’ closure appeared to intensify the existing challenges with ‘inappropriate’ admissions and ‘delays’ in discharges. The debate about what can be classed as an ‘inappropriate’ admission (Campbell, 2001; Hammond, Pinnington & Phillips, 2009) or a ‘delayed’ discharge (Bryan, 2010; Mann, 2016; Vetter, 2003) is ongoing globally. However, these authors rightfully pointed out the subjectivity of terms, haphazard measuring and hence lack of evidence to support the rhetoric.

Nonetheless, whilst working as a discharge coordinator, I witnessed first-hand the impact of inadequate health and social care resources in the community on the elderly population and people with complex care needs. Closer working between the discharge team and social workers was promoted, resulting in regular meetings where the discourse centred around ‘delayed discharges’, ‘inappropriate admissions’ and warnings to social services regarding penalties for the ‘bed-blockers’. However, the ‘new’ joint working between health and social care services did not ease the ongoing issues with lengthy A&E waiting times, crowded waiting rooms and reports of poor experiences (Ewbank et al., 2017).

The A&E four-hour waiting-time standard, introduced in 2004 by the DH, mandated that 98% of people presenting to an A&E department across the UK must be seen and discharged within four hours (either home or to a ward). The standard was set in response to lengthy A&E waiting times and crowded waiting rooms, which compromised the quality of care people received and led to reports of negative experiences (DH, 2001b). Despite policymakers' attempts to address the problems by championing ‘new’ roles and joint working for health and social care teams, the A&E waiting-time standard mainly remained unmet. Unsurprisingly, respondents to the urgent and emergency care surveys done between 2004 and 2012 reiterated their dissatisfaction with the care in A&E, attributing that mainly to the long waiting times and lack of privacy (Picker Institute, 2016). The surveys also highlighted the increase in A&E presentations of people with chronic conditions and increased numbers of people being re-admitted within twenty-four hours of discharge (Picker Institute, 2016).

Therefore, to streamline services and address ongoing concerns regarding shortages of resources, urgent and emergency care services were reorganised. The resultant closure of some units led to increased concerns about fragmented service delivery, low staff morale and unsafe care (Fernandez, 2011; Ham, Berwick, & Dickson, 2016; NHS England, 2013a, 2013c). Following high profile failures in the NHS, the quality of care patients received in hospitals came under more scrutiny, compelling the government to respond with several enquiries and subsequent policy interventions (Berwick, 2013; DH, 2013a, 2013b, 2014a, 2014b; Francis, 2013; Keogh, 2013; Ham et al., 2016).

1.2.1 The drivers for the establishment of AEC services

One of these policy interventions called for the introduction of initiatives such as AEC to reduce short-stay admissions, ease pressures on NHS Trusts, and thus improving the quality of care patients received (Manley et al., 2014; Murray et al., 2017; Tian et al., 2012; Wise, 2013).

> *Implementing AEC ensure that, where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day. (Royal College of Physicians [RCP], 2014, p. 1).*

As pressures increased in emergency care, the drive to establish AEC services intensified. An analysis of emergency activity showed that between eight to ten per cent of short-stay admissions could be managed without the need for in-patient admission, using an ambulatory pathway, leading to better patient experience and saving the NHS a significant amount of money (NHS Institute for Innovation and Improvement, 2010). In response to criticism regarding the A&E standard (Schimanski & Jones, 2010), the government replaced it with eight A&E clinical quality indicators in April 2011. NHS Trusts were required to record and publish information about the following eight indicators: 1) Ambulatory Care 2) Unplanned re-attendance rate 3) Total time spent in A&E 4) Left without being seen rate 5) Service experience 6) Time to initial assessment 7) Time to treatment 8) Senior consultant sign-off. The belief was that encouraging Trusts to be transparent about their performances in these areas would encourage new ways of working. In return, this would lead to changes in mindset that would positively impact the experiences of both those who receive and deliver care.

The ambulatory care indicator required NHS Trusts to have AEC pathways in place by 2016 to ensure clinicians in the A&E department considered the value of using the AEC pathways to reduce pressures in A&E (DH, 2010c). In response, some organisations established dedicated AEC units. Therefore, inadvertently signalling that for some NHS Trusts, the focus of delivering AEC was more on creating the physical space rather than changing practices.

However, whether it referred to a change in practice or establishing a physical space, the assumption was that the introduction of AEC would benefit both primary and secondary care services by offering NHS Trusts and General Practitioners (GPs) an alternative way to provide medical day-care. As noted previously, the number of patients with Ambulatory Care-Sensitive Conditions (ACSCs) who presented to A&E continued to increase from 2004. The evidence showed that the number of emergency medical admissions through A&E could be reduced through the appropriate management of patients with nineteen ACSCs conditions, as outlined in table 1.1 (Institute for Innovation and Improvement, 2012; Tian et al., 2012; Wise, 2013).

Acute conditions: All conditions suitable for management in the AEC except dental conditions, ENT and gangrene	Cellulitis Dehydration and gastroenteritis Pyelonephritis Perforated ulcer/bleeding Pelvic Inflammatory Disease Ear, nose and throat infections (ENT) Convulsions and epilepsy Gangrene Dental conditions
Chronic conditions: Effective care by GPs can prevent serious complications Any acute flare-ups/unwell can be managed in the AEC	Congestive Heart Failure (CCF) Asthma Chronic Obstructive Airway Disease (COPD) Iron deficiency anaemias Hypertension Nutritional deficiency Angina Diabetes complications
Vaccine-preventable: For GP management	Influenza and pneumonia Other vaccine-preventable conditions

Table 1.1 List of ACSC Adapted from the NHS Institute for Innovation and Improvement (2012a).

The appropriate management of people with ACSCs was listed as a key indicator of the quality of care they received in *The Operating Framework for the NHS in England 2012/13* (DH, 2011). ACSCs were defined as conditions for which hospital admissions could be avoided by preventative and primary care interventions (Ham, Imison & Jennings, 2010; Purdy, Griffin, Salisbury & Sharp, 2010).

The ‘new’ way of working needed GPs to embrace a holistic approach to the management of all their patients and NHS organisations to ensure early review by a senior doctor and coordinated discharge planning (Purdy et al., 2010; RCP, 2013; Tian et al., 2012; Wise, 2013). Therefore, closer working at the primary-secondary care interface was vital and included ease of access to acute secondary care services for people with acute conditions or exacerbating chronic conditions. To support AEC services’ drive, the AEC Network was formed to assist NHS Trusts with establishing or expanding their AEC services.

The network was part of the NHS Institute for Innovation and Improvement. The institution was established in July 2005 and replaced by NHS Improving Quality in April 2013 and was mandated to support NHS Trusts with service innovation and the introduction of new services. NHS organisations were invited to join the AEC network for a fee and, in exchange, received training and support in setting up their AEC service for twelve months. The NHS Institute first published an evidence-based AEC Directory in 2007, which contained information about emergency conditions and clinical scenarios that could potentially be managed in an AEC unit (AEC Network, 2018; NHS Institute, 2012a).

As in the early stages of day surgery, the uptake of AEC’s notion was slow when the concept was first introduced in 2007. However, as pressures on the NHS escalated, the interest in AEC was reignited, and in 2011/2012, the first cohort of NHS Trusts joined the AEC Network to establish AEC services successfully. In 2018 the AEC Network reported on their webpage that 120 organisations across England and Wales had completed the programme (AEC Network, n.d.).

The network offered a tailored AEC support package to NHS organisations. The package included a bespoke workshop for the whole team on setting up and measuring the service, two visits by the network team to the NHS sites, and a dedicated improvement coach to provide ongoing advice, guidance, and support. The NHS Trust, in which this study was undertaken, joined the network during one of the earlier cohorts. However, whilst the organisation's AEC steering group that included me attended the bespoke workshop, no further coaching or support from the network was requested during the twelve months. Thus, leading to the questioning of the membership's value by senior members of the steering group. Nevertheless, the NHS Trusts who actively participated and utilised the available resources and support effectively reported a return on their investment (AEC Network, n.d.).

In line with government guidelines and to address failing A&E targets, the NHS Trust, where this study took place, introduced the *Transformation of Emergency Care* project in 2012. The project included the launch of a purpose-specific AEC unit to accommodate medical day-patients referred from GPs or A&E. When first introduced, NHS managers expected that the service would reduce overnight admissions whilst simultaneously improving the experiences of both those receiving and providing care. The Research and Development (R&D) department of the NHS Trust funded the study with the proviso that I explored whether the service had achieved those aims.

AEC refers to

> *…clinical care which may include diagnosis, observation, treatment and rehabilitation, that is not provided within the traditional hospital bed base or within traditional out-patient services, and that can be provided across the primary/secondary care interface. (RCP, 2007, p. xxi).*

Thus, AEC services aimed to close the primary-secondary care gap created by hospital wards' closure by providing GPs with the needed access to urgent medical services. These short-stay medical day units are suitable for patients with a predicted hospital stay of fewer than twenty-four hours (Quemby & Stocker, 2013; RCP, 2007). Therefore, it mirrored the concept of elective day surgery, which in the UK refers to patients admitted and discharged on the same day for a planned surgical procedure (Quemby & Stocker, 2013; RCP, 2014). The assumptions were that these wards would combat the negative impacts of hospital admissions like exposure to hospital-acquired infections and anxieties about care arrangements (RCP, 2007).

AEC is deemed appropriate for people referred by A&E or by their GPs and can be seen and discharged on the same day (RCP, 2007). Thus, offering an alternative for admission to the Acute Medical Unit (AMU) and replacing the existing GP Assessment Unit (GPAU). From this point onwards in the chapter, the terms GPAU, AMU and AEC may appear to be mentioned arbitrarily; however, they denote different periods in the history of urgent and emergency medical care. To provide the reader with a guide to the different terms used in emergency medicine featuring in the thesis, I enclosed a table clarifying these concepts and their meanings in the glossary section.

Policymakers postulated that changing the way care was delivered in emergency medicine required a change in people's mindsets and that doing so would combat the rise in emergency admissions. Thus, a move away from the current practice that involved an admission for assessment and tests towards assessment and tests to determine if an in-patient stay was needed. That meant changing the discourse around medical admissions from 'admission' to 'assessment' and led to renaming or closing existing medical admission facilities. Figure 1.1 outlines the changes to these wards' names and function that occurred between 2005-2015.

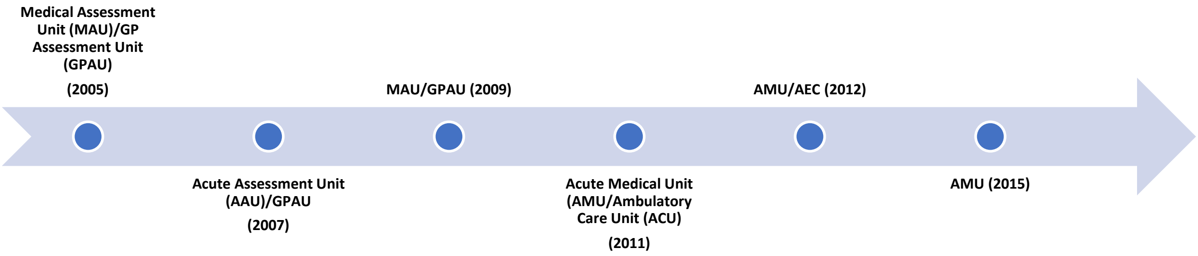


Figure 1.1 Historical changes in acute medicine

The AEC operated for three years before it was rebranded as an AMU in November 2015 to deal with the Trust's A&E pressures. This study covered the period from 2012 to 2016. However, the changes in the discourse surrounding emergency medical care delivery had practical implications as they ultimately led to restructuring. Wards were frequently closed or amalgamated, and, in the process, teams were formed and disbanded several times. Thus, leading to the loss of highly skilled staff, creating an uncertain environment, and ultimately hampering the establishment of new services, as reaffirmed by the participants in this study. Additionally, the tempo and frequency at which the restructuring occurred made any evaluation attempts of the impacts of these changes difficult (Braithwaite, Westbrook, & Oedema, 2005; Walshe, 2003).

1.3 PURPOSE OF STUDY

Therefore, despite the size of the problem of unplanned admissions in the NHS and increasing concerns over patient safety and quality of care, the evidence base for the impact that admission avoidance schemes have on experiences remains limited.

Nevertheless, when first introduced, proponents of AEC declared that "*improving patients' experience of care and their outcomes is a central aim to any AEC service development.*" (Carolyn Robertson Programme Lead for AEC Delivery Network, NHS Institute, 2012b, p.6).

At the time of this study, AEC was a relatively new concept in the UK with no available published research on how these units impacted patients, carers, or NHS staff's experiences. The purpose of this study thus stemmed from two overarching concerns. The first concern centred on the message that the introduction of AEC units would improve patients' experiences despite a limited evidence base supporting this claim. The second concern centred on the feedback received from patients, carers and NHS staff that conveyed their frustrations at being excluded from the decision-making process regarding new services.

This study aimed to address this gap and thus introduce a body of knowledge that to date was non-existent. The focus was to document the daily workings of an AEC unit, the challenges research participants faced, how they dealt with those challenges and how their experiences were impacted in the process. Concurrently, through a single qualitative case study and participatory data collection methods, offer them the opportunity to participate in shaping the service to suit their needs and values. In this study, the experiences of patients, carers and NHS staff were understood and captured in the daily interactions that took place on the unit and the data collected from interviews and focus group.

1.4 RATIONALE FOR STUDY

Evidence from the literature and personal experience as a nurse working in the NHS highlighted the impact of reducing beds and ward closures on patients and NHS staff. These included an increase in ‘failed’ discharges with an accompanying increase in readmission rates, inappropriate movement of patients around the hospital and the opening of ‘escalation’ wards managed by agency nurses and locum doctors (Poteliakhoff & Thompson, 2011). The resultant impact on emergency medicine was that patients remained longer in A&E and AMU due to the limited number of available beds on the wards to transfer them and a subsequent increase in the number of short-stay admissions. The potential effects on patients ranged from exposure to hospital-acquired infections, distress, confusion, low mood, and loss of functional independence, which ultimately affected patients and carers' experiences (NHS Connecting for Health, 2010). AEC units were introduced across the country to address some of these concerns.

I was aware of these services’ benefits and challenges from working in similar environments, such as Day Surgery and GPAU. However, as previously stated, there was little published evidence about how these services impacted patients, carers, and NHS staff’s experiences. Also, the tempo and frequency at which the restructuring of emergency medicine occurred made any research in these types of settings difficult due to the potential of ward closures in the middle of data collection (Braithwaite, Westbrook & Oedema, 2005; Walshe, 2003).

Thus, the increased attention placed by policymakers and hospital managers on the implementation of AEC units and the assumptions that it would improve patients and carers' experiences despite limited published evidence makes this study significant. Also, conversations with patients, carers and health care professionals always pointed out that "*they (managers) just make the decisions*" and imparted frustrations with the exclusion. This study's motivation was rooted in my intention to address the gap in the literature and offer patients, carers, and NHS staff the opportunity to shape the service to fit their needs.

1.5 LOCATION OF STUDY

An insight into the organisation's context where the unit was located is key to understanding the study findings. The NHS Trust provides children, adults, and primary healthcare services across two towns and treats more than 500 000 patients per year. The Trust started delivering ambulatory care aspects in 2003 when the medical division commenced a service for medical patients referred to the hospital by their GP for same-day assessment and discharge. A dedicated GPAU was established in 2005, which a nurse consultant and ANPs led. The unit was the precursor to the AEC unit established in 2012, as outlined in Figure 1.1.

1.5.1 Patient suitability for the AEC unit

Initially, patient suitability for the unit was determined by the shift lead using the ambulatory care (AMB) score and the National Early Warning Score (NEWS). The use of the AMB score (see table 1.3) as a tool to assess patients' suitability for management on AEC was introduced by one of the clinical leads at an NHS Trust that participated in the AEC Network (RCP, 2017). The tool is based on seven patient characteristics (Ala et al., 2012), and patients with an AMB score of ≥ 5 are deemed suitable for AEC (RCP, 2017).

The NEWS score (RCP, 2017), which measures six parameters of the patient (respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness or new confusion and temperature), was another safety predictor tool used (refer to table 1.2). Patients who had a NEWS score <4 were deemed suitable for AEC.

Physiological Parameters	**3**	**2**	**1**	**0**	**1**	**2**	**3**
Respiratory rate (breaths per minute)	<8		9-11	12-20		21-24	>25
Oxygen saturations	<91	92-93	94-95	>96			
Any supplemental oxygen		Yes		No			
Temperature	<35.0		35.1-36.0	36.1-38.0	38.1-39.0	>39.1	
Systolic BP	<90	91-100	101-110	111-219			>220
Heart rate	<40		41-50	51-90	91-110	111-130	>131
Level of consciousness				A			V, P, U

Table 1.2 NEWS score

However, the AMB score was abandoned after a few months due to it being unsuitable for the population the unit served; a view echoed in a study by Thompson and Wennike (2015). Patients with suspected Cellulitis, Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) were deemed low risk and thus suitable for out-patient management. Patients referred to AEC with possible DVT or PE would be screened with a blood test and a clinical probability stratification score to determine their suitability for ambulatory management.

Factors If the score is >5, consider AEC	1 Point if applicable 0 Point if not applicable
Female Sex	
Age <80	
Has access to transport	
Intravenous therapy not anticipated	
Not acutely confused	
NEWS Score=0	
Discharged within the last 30 days	
Total score	

Table 1.3 Ambulatory Care Score (AMB score). Adapted from Ala et al. (2012).

The AEC model followed in the unit varied from process-driven (accepting all clinically appropriate referrals) to pathway-driven (only accepting patients who meet pathways criteria like suspected DVT/PE, cellulitis, headache, first fit and low-risk chest pain). The unit also supported the medical wards by reviewing patients post-discharge who required follow-up on the accountable consultant's request. This cohort included patients who needed a repeat blood test, for example, a repeat kidney function after admission with acute kidney injury or dehydration, to assess for improvement or resolution of abnormality detected on admission blood results. Additionally, the unit also accepted patients who needed radiology results reviewed, for example, ultrasound and computerised tomography (CT) reports. Urgent or elective day procedures like paracentesis and lumbar punctures were also done on the unit.

However, the AEC was not without its dissenters. The idea of AEC, when first raised, was met with much resistance from physicians who felt that there was insufficient published data and guidelines to back up the view that out-patient management of the identified groups was safe. The subsequent publication of several guidelines alleviated their safety concerns. In 2010 The Scottish Intercollegiate Guidelines Network (SIGN) published the *Prevention and management of Venous Thromboembolism* guideline, and in 2012 the National Centre for Health and Clinical Excellence (NICE) published *Venous Thromboembolic Disease: The management of Venous Thromboembolic Diseases and the role of thrombophilia testing (full NICE guideline).* In 2005, the Clinical Resource Efficiency Support Team (CREST) published *Guidelines on the management of Cellulitis in adults,* and this was followed by the NICE (2005) guideline on the *Diagnosis and management of Cellulitis-acute.* Although late in the day for this study, support for AEC was boosted when the RCP developed an acute care toolkit (2014) addressing clinical governance, training, available resources, and suitable patients' selection. The AEC Network (2017) also developed an AEC operational guide to support hospital trusts to capitalise on AEC services.

As with most new NHS ventures, the unit's functioning (as a medical daycare unit or an overnight-stay ward) was determined by A&E capacity and bed shortages. The unit's function's unpredictability led to high levels of frustration and stress amongst staff and impacted their morale, which was linked to patients' experiences in other studies (Francis, 2013; Maben et al., 2012a, 2012b). Their perception of the futility of what they perceived as 'management-driven' reform agendas impacted their decisions regarding participation in the study. The study context's unpredictability and the resultant feelings of impotence expressed by patients, carers, and NHS staff influenced decisions regarding the research design and made transparency about the decision-making process vital.

1.6 PERSONAL AND PROFESSIONAL MOTIVATIONS FOR THE STUDY

This section addresses this research topic’s impetus and how different worldviews and the policy context influenced it. Additionally, how personal, professional, and academic experiences led to the decision to focus on patients, carers, and NHS staff’s experiences, using a participatory approach.

1.6.1 The research topic

When I applied for the professional doctorate programme (DProf) in 2009, my research proposal was a case study on the effect the introduction of single-sex accommodation had on patients’ privacy and dignity in an MAU. Unfortunately, in July 2011, after a significant event, new management took over, and the decision was taken to close both the MAU and the GPAU. The seventy bedded unit then became a sixteen bed AMU ward with a small waiting room, functioning as a GPAU (see glossary section for an explanation of terms).

Whilst remaining cognisant of the confusion the different terms used for the Acute Medical Units may create, the intent was to illuminate to the reader the confusion experienced by the patients, carers, and NHS staff due to these constant changes. Furthermore, to point out from the onset of the study how the policy context determined even small details such as the unit's name.

In September 2012, an unfavourable report by the Care Quality Commission (CQC) found that emergency care at the trust needed improvement. Coupled with failing A&E targets, this highlighted the existing unit’s unsuitability, and a new purpose-specific AEC unit was opened. As I was working in the department, the opportunity to conduct the study presented. However, in 2011, due to personal and professional reasons, I decided to ‘step off’ the doctoral programme for a year and resumed my studies in 2012.

In 2013, I applied and obtained funding from the R&D department at the NHS Trust, where the research was conducted. Undertaking a study that would improve patients’ and carers’ experiences and was valued by the employing organisation funding the doctorate was an essential part of the study’s decision-making process. However, after conversations with my line manager, it became clear that a study with quantitative elements, such as length of stay and admission rates, was preferred over one with qualitative aspects related to experiences. At that point, it seemed as if I was trapped between *“a rock and a (very) hard place”* (Judah & Richardson, 2006, p. 65) as the narrative about the importance of measuring the operational performance of the unit was notably prominent.

Subsequently, the initial study design reflected those requirements as the underlying message given to me was that by accepting the dominant discourse in healthcare (supporting quantifiable measurements), the study would be ‘legitimised’. Following high profile failures in the NHS, the policy shifted to the re-centring of delivering high-quality care and thus patient experience (Berwick, 2013; DH, 2010a; DH, 2013a, 2013b).

Therefore, with the support of a new line manager, the study was refocused. A new research proposal for a study examining the experiences of patients, carers and NHS staff in an AEC unit was submitted and accepted by the university supervisory team. This new topic marked the start of the struggle between the ‘beliefs-and-values-driven’ research I championed and the dominant discourse of measurability and demonstrability I encountered during my professional doctoral journey. Thus, reinforcing the importance of being transparent about my positionality from the start.

1.6.2 Combining the nurse-practitioner-researcher roles

> *Practitioner research, with its focus upon local inquiries…should be concerned not only with solutions, but with the conditions that produced the problems in the first place (Groundwater-Smith and Mockler, 2007).*

I qualified as a registered nurse in 1997 and have worked in surgical, medical, and mental health wards in South Africa (SA) and the UK. Nursing was not my first choice as a career, but I was determined to ensure that my practice remained rooted in my core values (centring on caring, justice, inclusivity, and self-determination). I aimed to ensure the patients, relatives, and colleagues I encountered were treated with compassion, dignity, and respect. Drawing from personal experiences of growing up in the Apartheid era of South Africa meant being mindful of the negative consequences of being treated without either dignity, respect, or compassion. Additionally. It made me acutely aware of how people who feel ‘unheard’ and ‘unseen’ and whose experiences are dismissed can feel invisible and insignificant. Thus, my core values are historically located and culturally relative, and I aim to live out my values, both personally and professionally.

However, personal experience has also taught me that active participation can balance the ‘powerless-powerful’ scales. Hence, those life experiences reinforced the importance of providing people with a platform to express their views of any services received and facilitating their participation in developing a service designed around their needs. The nursing profession has always emphasised the importance of hearing others’ views, including patients, carers, and colleagues. Listening to others and responding to their concerns and preferences is also one of the standards in the Nursing and Midwifery Council's [NMC] (2018) code of conduct. From a personal viewpoint, communication, engagement, and participation are equally important in both personal and professional arenas as it enables others to be active participants, not just passive receivers.

As a student nurse, I worked and trained in some of the most impoverished areas in Cape Town, with limited resources. Thus, the nurses did practical procedures that doctors would normally do, and patients (and their carers) were expected to participate actively in their health care planning and delivery. Shared learning, co-creation of knowledge and shared decision-making between health care professionals, patients and carers were integral to my practice (in other words, person-centred care).

When I was seventeen years old, I experienced the ethos of person-centeredness first-hand when my great-grandmother was discharged from the hospital with a feeding tube, and the nurses came to demonstrate to me how to use the feeding pump and how to deliver her care. They ensured I understood what to do and was comfortable with everything before they left, and despite being anxious and afraid, I enjoyed caring for her. The initial intense discomfort I experienced because of the 'not knowing' and how I managed those feelings is something I draw upon when trying to understand others' responses to certain situations.

1.6.3 Selection of case study as a methodology

Based on my beliefs that shared learning, co-creation of knowledge, and shared decision-making are fundamental aspects of nursing care, I endeavoured to practice in an environment that embraced these beliefs and, as a senior member of the team, support the development of this culture. The social co-creation of knowledge and meaning-making or social constructionism allows for the justification of knowledge, such as participants experiences on AEC, which can be interpreted and understood in several different ways. Seeing myself and others as integral parts of any situation, adopting a case study approach with participatory methods seemed appropriate for this study as it would enable an in-depth exploration of the issues that influenced participants' experiences (Stake, 1995). Stake's (1995) case study design aligned with my social constructionist assumptions that reality and meanings are constructed by society. Social constructionists are interested in the meaning-making activities per se, '*…because it is the meaning-making/sense making attributional activities that shape action or (inaction)''* (Guba & Lincoln 2005, p.197).

1.6.4 Reflexivity

This study's impetus was improving patients' experiences whilst simultaneously developing the practice setting, myself, and others through collaboration with the participants (Noffke, 2009; Somekh, 2006; Winter, 2015). Echoing the view, the International Association for Practice Doctorates (IAPD) urges doctoral students to ensure their research studies cross practice-academia barriers. However, the IADP also highlighted the importance of remaining aware and reflexive about the possible impact of the researchers' personal and professional experiences on the study and the participants (Costley & Lester, 2012).

There is a difference between reflection and reflexivity. Reflection is an integral part of my nursing practice and refers to a goal-oriented action to improve practice, whilst reflexivity refers to a continual process of engaging with and articulating my place in the research context and the process. Being reflexive means being self-aware of how my background, experiences, views, beliefs, biases, and perceptions can influence the construction of meanings throughout the study and continually reflect on this in my reflective diary and with supervisors, critical friends, and colleagues (Charmaz, 2017). The bidirectional relationship between myself and the research process (each affected by the other) was acknowledged through reflexivity, and the social, cultural, and behavioural dynamics that affect this relationship were interrogated.

In her seminal paper, Sue Wilkinson (1988) outlines three forms of reflexivity that can inform qualitative research: personal, professional, and disciplinary. Personal refers to the researchers' individual preferences, motivations and experiences that influenced decisions about the research topic, expectations, and the issues to be pursued. The professional level refers to their perceptions of participants, interpersonal dynamics, and communication styles. At the disciplinary level, the researcher clarifies decisions about epistemology, methodology and methods.

During the study, I adopted several practices to facilitate greater reflexivity, such as a reflection journal (captured important events or decision making at different stages of the research process). I also talked with my supervisors, my critical friend, and the Living Theory Skype Group members, who continually challenged and interrogated my assumptions and practices, which all were valuable and contributed to the research's quality. To enhance reflexivity and align with this study's philosophical frame, I have written this thesis in the first person.

1.7 RESEARCH AIMS

The following research aims were central to the study:

- To explore how the service has influenced the experiences of both those receiving and providing care.
- To contribute to developing an AEC service based on the study population's needs and therefore contribute to practice.
- To contribute to the public knowledge base of AEC units' impact on patients, carers, and NHS staff's experiences.

1.8 RESEARCH QUESTION

The following research questions were identified

1. How did the introduction of a purpose-specific AEC unit influence patients, carers, and NHS staff's experiences?
2. What factors influenced their experiences?

1.9 RESEARCH OBJECTIVES

In this section, the research objectives are introduced, followed by explaining how each one was achieved.

To critically explore the experiences of the patients, carers, and NHS staff:
This objective was achieved by collecting data from the staff focus group, observations done in the AEC and interviews with the patients, carers, and NHS staff. Data from the interviews and focus group were audio-recorded, and the data from the observations were

recorded in the fieldwork diaries. These methods are explained and clarified in chapter six. Discussions with the patients, carers, and NHS staff in the reconnaissance phase and reviews of the literature helped to shape a patient journey-mapping tool (Appendix 15), semi-structured interview guides (Appendixes 18, 19 and 20), and an observation topic guide (Appendix 16). In documenting the research findings, quotes from interview transcripts were used to capture the participants' voices. However, concerns regarding the influence of power, truth, and subjectivity on issues of voice, empowerment, and representation remained central throughout the study.

To determine which areas of the patient's journey through the AEC unit needed improvement:

This objective was addressed by collecting data from a staff focus group, observations done in the AEC and interviews with the patients, carers, and NHS staff. The data was recorded as above. Discussions with patients, carers, and NHS staff in the reconnaissance phase and reviewing the literature helped shape a patient journey mapping tool (Appendix 15). The tool was used to observe the patient's journey from referral to discharge from AEC to either home or the main wards, as described in chapter six.

To implement required changes to the AEC service by working with staff, GPs, and managers:

Based on action research principles, changes were implemented based on the staff focus group, observations, and interviews. An example of this is the establishment of the AEC strategy group. Feedback was received from NHS staff regarding the lack of support from senior managers, and the ward manager sent an email to senior managers raising the issue. The group was formed and consisted of the business manager, the clinical lead for AEC, the matron of acute medicine, ANPs and ward sisters. According to the terms of reference (Appendix 21), a monthly meeting to discuss the unit's issues was agreed upon by all members. However, this was abandoned after four months due to ‘pressures on the service’.

To reflect critically on my ‘lived’ experiences as a senior nurse trying to coordinate research in an uncertain NHS setting:

The objective was achieved by critical analysis and critique of how personal and professional lives intertwined, as discussed in chapter four. Still, it is also evident in other chapters as I aimed to weave reflexivity throughout the study. The transparency enabled the uncovering of those conditions, which created tensions and problems, thereby enabling the reader to judge the study based on all the information provided (Groundwater-Smith & Mockler, 2007).

1.10 CONTRIBUTION TO KNOWLEDGE

AEC is a relatively new concept in the UK, and whilst there is an increasing emphasis on establishing AEC services, the literature on how those services influenced the experiences of the patients, carers, and NHS staff are limited. Qualitative studies about the experiences of patients in emergency and urgent care services are also limited. Therefore, a study that addresses the gap can significantly contribute to the field of knowledge.

Furthermore, NHS staff frequently expressed their frustrations with the reforms and the lack of frontline staff involved in any decision-making and planning stages. Conversations about reform or service re-design were often laced with distrust and scepticism. Therefore the ‘change fatigue’ spoken about in books and articles was unmistakable in the practice setting. In the same vein, patients and carers expressed their confusion with all the different services in urgent and emergency care and the fast pace of the services' changes, resulting in what appeared to be acceptance of the status quo.

The study aimed to yield localised, context-driven data that can help shape AEC services' development based on cooperation and early engagement of all stakeholders. Furthermore, the study aimed to contribute to practitioner research's knowledge base by illuminating the everyday struggles the researcher faced in the field and the role resilience played in completing the study despite obstacles and setbacks.

1.11 SYNOPSIS OF CHAPTERS

While the chapters were written in a traditional, linear way, the reader must consider that the research journey was not linear. Chapter one provided the background, purpose, and justification for the study. The research questions, aims and objectives were clarified. The chapter also outlined personal and professional motivations for the research and the contribution to research clarified. Chapter two gives the reader an overview of the policy context and situates the government's drive to improve patients' experiences as a prevalent concept through an NHS timeline. Chapter three provides a synthesis of the literature relating to the research questions and critically examines the contribution of available literature to the research topic debate. Thus, identifying the gaps in the literature which this thesis will seek to address.

Chapter four contains a narrative reflection of the experiences, biases, and assumptions I brought to the study. The Bordieuan concepts of field and habitus were used to shed light on the community's influences on my development, both personally and professionally.

Furthermore, this chapter sheds light on other personal experiences that helped develop the resilience required, which enabled the continuation and completion of the study despite the obstacles. Chapter five focuses on the methodological choice of case study and provides the reader with an insight into the choices made regarding methodology. The chapter also gives an overview of the study setting and justifies the sampling strategy, recruitment techniques and ethical issues. The chapter demonstrates how quality criteria were ensured. In chapter six, the selected methods, the development of the data collection tools, and the data collection process are discussed in detail.

Chapter seven details the data analysis process and clarifies how the data were synthesised into the four main themes. In Chapter eight, the results are discussed. Chapter nine includes discussing the findings and using a sensemaking conceptual framework to frame the study’s findings and limitations. Chapter ten contains the conclusion of the study and the recommendations for further research.

CHAPTER TWO THE NHS - RESTRUCTURING AND REFORM

2.1 INTRODUCTION

Chapter one provided an overview of the urgent and emergency care challenges that led to AEC's introduction. The chapter also highlighted the reasons for focusing on participants' experiences and why a case study approach was deemed appropriate. Following on, this chapter aimed to provide a brief, descriptive overview of the NHS's history through a timeline. The intention was to situate the focus on patients, carers, and NHS staff' experiences in an AEC unit in a broader NHS policy context.

The chapter picked up two threads from the previous chapter. Firstly, how and when the concepts of 'improving experiences' and 'values-based care' became embedded in the NHS policy context. Secondly, how the current reorganisation of NHS services and the resultant difficulties to coordinate and standardise services were related to the close link between Whitehall and the NHS (Sturgeon, 2013, p. 20). Therefore, this chapter contextualised the transitory nature of the admission avoidance schemes, including the AEC unit where this study was done, and the difficulties NHS staff experienced with service transformation attempts at the periphery.

2.2 THE LAUNCH OF THE NHS

The NHS was established on the 5th of July 1948 to deliver universal, comprehensive, and free healthcare at the point of contact, available to all citizens equally, based on need and not affordability (Gorsky, 2008; Sheard, 2011; Sturgeon, 2013). Since its inception, the NHS's administration has been centrally directed from Whitehall, answerable to the

Minister of Health. Thus, the NHS was bounded irrevocably to the political landscape, a process instigated by Aneurin Bevan (1897-1960), when he declared, "*when a bedpan drops in a hospital, I want the noise to reverberate in the corridors of Westminster*" (Klein, 2018, p. 4). Bevan, the Labour Party Minister of Health in 1945, is frequently called the NHS founder. However, to pass the NHS Act in 1946, Bevan had to reach an agreement with the medical profession, resulting in a tripartite healthcare system (Ham, 2009). The 'compromise' is still reflected in the divisions between secondary care (hospitals) and primary care (GPs and district nurse services), leading to healthcare services frequently being described as disjointed.

The *Beveridge Report on Social Insurance and Allied Services*, widely known as the blueprint of the NHS, was published in 1942. The report concluded that it was the government's responsibility to provide free healthcare for all citizens from *"cradle to grave"* (Beveridge, 1942, cited in Sheard, 2011, p. 433). The report also postulated that free healthcare would reduce illnesses in the communities, thus reducing healthcare expenditure (Sturgeon, 2013). However, the evidence was notably based on a few communities' research and the conjecture that the evidence was transferable between different settings (Ham, 2009).

After the NHS was established, demand and expectations surpassed supply, and Bevan faced the same questions that current Ministers of Health still face. The questions were related to the organisation and management of the NHS, appropriate funding of healthcare services, managing all stakeholders' expectations, and the appropriate use of resources (Klein, 2018; Rivett, 1998). Additionally, the NHS's projected cost was underestimated, and in the first year, the estimated cost doubled. Due to growing demand, the cost continued to rise, and the predicted savings from a ‘healthier nation’ never came to fruition (Sheard, 2011). However, a review of the NHS expenditure, led by the Guilleband Committee in 1956, found no evidence of wastefulness or indulgence. Instead, the report highlighted the need for stability and increased funding if the NHS were to succeed (Ham, 2009).

Despite the ongoing concerns about the NHS’s financial viability, its management remained relatively unchanged in the first two decades after inception. The reluctance to impose changes was likely due to the public reverie and the resultant ‘political visibility’ (Gorsky, 2008). However, it soon became evident that the visibility cuts both ways as successive governments attempted to tame-the-dual-headed-dragon (public affection and continuous forecasting of demise). These attempts included frequent policy changes and subsequent restructuring of NHS that started in the 1970s (Klein, 2018).

The key structural reforms included the restructuring of the NHS in 1974 and the resultant cost implications (Rivett, 1998; Sturgeon, 2013); the introduction of managerialism in 1974; the introduction of the internal market and competition in the 1990s and the reassertion of the role of the state in managing finances and regulating quality in the 2000s (Frisina Doetter & Götze, 2011, p. 492). The narrative surrounding the reasoning for the initial stability and the subsequent instability varied. For some, the changes were due to the movement towards a market-orientated health service, whilst for others, it was the consequence of increased consumerism, increased demand, and increased patient choice. Whatever narrative was chosen, the ‘Thatcher era’ was named by most writers as the turning point (Gorsky, 2008; Mould, White & Gallagher, 2011.

2.3 THE CONSERVATIVE GOVERNMENT (1979-1996)

> *The NHS is so structured as to resemble a mobile, designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction (Griffiths, 1983 cited in Gorsky, 2013, p. 89).*

The election of the Conservative Government in 1979 signalled the changeover from the existing political discourse of consensus and bargaining to one of managerialism and market-type competition. The consultation document *Patients First* (Rivett, 1998; Sturgeon, 2013) contained their NHS plans. This document reiterated their commitment to devolve responsibility for healthcare delivery from Whitehall to patients and the public. Their vision was to reduce bureaucracy by encouraging the public to control their health and become independent of the state.

During the 1983 election, accusations about the NHS's privatisation abounded, and despite the Thatcher government's reassurances, spending cuts and job losses followed their election victory, leading to industrial action (Rivett, 1998). In response, Sir Roy Griffiths (1926-1994) was asked to review the NHS's management. The subsequent Griffiths Report published in October 1983 highlighted the areas of concern. These included the shortages of general managers, the lack of measurement for improvement, and the dilemma of decentralising services whilst *"retaining political accountability" (Gorsky, 2013, p87).* The report also highlighted the importance of involving staff, patients, and the public in decision-making (Gorsky, 2013, p. 87). Additionally, the report also linked effective management with customer satisfaction, thus foretelling the vital role service users' views of healthcare services would play in the NHS's future discourse (Gorsky, 2013; Klein, 2010). Sir Griffiths also warned that failure to change the consensus model the NHS was founded on would ensure that the institutional stalemate remained, a view that was also supported by Klein (2010).

The government implemented the recommendations made by the report whilst remaining focused on cutting public expenditure. A leaked paper by the Central Policy Review Staff suggested replacing the NHS with a private insurance scheme to reduce costs, increased criticism from the British public and NHS staff (Rivett, 1998). To allay the fears about the NHS's privatisation, the party reiterated their support to the NHS's foundational values in the White Paper: *Working for Patients* (DH, 1989). The paper highlighted how problems with long waiting lists, bed shortages and insufficient staffing levels impacted the quality of care delivered in the NHS. According to the paper, focussing on offering patients more choices regarding where to receive their treatments or surgeries and increasing staffing levels will address some issues.

Furthermore, the paper set out the planned reforms, which included creating the internal market, allowing GPs to become fund-holders and introduced the new GP contract. Additionally, it introduced formal auditing procedures to assess whether services rendered were of high quality and value for money (Frisina Doetter & Götze, 2011; Ham, 2009). The reforms were initiated with the launch of the *NHS and Community Care Act 1990* (DH, 1990), which introduced the internal market, measurements and increased regulations, all aimed at increasing competition, efficiency and responsiveness (DH, 1990; Frisina Doetter & Götze, 2011). However, the sense of public dissatisfaction continued to increase.

To sway public opinion, the Conservative Government reaffirmed their commitment to delivering high-quality services and set out their aspirational vision for NHS patients in *The Patient's Charter* (DH, 1991; Goodrich & Cornwall, 2008). Despite criticism that the charter was vague about how it would be implemented in practice, a report on the charter by the Public Service Committee (1997) concluded that the initiative made *"a valuable contribution to improving public services"* (para 92). The charter's publication introduced the emphasis on a patient-centred NHS by the government.

Paradoxically, to defend decisions made regarding the NHS during their time in office, they continued to champion their principles of equity, efficiency, and responsiveness in the White Paper: *The National Health Service: A service with ambitions*. The paper cautioned that *"ambitious plans take time and resources to achieve, and difficult choices - about service and patient priorities - sometimes have to be made"* (DH, 1996, p. 29).

The key themes from this period that influenced people's experiences and affected their perceptions regarding the longevity of services were developing patient-centred services, developing guidelines for best practice, and setting targets for reductions in mortality rates for key conditions like cancer. Notably, these themes laid the groundwork for the policies on NHS reform for the incoming Labour Party and are still evident in the current NHS. The concept of 'improving patients experiences' also started to appear in policy documents during this period.

2.4 NEW LABOUR (1997-2009)

In 1997, the New Labour Government came into power, and despite initial reassurances that there would be no further restructuring of the NHS, they introduced a raft of reforms through a series of White Papers and policy documents. They reasserted their commitment to the NHS's founding principles in the White Paper: *The New NHS: Modern, dependable* (DH, 1997; Klein, 1998). However, simultaneously set the wheels in motion for the most extensive restructuring plans in the NHS's history.

The dominant rhetoric in the paper was about cooperation and collaboration. Concurrently, relaying a vision for an NHS where the delivery of high-quality care was fundamental and in return promised increased funding and less interference from Whitehall (DH, 1997; Goodrich & Cornwall, 2008; Klein, 1998). They aimed to move the discourse away from performance measurement, consensus and general management towards good governance (Rivett, 1998). The crux of the reform agenda focused on improving patients' experiences of care and clinical outcomes.

The reforms were in response to the available research in the late 1990s that demonstrated that the UK compared unfavourably with peers regarding the mortality and survival rates, patient hospital experiences and hospital waiting times (Smee, 2005). To align UK health care with other European countries, the labour government introduced several targets. Two of these targets were critical in this study: patients being seen and treated in A&E within four hours and measuring patients' experiences in the NHS through national patients' surveys. Whilst the focus on improving the quality of care patients were receiving was welcomed, their initial efforts signalled further centralisation and more measuring, which contradicted their decentralisation claims and less number counting.

In a subsequent consultation document, *A first-class service: Quality in the new NHS* (DH, 1998), they committed to a ten-year modernisation agenda and pledged revitalisation of the NHS and improved quality of the services patients received through increased investment (Leatherman & Sutherland, 2008). Responding to the Bristol Royal Infirmary Inquiry Report (Kennedy, 2001) and reports of care variations, the government introduced a three-pronged approach. They aimed to standardise the availability and quality of services across the NHS (DH, 1999). The first part included standards-setting and performance measures which led to the introduction of NICE, established in 1998. The role of NICE was to provide clinical guidelines and approve cost-effective medicines and interventions in the NHS. Clinicians would also shape national Service Frameworks (NSFs) to set the quality standards for mental illness, cancer, and heart disease, launched in 1998.

The second part involved introducing Clinical Governance in NHS Trusts to ensure that the standards were delivered and *"underpinned by modern mechanisms of professional self-regulation and lifelong learning"* (DH, 1999, p. 3). Lastly, to ensure that NHS organisations had the systems in place for quality improvement, the Commission for Health Improvement (CHI) was established in 2001. The above changes represented the national quality strategy outlined in *First Class Service* (DH, 1998), as summarised in Figure 2.1.

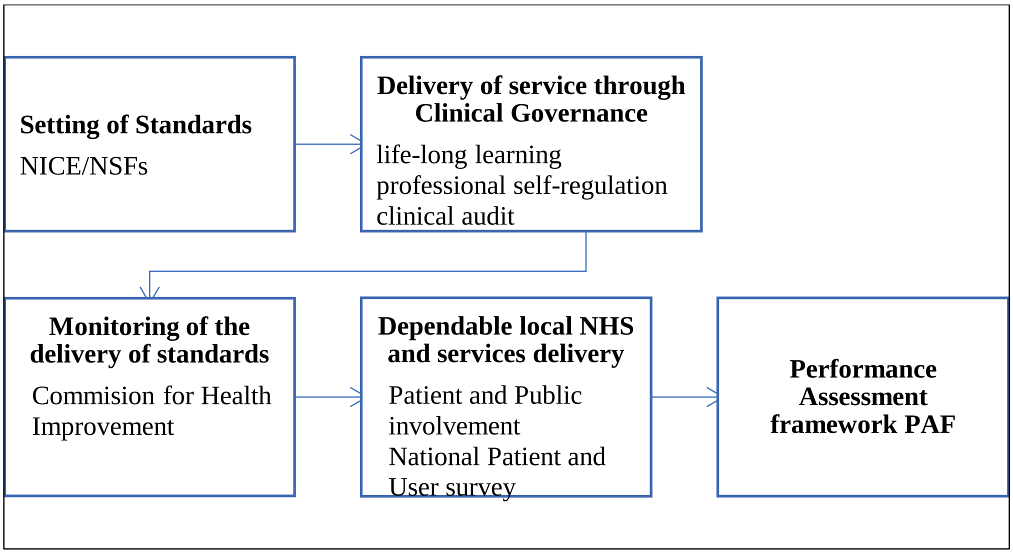


Figure 2.1 The NHS National Quality Strategy. Adapted from a First Class Service: Quality in the NHS (DH, 1998).

Furthermore, the *NHS Performance Assessment Framework* (DH, 1999) was published and contained six performance indicators, as demonstrated in Figure 2.2. Based on a concept used in the private sector, it was touted as a comprehensive performance management system that would improve NHS services, lead to better health outcomes for patients and improved accountability to the public and Parliament (DH, 1997). However, as predicted, it was viewed as another performance measurement tool that would increase NHS Trusts' accountability to Parliament rather than the patients (Ham, 2009; Klein, 2007).

The two performance indicators pertinent to this study were "*patient/carer experience … to ensure that the NHS is sensitive to individual needs*" (DH, 1999, p. 8) and "*effective delivery of appropriate healthcare to recognise that fair access to care must be effective, appropriate and timely…*" (DH, 1999, p. 8).

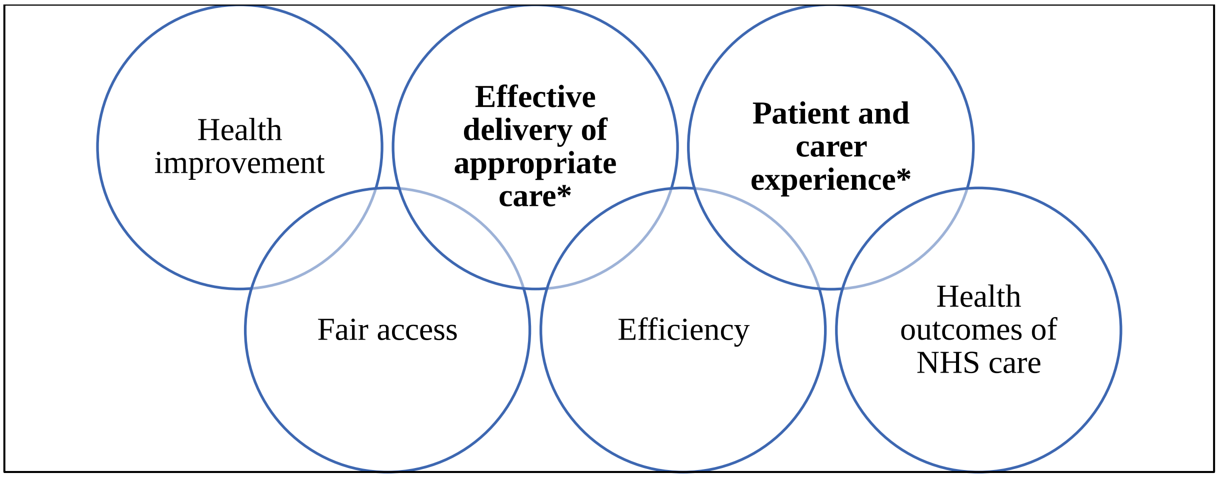


Figure 2.2 NHS Performance Assessment Framework. Adapted from: The NHS Performance Assessment Framework (DH, 1999).

To expedite and cement the efforts to modernise the NHS, *The NHS Plan: A plan for investment, a plan for reform* (DH, 2000), was published. The plan included increased funding for the NHS, increased staffing, hospital beds, and improved access to GPs with shorter waiting times (Klein, 2007; Rivett, 1998). To boost the modernisation agenda, the NHS Modernisation Agency was established in 2001. The primary purpose of this team was to support and encourage service transformation and innovation. The agency was replaced by the NHS Institute for Innovation and Improvement in 2005, which played a vital role in establishing AEC services, as discussed in chapter one.

In *Shifting the Balance of Power* (DH, 2001a), the government reiterated their commitment to transfer responsibility for budgets and services to regional NHS organisations and standardise care quality through national targets and standards. The result was abolishing district health authorities and replacing them with Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). The publication of the NHS White Paper *Delivering the NHS Plan - Next steps on investment, next steps on reform* (DH,

2002) was an effort to reinforce the message of their commitment to improving the NHS's quality of care. This paper's central message was that patients would be "*in the driving seat"* (DH, 2002, p.24), thus able to choose their preferred service provider based on the quality of the care offered.

In opposition, the Labour Party opposed introducing the internal market and declared ending it when they got elected. However, *"with the competitive genie out of the bottle, politicians experienced difficulty squeezing it back in"* (Ham, 2004, p. 51). Thus, despite their declarations to abolish the internal market, it soon became evident that their reforms continued in the same vein as their predecessors, at times even further advancing competition and the internal market (Frisina Doetter & Götze, 2011; Ham, 2014).

The movement towards competition increased with the publication of *Delivering the NHS Plan* (DH, 2002), which laid out plans to establish Foundation Trusts (an NHS organisation with more financial freedom), expand patient choice and allow PCTs the freedom to choose whom the contracted services to. The aim was to introduce greater plurality among providers whilst retaining some control over provider competition, a process which was started by the Conservatives' internal market reforms. The *Health and Social Care (Community Health and Standards) Act* (2003) legitimised the establishment of the NHS Foundation Trusts.

An independent regulator (Monitor) was introduced to monitor and approve Foundation Trusts. NHS Trusts were given a star rating with a zero leading to organisations being put under special measures. Hospitals with three stars could apply to become independent

Foundation Trusts (Stevens, 2004). One of the ratings assessed the quality of services against the government's core standards and national targets.

However, despite the above-mentioned increased focus on service improvement, a report by CHI on patients' experiences of using health services highlighted the variations in the quality of care, especially for *"…those patients who are very unwell or admitted to hospital on an emergency basis…"* (CHI, 2004, p. 5). The report stressed the national public service agreement (PSA) target concerning patient experience contained in the NHS Plan (2000), which required the government to: "*secure sustained national improvements in patient experience as measured by independently validated surveys"* (CHI, 2004, p. 7).

The NHS Improvement Plan: Putting people at the heart of public services (DH, 2004), built on the *NHS Plan* of 2000 and set out the priorities for reform between 2004 and 2008 and linked improving performance with devolution from Whitehall. In *Creating a patient-led NHS* (DH, 2005a), the government's support for practice-based commissioning was reaffirmed, mirroring GP fundholding of the 1990s, and reinforced the views held by some people that they supported the internal market of the previous government (Ham, 2009). These reforms were justified as necessary to ensure the improvement of NHS performance through decentralisation.

However, it was becoming evident that more control was needed at the periphery as an over-reliance on top-down targets and intervention by regulators and inspectors were unsustainable (Blunt, 2015; Ham, 2014). A succession of Secretaries of State echoed the message, with Frank Dobson declaring *"local doctors and nurses … will be in the driving* *seat shaping services"* (Secretary of State for Health, 1997, cited in Klein, 2018, p. 5). This message was followed by Alan Milburn's reaffirmation that *"... power needs to be devolved to locally run services"* (Secretary of State for Health, 2002, cited in Klein, 2018, p. 5), both echoing Ken Clarke's 1989 message.

Their messages were echoed in *Health Reform in England: Update and next steps (2005b),* which called for a patient-led NHS if a balance of incentives, patient choice, plurality, and transparency were to be achieved. The controversial decision to continue the movement of care from the hospital into the community, with an accompanying transfer of resources, was proposed in the White Paper: *Our health, our care, our say* (DH, 2006). The aim was to increase choice, improve community services and provide more support for people with long-term conditions through practice-based commissioning (Rivett, 1998). Therefore, there was a call for the delivery of more home-based care, the development of a joint health and well-being board and the encouragement of innovation in services and delivering high-quality services through incentives. In practice, as discussed in chapter one, it led to the closure of rehabilitation and long-term wards and was opposed by patients, carers, and health care professionals and was far removed from the promised patient-led services.

As the government continued their drive to embed the delivery of patient-centred care in all NHS services, assessors of the service agreed that whilst the quality of patients' experiences was improving; there were still areas of deficit that needed addressing (DH, 2008a; Healthcare Commission, 2006; Picker Institute, 2005, 2008). In his 2007 review of health services in England, Lord Darzi emphasised the importance of the NHS's personalisation to ensure that the development of services is led by patients and frontline staff (DH, 2008a). He called for the replacement of centrally led and target driven services with "*locally-led, patient-centred and clinically driven*" (DH, 2008a, p. 17). In response, the government published the *NHS Constitution* in 2009 and established the CQC in the same year. The NHS Constitution (DH, 2009) outlined the rights and responsibilities of NHS staff and patients, whilst the CQC's responsibilities included inspection of NHS services, addressing poor performance and assuring quality standards were consistent.

During this period, the main policy changes linked to experiences and the durability of transformation efforts were built on the previous government's policies and continued in a similar vein. There was a renewed commitment to improving patient’s experience and improving clinical outcomes, and this led to extensive reforms, which contributed to the perceptions that the NHS environment was unstable. Thus, due to the speed of changes, service transformation efforts were short-lived. During this period, the concepts of patient-centred care, improving experiences, and values-based care became firmly embedded in the NHS policy context.

2.5 THE COALITION GOVERNMENT (2010-2014)

In 2010, a new coalition government between the Conservative Party and the Liberal Democrat Party was formed and led by the Conservatives. In line with previous governments, the government declared its commitment to the NHS's founding principles while simultaneously delivering its restructuring plans for the NHS. The White Paper: *Equity and Excellence*: *Liberating the NHS* (DH, 2010a, p. 1) sets out their vision to create an NHS that was "*more accountable to patients*" and to "*free staff from excessive bureaucracy and top-down control*". The paper highlighted their commitment to increasing patient choice and control, empowering staff, and improving clinical outcomes.

As part of the commitment to improve quality of care, NICE was instructed to develop a quality standard for adult NHS services' patient experiences (NICE, 2012b). Additionally, the National Quality Board (consisting of leaders from the national regulatory organisations) published the NHS patient experience framework in 2011 (see figure 2.3) and a report on what a good experience of care entailed (DH, 2012c; National Quality Board, 2015). As figure 2.3 demonstrates, patient experience entails not only what happened to patients (objective) but how they felt about it (subjective) (Foot, 2015; National Quality Board, 2015).

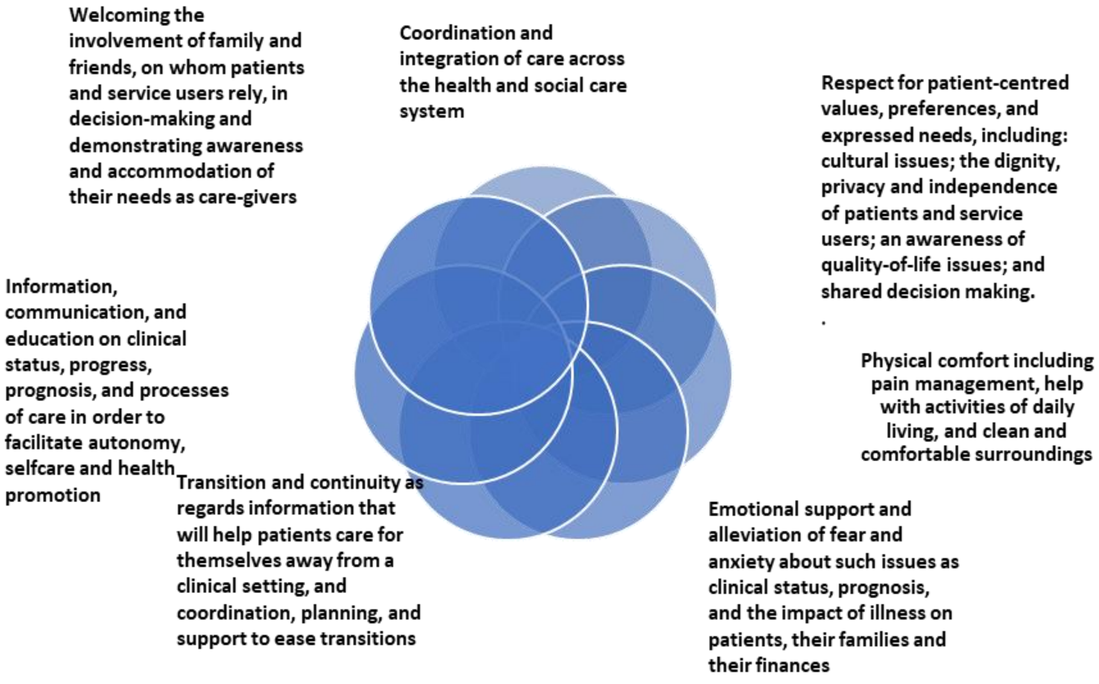


Figure 2.3 The Patient experience onion. Adapted from The National Quality Board patient experience framework (2015).

On the other hand, the White Paper also reiterated the importance of reducing the deficit and emphasised that increased competition amongst healthcare services providers can ease the NHS's financial pressure. Thus, refuelling the public's concerns about the NHS's privatisation (Black, 2013; Sturgeon, 2013) and therefore led to strong opposition to their plans. However, despite the objections, the Health and Social Care Bill was published in 2011 (House of Commons, 2011) and became an Act of Parliament in March 2012 (Dixon & Ham, 2010; Ham, Baird, Gregory, Jabal, & Alderwick, 2015). The Act codified patient experiences and the delivery of person-centred care in law.

The *Health and Social Care Act* (2012) appeared to mirror the 1988 reforms and incorporated some of the themes of the Griffiths Report of 1983. Recommendations calling for forming a new NHS management board and closer involvement of clinicians and patients in managerial decisions were included (Greer, Jarman & Azorsky, 2014). Also, an attempt was made to separate powers from Whitehall by delegating it to the NHS Commissioning Board and the economic regulator, Monitor. Thus, leading to the abolishment of PCTs and establishing GP consortia and Clinical Commissioning Groups (CCGs) to create a tier of clinical managers. Consequently, NHS England, CCGs, Monitor, and CQC became responsible for monitoring the quality of services and people's experiences.

Central to the Act was a Big Society theme, a programme that focused on aiding charities, voluntary organisations, and social enterprises to compete to offer public services. The aim was to foster active participation in society and transferring decision-making to councils and neighbourhoods. The discourses intention was to underscore the government's message that social commonality and shared responsibility were imperative to ensure continued access to collective healthcare (DH, 2010a). Using a language of inclusion, their campaign slogan '*we are all in this together'* reiterated that addressing the deficit would require sharing the responsibility for investment and cost containment.

Whilst the ongoing restructuring continued, reports of failures occurring at different NHS organisations began to surface, leading to a series of government-mandated reviews. The Winterbourne Review (DH, 2012a) contained the final report and the government's responses to events at a hospital for people with learning difficulties. The Keogh Mortality Review (Keogh, 2013) examined the quality of care and treatment provided by fourteen hospital trusts who were outliers on mortality indicators. Furthermore, care failures at the Mid Staffordshire NHS Foundation Trust (DH, 2013a; 2013b) led to a review of patient safety in the NHS. Following the Francis Report's publication, Professor Don Berwick was asked to review the report and recommendations and summarise the changes needed, which he published in *A promise to learn – A commitment to act. Improving the safety of patients in England* (DH, 2013c).

In response, the Health Secretary outlined his NHS objectives in the revised version of the *Mandate* (DH, 2012b, 2013d), highlighting the healthcare areas where the government expected the NHS Commissioning Board to improve. The *Mandate* corresponded with the *NHS Outcomes Framework*, which was developed in 2010, and contained sixty-eight indicators, grouped into five performance measuring domains. The domains focused on improved quality of life for people with long term conditions, safety, premature death prevention, and helping people recover from ill-health episodes or following injury (DH, 2011). Another focus was to facilitate care and treatment that included compassion, dignity, and respect (DH, 2013d).

The message was reiterated by NHS England in their three-year plan to measure healthcare services' performance, including an eleven-point scorecard for measuring their success of critical priorities. The scorecard emphasised hearing and acting upon feedback from patients, their families, and NHS staff. Additionally, the scorecard highlighted the five domains of the *NHS Outcomes Framework* noted above, the NHS Constitution, promoting equality and effective financial management. Thus, supporting the recommendations made by Robert Francis QC (Francis, 2013) to drive forward improvements by putting patients at the heart of the NHS. The publication of the plan was accompanied by the launch of the *NHS Friends and Family Test* (NHS England, 2013b), which asked patients whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment.

Building on this, the *NHS Five year forward view* (NHS England, 2014a) outlined the progress made since 2015 and the government's priorities for the next two years. They set out their vision for the NHS and the reasons for the ongoing drive to change the NHS, citing gaps in health, quality, and the need for financial stability. The document explained their planned focus on integrating health and social care, which included improving the urgent and emergency care system to reduce waiting time in A&E, thus improving the care patients received while strengthening GP services and primary care access.

Also, improvements in cancer services (including performance against waiting times standards) and mental health were included. Building on the previous governments' work but trying to balance efficiency, demand, and quality of care, the coalition government reiterated the centrality of the concepts of ‘improving experiences’ and ‘values-based care’ in the NHS policy context. However, at the periphery, service transformation efforts remained short-lived due to the speed of changes.

2.6 THE CONSERVATIVE GOVERNMENT (2015 to present)

After gaining power in 2015, the Conservative Government continued to build on the coalition government's work. That included updating policy documents such as the *Mandate* (DH, 2014c), the *NHS Constitution* (DH, 2015a) and the *NHS Outcomes Framework* (DH, 2015b). Improving the quality of care delivered in urgent and emergency care, primary care, cancer, mental health, dementia, learning disabilities and maternity care were highlighted as focal points in 2017 and 2018 (NHS England, 2017). As the gap between the health of the population, the quality of service and the funding of services continued to widen, NHS organisations were asked by the government to work together to create sustainability and transformation plans to deliver the *NHS Five year forward view* (NHS England, 2017, 2018).

Therefore, this period's focus appears to be on integrating services and working across the primary-secondary care interface. This government's communication echoed previous governments' sentiments and commitment about the NHS and service delivery. They reinforced a focus on delivering high-quality care against the five domains of the Outcomes Framework, upholding patients' rights as displayed in the NHS Constitution, improving public engagement and ensuring equality of care (NHS England, 2015).

However, no robust evaluation of services working in this way has yet been published. Furthermore, the Health and Social Care Committee requested that the explanations regarding integrated care be more precise as currently "*The language of integrated care* *is like acronym soup: full of jargon, unintelligible acronyms and poorly explained"* (House of Commons, 2018, p. 25). Whilst the public remains relatively satisfied with the quality of care delivered in the NHS, access has worsened, and concerns remain regarding variations in the quality of care delivered (CQC, 2017). In a report on NHS healthcare services, Lord Darzi warned: "*there is increasing evidence that we are reaching a tipping point with the drivers of improvement coming up short, given the pressures on the system"*. (Darzi, 2018, p. 5). Figure 2.4 contains a summary of the policy drivers that propelled the embedding of the concepts of 'improving experiences' and 'values-based care' in the NHS policy context.

1990-1997
- DH, (1989) *Working for Patients.*
- DH (1991). *The Patient's Charter: Raising the standard.*
- DH (1997). *The New NHS: Modern Dependable*. Cm 3807.

1998-1999
- DH (1998). *A First Class Service: Quality in the new NHS.*
- DH (1999). *The NHS Performance Assessment Framework*

2000
- DH (2000). *The NHS Plan: A plan for investment, a plan for reform*.

2001
- DH (2001a). *Shifting the Balance of Power.*
  Kennedy (2001). Learning from Bristol: *The Report of the Public Inquiry at the Bristol Royal Infirmary.*
- .

2003-2005
- *Health and Social Care Act (2003).*
  CHI (2004). *Unpacking the patients' perspective: variations in NHS patient experience in England.*
- DH (2005). *Creating a Patient-led NHS: Delivering the NHS plan*

2006
- DH (2006). *Our Health, Our Care, Our Say.*
- NHS Act 2006 (c41).
- Healthcare Commission (2006). *Variations in the Experiences of Patients Surveys of Patients.*

2007
- DH (2007a). *The NHS in England: The operating framework for 2008/09.*
- DH (2007b). *What Matters*
- RCP (2007). *The Right Person, in the Right Setting*

2008a
- *Health and Social Care Act 2008*
- DH (2008a). *High Quality Care for All.*
- *Picker Institute (2008)*
- DH (2008b). *Real Involvement:*

2008-2009
- NHS Confederation (2008). *Compassion in Healthcare*
- DH (2009*) The NHS Constitution*

2010-2012
- DH (2010). *Equity and Excellence: Liberating the NHS*
- DH (2012c). *The NHS Patient Experience Framework*

2012
- *Health and Social Care Act (2012)*
- NICE (2012b). *Patient experiences in NHS services*
- DH (2012a). *Transforming care: a national response to Winterbourne View Hospital*

2013
- DH (2013a). *Patients First and Foremost: The initial government response to the report of the Mid Staffordshire Trust public inquiry*
- DH. (2013b). *Hard Truths: The journey to putting patients first*.

2013b
- NHS England (2013c). *A promise to learn. A commitment to act.*
- *DH (2013d). The Mandate (updated)*

2014
- NHS England (2014a) *Five year forward view.*
- NHS England (2014c). *Statistical bulletin: overall patient experience scores. 2013 adult inpatient survey update.*

2015
- NHS England (2015). *A toolkit to support NHS commissioners to reduce poor experience of in-patient care. NHS England.*
- CQC (2015). *National results from the 2014 Inpatient Survey*

2015
- DH (2015) *NHS outcome framework 2015/2016*
- National Qality Board *(2015). Improving experiences of care: Our shared understanding and ambition.*

Figure 2.4 Patient experience policy drivers

2.7 SUMMARY

> *The NHS stands on a burning platform - the model of acute care that worked well when the NHS was established, is no longer capable of delivering the care that today's population needs… Prof Sir Mike Richards (CQC, 2017, p. 4).*

The review of the NHS's history demonstrated that improving patients' experiences has remained a focal point for politicians. However, to what extent it is a survival technique remains unclear. Situating the NHS in the historical context had enabled me to trace when the concepts of ‘improving experiences’ and ‘values-based care’ became embedded in the NHS policy context, as summarised in Figure 2.4. The review also highlighted the recurrent, consecutive reorganisation and restructuring, which propagated inconsistencies and led to a series of 'failed' initiatives. Thus, resulting in a health service overloaded and in turmoil with staff displaying signs of change 'fatigue' which often leads to either passive or active resistance to change efforts (Ham, 2014; Klein, 2013). Furthermore, the culture of compliance due to fear or inertia and the lack of stability have also negatively impacted service delivery and patient care, as evident in recent high-profile cases (Berwick, 2013; Francis, 2013).

The review also explained the frustrations expressed by some frontline staff at the circular nature of change efforts as the repetitive nature of the reforms illustrated that *"…institutional memories in the public sector can be very short*" (Smee, 2005, p.88). Furthermore, it highlighted three key issues which were critical to understanding the difficulties experienced when introducing new services and why change efforts sometimes failed. Firstly, an essential aspect of developing new services is research and evaluating them; otherwise, any deliberations about the appropriateness and the successes or failures of these services will be futile (Smee, 2005). As far back as 1993, DH officials called for the monitoring and evaluating of NHS services to identify any facilitators and barriers. However, the rate and frequency at which restructuring occurs makes embedding and measuring the impact of these services very difficult.

Secondly, the various roles and the power imbalances between the different role players can lead to active and passive resistance to change efforts. Lastly, the review highlighted that switching from a centrally led and provider-focussed NHS to one that is informed by patients and NHS staff has been the mantra for more than thirty years. A mantra steeped in conversations about engagement, sharing information, offering choice and involvement in designing and delivering services. Nevertheless, these conversations rarely involve patients, carers, and frontline staff. Thus whilst some progress has been made, it has been prolonged and inconsistent, leading to ongoing expressions of dissatisfaction with services. In the next chapter, the literature associated with patients, carers, and NHS staff experiences of care in the emergency and acute care environment will be critically reviewed to identify the gap this study was trying to address.

CHAPTER THREE LITERATURE REVIEW

3.1 INTRODUCTION

The previous chapter addressed the broader health system and traced the origins of the focus on improving patient’ experience through a timeline of the NHS's history. The chapter concluded with a summary table of the policy drivers for improving the care experiences of patients. This chapter explored the literature on patients, carers, and staff in the acute and emergency care sector. Despite my attempts to keep the policy literature separate (chapter 2), a small element is included in this chapter to support the literature review's contextual situating.

The chapter is divided into four sections focussing on the search strategy, definitions, discussion of the key papers and the emerging themes. The literature search strategy is outlined in section one and includes a description of how studies were selected and critiqued. Section two clarifies the definitions of urgent and emergency care, quality, care experiences, and person-centred care.

Section three focuses on the three research papers regarding AEC, highlighting the issues that impacted care experiences. In section four, the themes extracted from the literature review pertinent to this study are explored and critiqued. The themes consist of the relational aspect of care experiences, the impact of culture, difficulties in setting up new services and why experiences are measured. The summary provides an overview of the discussion of experiences and highlights the gap in knowledge this study aimed to address.

SECTION ONE SEARCH STRATEGY AND RESULTS

3.2 LITERATURE SEARCH STRATEGY

The search strategy started with developing the search terms in table 3.1 and was further elaborated by scanning the literature, looking at keywords, and subject headings when the initial searches turned up a few relevant papers. The search was narrowed or expanded using Boolean operators (AND, OR, NOT) and truncation (*) and filters or limiters to refine results. The NHS Trust librarian was of great help during this phase, helping me narrow down the results as at one stage, unmanageable amounts of inappropriate articles were retrieved.

CATEGORY	SEARCH TERM
Population 1	patients/service users/patron/participant/consumer/customer
Population 2	carers/informal carers/companions/relatives/family/families/family member/close friends
Population 3	health professional/healthcare professional/caregiver/primary care provider/health personnel/healthcare worker/multidisciplinary care team
Intervention 1	ambulatory care/ medical day care/ambulatory emergency care/admission avoidance scheme/subacute care/surgical day care/day surgery/ambulatory surgery/ambulatory day care/outpatient
Intervention 2 (alternative for comparison)	medical admissions unit/medical assessment unit/ accident and emergency department/emergency department/emergency services/ casualty/emergency room
Outcome	experience/views/feelings/perceptions/perspectives/beliefs /attitude/opinion
Study design	Qualitative research/mixed methods design/action research/case studies

Table 3. 1 Search Terms

A systematic computerised search was carried out and included the following health databases: Allied and Complementary Medicine (AMED); Applied Social Sciences Index & Abstracts (ASSIA); The Cumulative Index of Nursing and Allied Health Literature (CINAHL); British Nursing Index (BNI); EMBASE; Health Management Information Consortium (HMIC); Health Business Elite; MEDLINE and PsycINFO. The PICO search strategy tool (Richardson, Wilson, Nishikawa & Hayward, 1995) was used to facilitate the literature search. PICO stands for *Patient problem, Intervention, Comparison, and Outcome,* and as a comparison was inappropriate in this study, *Intervention* was used twice. The search strategy was done separately for patients, carers, and healthcare professionals (see Appendix 5).

The search also included the Cochrane library and DARE, HTA, and NHSEED databases of the NHS Centre for Reviews and Dissemination (CRD). Furthermore, the University of Salford thesis repository (USIR), the British Library E-Theses Online Service (EThOS), Networked Digital Library of Theses and Dissertations (NDLTD), Google and Google Scholar were searched for electronic theses and dissertations relevant to the topic. This approach was supplemented by hand searching key journals, reference list checking and citation tracking. Grey literature, including publications from the DH, NICE, the Picker Institute, the King's Fund, the Care Quality Commission, the Institute of Medicine, and the Institute for Healthcare Improvement, was also searched. Also, articles were sent to me by my supervisors, colleagues, and critical friends.

3.2.1 Selection of studies

3.2.1.1 Inclusion and exclusion criteria

As there were no published studies on the experiences of patients, carers or NHS staff available, I made the conscious decision to initially 'cast the net wide and read everything', and over the years, I altered what was included and excluded. No time limit was applied due to the infancy of AEC's concept, and studies looking at both adult and paediatric (children) services were included. The decision to include paediatric services was because the setting was appropriate as it shared similar features. Also, this study was investigating the experiences of three populations and whilst children were excluded, the experiences of parents (carers) and NHS staff were deemed appropriate to include.

As AEC formed part of the urgent and emergency care pathway, as discussed below, the literature review included studies of emergency departments, out-of-hours, and urgent care services. Additionally, the review included studies on patients', carers, and staff experiences on short-stay surgical units as AEC mirrored the concept of elective day surgery (Quemby & Stocker, 2013; RCP, 2014). In all these settings, the patients were seen and treated without the need for overnight admissions, referral criteria were in place, and the focus was on improving delivering person-centred care and improving experiences; thus, the findings were transferable. Table 3.2 sets out the relevant inclusion and exclusion criteria.

Factors	**Inclusion**	**Exclusion criteria**
Time	Any	None
Phenomenon of interests	Studies concerned with patients, carers and/or staff experiences	Studies not concerned with identified phenomenon of interest.
Population	Adult patients, carers (formal or informal and staff)	Children
Settings	Acute care settings	Not acute care settings
Availability of resources	Full text	Full text not available.
Language	Written in English	Other languages as I had no access to translators
Geographical location	Any country	

Table 3. 2 Inclusion and exclusion criteria

3.2.2 Search results

The initial searches generated two thousand five hundred and fifty potential articles. Following an initial scan of titles and abstracts and the removal of duplicates, three hundred articles were screened by applying the inclusion and exclusion criteria as per table 3.3, and a further two hundred papers were excluded. The remaining one hundred articles were read and screened for eligibility. Sixty of those papers were included in the literature review as per figure 3.1. The literature reviewed reflected various research designs and methodologies, so the overview of the papers presented here represents a combination of qualitative and quantitative research studies. Only two studies and a literature review about the experiences of carers and NHS staff in AEC settings were identified, and all three were related to paediatric services. A synthesis table of the studies included in this review is included in Appendix 6.

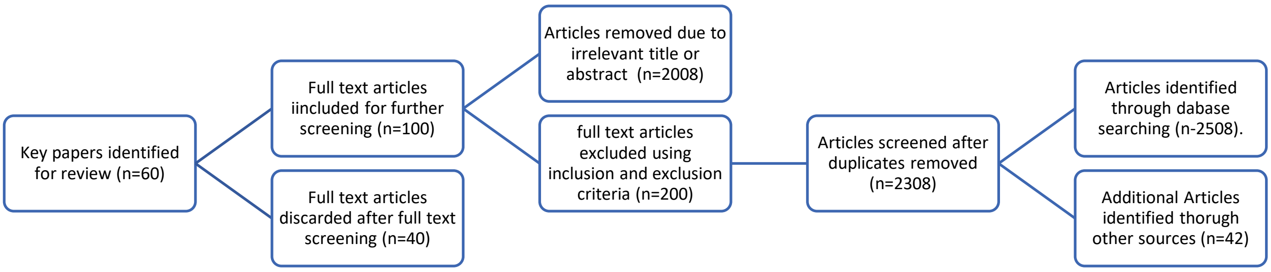


Figure 3.1 PRISMA Flow diagram: Adapted from Preferred Reporting Items for Systematic Reviews and Meta-Analyses, PRISMA Flowchart (Moher, Liberate, Tetzlaff, & Altman 2009).

3.3.3 Appraisal and data extraction

All selected papers were critiqued using a Critical Appraisal Skills Programme [CASP] (2018) qualitative checklist tool as guidance. The CASP tool is defined as "…*a generic tool for appraising the strengths and limitations of any qualitative research methodology*" and is widely used to appraise the quality of health-related qualitative evidence and has been endorsed by the Cochrane Qualitative and Implementation Methods Group (Long, French & Brooks, 2020, p. 33). The tool has ten questions that focus on qualitative studies' methodological aspects (see table 3.3).

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Table 3. 3 The ten questions of the CASP qualitative checklist tool

Using the CASP tool helped me reach a more informed judgment on the chosen papers' strengths, limitations, and ethics. Critical appraisal tools are often used to decide whether to include or exclude a study and are often used to exclude results deemed to be of lower quality (Hannes & Macaitis, 2012). However, the danger in using it as an inclusion or exclusion tool is that valuable insights may be excluded from the synthesis. As Dixon-Woods, Booth & Sutton (2007) points out, studies deemed “low quality” due to methodological flaws or poor reporting may still offer new insights (grounded in the data). On the other hand, methodological sound studies may not give you the required insight into the phenomenon due to an inadequate interpretation of the data. Their advice was pertinent in this study due to the scarcity of information on patients, carers, and NHS staff’s AEC experiences.

Thus, all papers were assessed based on whether they contributed to understanding patients, carers and staff’s experiences (Aveyard, 2007; Thomas & Harden, 2008). None of the studies was excluded. The literature search and critique were an iterative and recursive process throughout the study. The literature review highlighted the importance of clarifying definitions used from the onset. The following section clarifies the definition of urgent and emergency care and is followed by the key definitions about experiences.

SECTION TWO DEFINITIONS

3.3 DEFINING URGENT AND EMERGENCY CARE

The urgent and emergency care spectrum has changed over the last few years as the population's demands and needs are continually changing. In an effort to demonstrate responsiveness, successive governments introduced new urgent care providers and altered existing services. Consequently, the NHS urgent health care arena expanded to include a range of services (GPs, out-of-hours, walk-in centres, urgent care centres, minor injuries units and NHS 111 (a national telephone helpline for out of hours urgent care). The purpose of urgent care services was

> *…to assess and manage unscheduled or unforeseen conditions that arise in the out-of-hours period, providing care for people with pressing health-care needs which cannot wait until primary care services are available" (Pope et al., 2019, p. 436).*

Policymakers envisioned that most peoples' illness could be self-managed or managed by urgent care providers such as GPs, out-of-hours, urgent care centres, community nurses or pharmacists. The people with more severe or life-threatening conditions would then have access to the hospitals' specialist services and emergency departments. The urgent care services' locations vary, and sometimes they are co-located with GP surgeries, A&E departments, and pharmacies. Thus, urgent care's aims to improve patients' experiences by offering them improved access to the appropriate services and giving them more choice whilst simultaneously diverting people away from overburdened A&E departments (Pope et al., 2019; Tan & Mays, 2014).

However, the urgent and emergency services' multifarious nature led to confusion and uncertainty amongst both the users and the providers. As an ANP working in one of these services and as a user, I am aware that access to these services can be problematic and can cause duplication, long waits, delays, and frustrations, as the patient's pathway below illustrate. The research findings supported these issues with duplication and waiting times (Knowles et al., 2012). However, some studies found that despite the reported issues, many people were satisfied with the services (Foley et al., 2017).

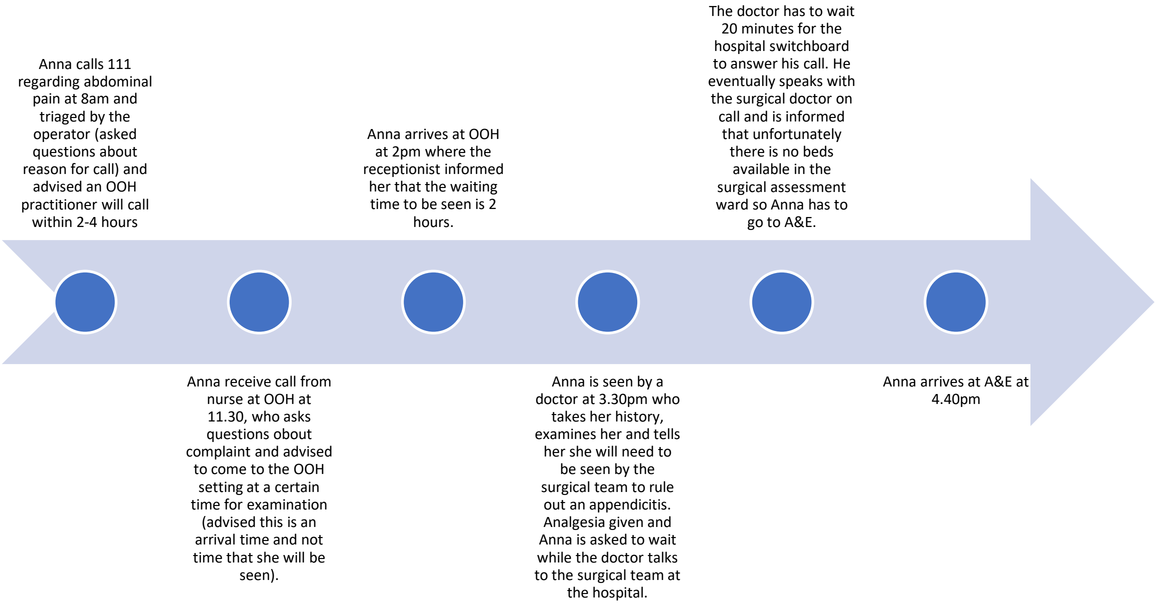


Figure 3. 2 An example of a patient navigating the urgent and emergency care system

Another concern was that the definition of urgent and emergency care remained unclear, despite being modified several times by the DH to keep up with policy changes. Therefore, users of emergency and urgent care services, such as patients, carers, NHS staff and commissioners, continued to use the terms ‘urgent’ ‘emergency’, ‘unscheduled’ or ‘unplanned’ care interchangeably, which mirrored the interchangeable usage of the services by people (Manley et al., 2014; O’Cathain et al., 2008). To clarify the meaning of urgent care, the DH defined it as

> *the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need’ (DH cited in RCGP, 2010).*

Hence, urgent care became the umbrella term for unscheduled care, unplanned care and emergency care, encompassing all NHS services across primary and secondary care

(Bridges, 2008). However, the definition appeared to explain and defend the DH's vision of the services and instead of clarity, it brought more confusion for patients, carers and NHS staff (Manley et al., 2014). To simplify the definition, the Academy of Medical Royal Colleges (AMRC) separated urgent and emergency care definitions:

> *Urgent Care [refers to] …the assessment and management of common problems where the patient thinks there is a moderate degree of urgency.*
>
> *Emergency Care [refers to] …the assessment and management of illness and injury where the patient or the clinician thinks there is a need for immediate assessment and care of their problem (AMRC 2007, cited in Manley et al. 2014, p. 17).*

In 2011, the DH revised the definition for urgent and emergency care again and stated, "*Urgent and emergency care is the range of healthcare services available to those who need medical advice, diagnosis, and treatment quickly and unexpectedly*" (DH, 2011, cited in Manley et al., 2014, p.18). However, the subjective nature of 'quickly and unexpectedly' meant service users turned up at any of the services in the hope to be seen quickly as everyone deemed their problems as 'urgent', potentially increasing demand (Knowles et al. 2012; Tan & Mays, 2014). Hence a significant proportion of patients presented to A&E departments which should have been seen elsewhere.

Another point of controversy already raised in chapter one concerning the increase in acute medical admissions is whether the increases were due to 'appropriate' or 'inappropriate' admissions. This study does not support the 'appropriate/inappropriate patient' narrative but rather supports the narrative that the question of appropriateness/inappropriateness should relate to the clinical setting and cannot be generalised. Thus, the question should be, "Would a more *appropriate clinical setting* have avoided *this* admission for *this* patient?" Furthermore, the increase in admissions reflected the confusion and ‘information overload’ caused by the recurrent reorganisations (Bridges, 2008; O’Cathain et al., 2008; Pope et al., 2019), thus leading to both providers and users falling back on what they know best, the A&E department.

3.4 KEY DEFINITIONS OF EXPERIENCE

Any discussion regarding experiences needs to start with acknowledging that the concept ‘experiences’ is complex, multifactorial, and can sometimes appear vague (Wolf, Niederhauser, Marshburn & La Vela, 2014). So, in this section, the definition of experience used for this study is clarified. Additionally, as experience is a central pillar of quality and linked with patient-centred or person-centred care (Wellstood, Wilson & Eyles, 2005), these terms are discussed as well.

The definition of quality in this study referred to the Institute of Medicine (2001) and Lord Darzi (DH, 2008), which viewed quality as having three strands: patient safety, clinical effectiveness, and the importance of a positive experience. This definition centred the relational aspect of care and allowed room for safety and efficiency (Doyle, Lennox, & Bell, 2013; Murrells, Robert, Adams, Morrow, & Maben, 2013; NICE, 2012b). Thus, when patients and carers perceived their experiences to be good, they viewed the quality of care as good and vice versa (Wellstood et al., 2005).

The concept of experience is also often used interchangeably with satisfaction; however, the terms are separated for this study. According to the literature, satisfaction refers to a response (emotional or cognitive) that is related to a particular focus (experience, expectation or product) and determined at a particular time (retrospective or accumulative) (Olthuis et al., 2014). Thus, satisfaction refers to “*when the patient’s* *expectations for treatment and care are met or exceeded*" (Trout, Magnusson & Hedges, 2000, p. 695). On the other hand, for this study's purpose, experiences refer to those individual and collective "*occurrences and events"* that shaped patients, carers, and NHS staff' perceptions of their AEC experiences (Goodrich & Cornwall, 2008; Wolf et al., 2014, p. 7). Hence, from a constructionist perspective, patients, carers, and healthcare workers' experiences are constructions of actions, events, and occurrences based on their interpretations.

The concepts 'patient-centred' and 'person-centred' are used interchangeably in the literature. Person-centred approaches focus on the person as a whole and consider family situations, social circumstances, lifestyle, emotional, spiritual needs, values, strengths, and weaknesses (DH, 2010; Gill, 2013; Harkness, 2005; Lutz & Bowers, 2000). The approach recognises the patient and their carer as 'experts' in their condition.

In 2001, the Institute of Medicine included patient-centredness as one of its six aims of health care quality, and it was defined as the delivery of "*care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions"* (Institute of Medicine, 2001, p.3). This definition of patient-centred care focussed on the patient, whilst the definition of person-centredness by McCormack and McCance (2010) embrace the holistic and empowering ethos and includes patients, carers, and healthcare staff

> *An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development. (p 13)*

The term patient-centred care was gradually replaced by person-centred care, which is now recognised by the World Health Organisation (WHO) (2007) and is internationally accepted. Over the following decade, the ideas of person-centeredness started to feature in UK health policy, started with the call for personalisation and care coordination in *the NHS Plan* (DH, 2000). Following on, the *Wanless report* (2002) concentrated on enablement and empowerment, with patients as partners in care.

In 2008, Lord Darzi’s report *High quality care for all* reiterated the importance of involving patients, carer and NHS staff in service development and involving patients in decisions about their care. In England, the NHS constitution (DH, 2009) has person-centred care as one of its seven core principles. This philosophy is also built into National Service Frameworks, monitoring requirements and legislation in all four UK countries (Redding & Hutchinson, 2017; The Health Foundation, 2016). The change in the discourse signalled a move away from the traditional medical model towards a more holistic and empowering one.

The knowledge base of the central role that the delivery of person-centred care plays in improving experiences for patients and carers have expanded over recent years (Colling, 2014; Coulter & Ellis, 2006; Coulter, Fitzpatrick & Cornwall, 2009; de Silva, 2014; McMillan et al., 2013; Mead & Bower, 2002; Murrells et al., 2013; Redding & Hutchinson, 2017; Robert et al., 2013; Shaller, 2006; The King’s Fund, 2012). The literature highlighted the value patients and carers placed on person-centred and individualised care (Bolster & Manais, 2010; Lutz & Bowers, 2000; Mead & Bower, 2002; Picker Institute, 2008). Two of the key themes that influenced patients and carers' perceptions of the delivery of person-centred care (and their experiences) were interpersonal interactions with staff and organisational culture (Petry et al., 2018; Wolf, Ekman, & Dellenborg, 2012).

As the definition by McCormack & McCance indicates, delivering person-centred care benefits healthcare professionals as well. The reported benefits included increased job satisfaction, increased morale, reduced the potential for emotional exhaustion and ‘burn out’ and increase the sense of satisfaction for staff (Attree, 2001; Black, 2004; Lewin, Skea, Entwistle, Zwarenstein & Dick, 2001; Nolan et al., 2004; The King’s Fund, 2012; van den Pol-Grevelink, Jukema & Smits, 2012). The identified barriers to person-centred care were negative experiences with waiting times, inadequate staff-patient interactions, poor communication, and inconsistent information sharing (Bolster & Manais, 2010; Gordon, Sheppard & Anif, 2010; Harkness, 2005; Wellstood et al., 2005).

The development and sustaining of a person-centred culture is influenced by contextual factors such as the setting's culture (ward/unit and organisational) and the learning culture (McCormack, Dewing & McCance, 2011. Therefore, for organisations to reap the benefits of person-centred care required fundamental changes to how services are delivered and the roles patients, carers and health care workers played in their relationships. These changes can only occur if patient-centred care is adopted as the new norm and becomes a part of ‘business as usual’ (Redding & Hutchinson, 2017. However, in a study for National Voices, Redding and Hutchinson (2017) pointed out that despite the policy focus on person-centred care and experiences, studies measuring person-centred care remains lacking, and people’s experiences continue to be varied.

SECTION THREE A REVIEW OF THREE PAPERS

3.5 REVIEW OF STUDIES RELATED TO AEC SPECIFICALLY

Only three papers were extracted from the literature review that pertained to the experiences of carers and NHS staff, and all three were related to paediatric AEC services. The rationale for reviewing these three papers was that despite the patient population differing from the study's patient population, the carers and NHS staff shared similar characteristics. Furthermore, the studies were relevant as they focussed on the impact of the introduction of alternatives to inpatient admissions (on readmissions, cost reduction and satisfaction). Additionally, they highlighted the factors that influenced the introduction of these services (from the GPs point of view) and the service's impact on carers and staff.

Due to the lack of information about AEC's impact on patients, carers, and staff's experiences, the studies offered insight into carers and staff's experiences. Furthermore, the papers highlighted the data collection methods used (interviews, surveys and observations) and gave me a starting point for considering the appropriate measurement of satisfaction tools/ instruments to use in the study. I worked a few shifts on the paediatric AEC unit at the Trust this study was completed in, and the set-up of the units, the day-to-day activities and the referral process correlated, so I was comfortable that the information from the three studies was transferable.

3.5.1 PAPER ONE

In a systematic review of the literature on the impact of introducing hospital-based alternatives to acute pediatric admissions, Ogilvie (2005) concluded that acute paediatric day-assessment services are a safe, efficient, and acceptable alternative to inpatient admission, however, observed that most of the evidence was of limited quantity and quality. The reviewer stated that further research was required to confirm that this type of service reorganisation does not disadvantage children and their families, particularly where inpatient services are withdrawn from a hospital. The primary outcome measures were admission or discharge, unscheduled returns to hospital, parents and general practitioners' satisfaction, effects on health service activity, and costs.

The review found that several studies were of uncertain quality or were open to significant potential bias. About forty per cent of children attending acute assessment units in pediatric departments, and over sixty per cent of those attending acute assessment units in A&E departments, do not require inpatient admission. There is little evidence of serious clinical consequences in children discharged from these units, although up to seven per cent may subsequently return to the hospital. There is some evidence that carers were satisfied with these services and that they contributed to the reductions in inpatient activity levels and certain hospital costs. This review concluded that evidence about the impact of urgent outpatient clinics is minimal.

3.5.2 PAPER TWO

The study by Williams et al. (2008) reviewed the setting up of a paediatric rapid access outpatient clinic from the perspectives of the GPs who refer to the service. They interviewed fourteen participants from three GP practices through group interviews. Four topic areas were covered in the interviews: understanding the services, personal experiences, what the interviewees valued about the services and ideas for future development. The identified benefits of the service were: good telephone access, observation, access to specialist opinion, diagnostic tests and location.

The study highlighted issues with unclear referral criteria, time restrictions as referrals were not accepted after 4 pm and confusion between referring to the unit or the admission ward. Issues with communication and sharing of information limited GPs understanding of the unit and the available services offered. This also impacted safety concerns as they were unaware of the unit's facilities and the training staff received. The study also highlighted the dangers of inadequate stakeholder engagement when setting up alternative services to local inpatient units. The study concluded by reaffirming the importance of ongoing communication between primary and secondary care teams and the early engagement of primary care to ensure the unit functions effectively and remain sustainable.

3.5.3 PAPER THREE

Blair et al. (2008) studied the impact of introducing a paediatric ambulatory care unit on families and staff. Whilst the patient population was different, the study explicitly focussed on the experiences of the parents (carers) and the staff working on the unit. The data collection methods included a parent survey (n=104), patient journey mapping (n=10), staff interviews (n=10), a referrer survey (n=16), routine activity analysis, and a comparison with the A&E service (A&E parent survey: n=41). The key themes were:

access issues, waiting time, parental anxiety, information, confidence and understanding, appropriateness of clinical decisions and overall satisfaction. The study concluded that parents and staff felt the unit contributed to safe care delivery and positively impacted their experiences. Parents had no concerns over access to the unit and felt the information was shared appropriately, thus relieving their anxieties. Staff reported overall satisfaction but pointed out that the referral criteria were unclear and caused friction with GPs and A&E staff.

SECTION FOUR ANALYSIS AND SYNTHESIS OF STUDIES

3.6 REVIEW OF STUDIES' RESEARCH DESIGNS

The review included studies that were done in various countries, including the following: UK (N=20); USA (n=4); Australia (n=4); Netherlands (n=2); Ireland (n=3); Sweden (n=8); Canada (n=1); Denmark (n-1); New Zealand (n=1); Turkey (n=1); Finland (n=1); Germany (n=1) and Switzerland (n=1). Some literature and systematic reviews were also included (n=12). The empirical studies largely self-identified as belonging to the following methodical groups: qualitative studies (n=24); quantitative studies (n=12); mixed methods (n=6); grounded theory (n=2), phenomenology (n=2), ethnography (n=1) and case study (n=1). Only six studies explicitly identified a methodology (Attree, 2001; Baillie, 2009; Frank, Asp & Dahlberg, 2009; McCabe, 2004; Mottram, 2011; Olthuis et al., 2014). From the analysis of these studies, it was evident that the discussion of the research design rarely contained a clarification of the methodological foundation of the study. Limitations such as editorial space or word count could have been a contributing factor.

The data collection methods used in the studies included semi-structured interviews with patients, relatives and staff, focus groups, observations, surveys and questionnaires. Only two studies used telephone interviews (one used semi-structured interviews, and one used questionnaires).

Semi-structured interviews were used to study people's experiences of accessing emergency care (Baillie, 2009; Bolster, & Manias, 2009; Bridges & Nugus, 2009; Britton & Shaw, 1994; Carter, Kilburn, & Featherstone, 2007; Considene et al., 2010; Frank, Asp & Dahlberg, 2009; Kihlgren, Nilsson, Skovdahl, Palmblad & Wimo, 2004; Kihlgren, Nilsson, & Sørlie, 2005; Maben et al., 2012; Morphet, et al., 2015; Moss et al., 2014; Nystrom, Dahlberg & Carlsson, 2003; Nystrom, Nyden, & Petersson, 2003; O'Cathain et al., 2008; Olofsson, Carlstrom, & Back-Pettersson, 2012; Olthuis et al., 2014; Petry, Steinbrüchel-Boesch, Altherr, & Naef, 2018; Sørlie, et al., 2006; Wellstood, Wilson, & Eyles, 2005). Interviews were also used to explore patients' day surgery experiences (Majholm et al., 2012; Mottram, 2011) and paediatric AEC experiences (Blair et al., 2008).

Several studies used triangulation of data collection methods and combined semi-structured interviews with observations, focus groups and surveys (Baillie, 2009; Blair et al., 2008; Bolster & Manias, 2009; Considene et al., 2010; Dixon-Woods et al., 2014; Maben et al., 2012; O'Cathain et al., 2008; Olthuis et al., 2014; Tsiakanas et al., 2012). Focus groups were used to study the interactions between patients and nurses (Bolster & Manias, 2009; Kieft, de Brouwer, Francke, & Delnoij, 2014; Maben et al., 2012; O'Cathain et al., 2008; Picker Institute, 2008). Observations were used alongside semi-structured interviews to explore patients' experiences in A&E (Baillie, 2009; Considene et al., 2010; Olthuis et al., 2014).

Survey methods were used to establish the range of urgent and emergency care services (Foley et al., 2017) and establish people's attitudes and reactions to these services (Knowles et al., 2012). Both surveys and questionnaires were used to measure patients' experiences in A&E (Adams & Burstin, 2001; Bos et al., 2013; Eckwall, Gerdtz, & Manias, 2007; 2009; Keating et al., 2002; Picker Institute, 2008). Surveys were also used to look at patients' experiences in day-case units (Erkal, 2007; Majasaari et al., 2005; Schoenfelder, Klewer, & Kugler, 2010) and in a paediatric AEC unit (Blair et al., 2008; Williams et al., 2008).

The debate about the usefulness of survey data, including the Picker Institute's data on behalf of the CQC, is ongoing (Coulter et al., 2009; De Courcy, West & Baron, 2012; Foot & Cornwell, 2010; Goodrich & Cornwell, 2008). Other researchers pointed out that to use the data from patient experience surveys appropriately and effectively, examining the organisational barriers and facilitators must be done in conjunction with the analysis (Foot & Cornwell, 2010; Gleeson et al., 2016).

This review's findings correlated with the case study literature that advocates for triangulation of data sources and methods (Robson, 2015; Creswell, 2014; Stake, 1995; Yin, 2009). Additionally, it correlated with the literature that vouched for the use of semi-structured interviewing as a suitable method to generate and explore attitudes, values, beliefs, and motives (Polkinghorne, 2005; Rubin & Rubin, 2012; Seale, 2004).

Focus groups and observations are also valuable tools to use when the researcher is interested to understand what is happening in a setting (Holstein & Gubrium, 2008; Ledderer, 2011; Ryan et al., 2014). The studies' review confirmed that a qualitative approach was appropriate for this study that wanted to explore the experiences of patients, carers, and NHS staff in an AEC unit (Baxter & Jack, 2008; Flick, 2009; Merriam & Grenier, 2019; Robson, 2015).

When reviewing the studies' research design, I also reflected on the barriers and enablers to using the different methods to collect patient experience data, including limitations of resources such as time, staff (Gleeson et al., 2016). Another barrier pointed to a lack of staff commitment either out of fear of repercussions if things go wrong or unwillingness to take on extra work (Coulter et al., 2014). Furthermore, the organisational culture, which focused on managing outcomes and viewing the data as a potential regulatory tool for the CQC, also limits the use of feedback data for improvement purposes (Coulter et al., 2014; De Courcy et al., 2012; Reeves, West & Baron, 2013).

The enablers of using experience data to improve services are strong leadership, committed staff, engagement, and trust-wide coordination efforts (Reeves et al., 2013). However, the enablers can become barriers if staff shows disinterest or withdrawn from the projects (Reeves et al., 2013). An additional difficulty with the experience surveys is that the aspects of care that have improved can be linked to national targets and high-profile media reports (Reeves et al., 2013).

3.7 THE EMERGING THEMES

Each of the selected sixty papers was read, appraised, and summarised, and four themes that provided insight into the experiences of patients, carers and NHS in urgent and emergency care services were extracted. The key themes were: the relational aspect of experiences, the impact of culture, issues with setting up new services and the importance of measuring experiences.

3.7.1 The relational aspect of experiences

The critical role the relational aspect of care played in how patients and carers view their experiences has been highlighted by several studies (Boudreaux & O'Hea, 2004; Bridges, Flatley & Meyer, 2010; Ekwall, Gertz & Manais, 2009; Entwistle, Firnigl, Ryan, Francis & Kinghorn, 2012; Smith, Pearson & Ross, 2009; Tsiakanas et al.,2012; Wellstood et al., 2005). When patients and carers enter the healthcare arena, they expect a balance of competence and empathy (Nystrom, Dahlberg & Carlsson, 2003). Thus, when the NHS staff struggled to find the balance, patients and carers reported inconsistency in care, ranging from supportive to unsupportive; comprehensive to fragmented; proactive family engagement, and no family engagement (Petry, Steinbrüchel-Boesch, Altherr, & Naef, 2018).

Furthermore, they expressed negative experiences when healthcare professionals placed a greater emphasis on 'medical-technical' skills and efficiency instead of care and emotional support (Bridget & Nuges, 2010; Ekwall et al., 2009; Gordon et al., 2010; Nystrom et al., 2003). Positive experiences were linked to acknowledging and involving patients and relatives in care and positive relationships with staff, thus 'being seen', being recognised and being involved (Bridges et al., 2010; Bridges & Nuges, 2010; Morphet et al., 2015; O'Cathain et al., 2008). Thus, other factors that can influence experiences like the dependency levels of patients, staffing levels on the units, and staff competency levels often remain ‘hidden’ to patients and carers (Maben et al., 2012; Muntlin et al., 2006).

Patients and relatives pointed to the initial encounter as pivotal when forming their perspectives about the care experiences (Ekwall et al., 2009; Morphet et al., 2015; Olofsson et al., 2012). If they were informed from the onset about what was happening, waiting times and what to expect, it formed a positive first impression and reduced anxiety and frustrations (Bridges 2008; Bridges et al., 2010; Ekwall et al., 2009; Picker Institute, 2008). The perceptions of waiting times (Boudreau & O’Hea, 2004; Cassidy-Smith, Baumann & Boudreaux, 2007; Ekwall et al., 2009; Muntlin, Gunningberg & Carlson, 2006; Nairn et al., 2004; Trout, Magnusson & Hedge, 2000) and issues with information (Muntlin et al., 2006) were interlinked.

The ‘relationship-centred approach’ included the well-being of both patients and staff (Boudreau & O’Hea, 2004; Bridges, 2008; Bridges, Flatley & Moore, 2010; Tsiakanas et al., 2012). Studies also pointed to the psychological impact of poor experiences on all involved in the creation of a caring environment (Bridges et al., 2009; Ekwall et al., 2009; Gordon et al., 2010; Moss et al., 2014; Nystrom et al., 2003; Olthuis et al., 2014). In studies looking at patients’ experiences in the emergency department, they expressed feelings of being forgotten, abandonment and that their illnesses were minimised by staff (Nystrom, Nyden & Petersson, 2003). The Francis Report (2013) echoed the findings and indicated that a culture deprived of care and empathy and bolstered by a top-down management approach, which thrived on fear, secrecy and blame, led to patients feeling dehumanised.

Olthuis et al., 2014, referred to this emotional aspect of entering the urgent and emergency care system as a type of labour for patients (Olthuis et al., 2014). However, the perceptions that A&E has become like a ‘conveyer belt’ impacted both patients and nurses' wellbeing. Thus, patient struggled with feelings of being ‘dehumanised’, and nurses struggled with balancing their moral ethic of care with workload (Francis, 2013; Maben et al., 2012; Moss et al., 2014; Sørlie, Torjuul, Ross, & Kihlgren, 2006).

To balance these emotional labour and care needs, behaviours are adapted to suit the environment (Considene et al., 2010; Nystrom, Dahlberg & Carlsson, 2003; Smith, Pearson & Ross, 2009). The patients perceived the nurses were busy, and the units were short-staffed, and in response, they omitted to ask for help when needed (Wolf et al., 2012). They also reduced their expectations in response to the nurses' stress (Nystrom et al., 2003a, 2003b) and tried to become a ‘good’ patient (Nystrom et al., 2003a, 2003b). The ‘acceptance’ of healthcare workers' restrictions often leads to the direction of blame and anger towards the managers or politicians (Nystrom et al., 2003a, 2003b). Williams, Coyle and Healey, (1998) pointed out how patients and carers adapted their expectations when they realised their previously held expectations were unsuited for the current situation. Dissatisfaction arises when expectations are not met (Cassidy-Smith, Baumann & Boudreaux, 2007).

The qualitative study by Coughlan and Corry (2007), looking at the experiences of patients and families in A&E, reported how the department was described as overcrowded, dirty and lacking resources; however, the feedback was generally positive. Patients and relatives justified the ongoing concerns regarding long waiting times and dissatisfaction with care elements as the consequence of staff shortages due to lack of funding and government reforms (Nystrom et al., 2003a, 2003b). Older people were less critical, reluctant to complain and often expressed a feeling of gratitude even if some of their needs were unmet (Considine et al., 2010; Richardson, Casey & Hider, 2007).

Some studies highlighted the role of interpersonal behaviours of healthcare providers played in the variations of the care received (Nystrom, 2003b; Petry et al., 2018; Schoenfelder, Klewer & Kugler, 2010). These reports of negative experiences relayed issues with staff acting indifferently towards patients and fragmented nurse-patient encounters and thus care (Nystrom et al., 2003a, 2003b; Olofsson et al., 2012). Relatives also conveyed feeling unwelcome and uncomfortable with the negative discourse healthcare professionals used around elderly patients (Morphet et al., 2015).

Bridges et al. (2012) pointed out that the broader organisational culture influenced the nurse-patient relationship. Furthermore, how contradictions and conflict between individual and organisational values can ultimately lead to disengagement from the care relationship and burnout (Bridges et al., 2012).

3.7.2 Impact of culture on experiences

As AEC is part of the acute and emergency care division, to understand the factors impeding the relational aspect of care, it was necessary to move beyond the individual or the practitioner-patient relationship to include the influence of A&E and the broader organisational culture as well (Darby, 2014). To review the experiences of care as perceived by patients requires a critical review of organisational cultures. "*The key challenge facing all NHS organisations is to nurture cultures that ensure the delivery of continuously improving high quality, safe and compassionate healthcare*." (West et al., 2015, p.2). The concept of culture is complex and vague. In this study, culture referred to the values, behaviours, attitudes and practices, thus 'how things are done around here'. In one organisation, there are several sub-cultures which at times can be competing and lead to conflict.

As noted, a 'good' experience of care for patients and relatives involved the act of 'relating', not just 'doing', hence described as relational and cooperative (Dixon-Woods et al. 2014; Tronto, 1993; Van Heijst, 2011). However, patients' experiences are affected by what happens in a hospital's care environment, which can be influenced by the national context (Goodrich & Cornwall, 2008). Therefore, it was imperative to place these interactions in a relational as well as a contextual frame. The goal was to ensure the social, political, and cultural influences that impact patient experiences are highlighted, thus preventing the unidirectional view of patients as passive receivers of experiences. Raleigh et al. (2009) supported this view and called for evaluating patients' experiences on four levels: individual-staff interaction, the team-ward culture, the institution and the wider health system.

The Picker Institute (2008) survey data confirmed that some organisations consistently deliver good care experiences for their patient population. According to researchers, those organisations refocused their culture from a 'provider' focus to a 'patient' focus and espoused to continuously deliver person-centred care (Luxford, Gelb, Saffran & Delblanco, 2011). Thus, in those organisations, management, patients and staff had co-

constructed a clear, visible vision of person-centred care, which was sustained through the provision of the support and structures needed for the delivery of that vision (Dixon-Woods et al., 2014; Luxford et al., 2011; Raleigh et al., 2009). Furthermore, changing an organisation’s culture requires the workforce's engagement from the onset (Raleigh et al., 2009).

Nevertheless, any attempts to change an organisation’s culture are part of a slow process that requires active participation, ongoing commitment from senior managers, and supportive learning culture (Nembhard & Edmondson, 2006; Raleigh et al., 2009; Walumbwa & Schaubroeck, 2009). The literature supported this view and highlighted that curtailing the voice of either the users of the service or the staff that deliver it, ultimately impacts organisations’ ability to embrace and sustain transformation and change efforts (Raleigh et al., 2009).

The current discourse of changing patient-centred culture as a ‘journey’ explains its difficulties as the metaphor allows for the ‘baggage’ you take on the ‘journey’, and any stops you make (voluntarily or reluctantly) (Raleigh et al., 2009). The struggle between meeting the service's demands, juggling the impact of contextual factors and delivering person-centred care complicates the ‘journey’ of health care organisations to deliver person-centred care (McCance, Gribben, McCormack & Laird, 2013). One of the sub-cultures in the organisational context is ward (unit) cultures. According to Geertz (1973), ward cultures are created by the members and therefore, the role of ward leadership in mirroring person-centred care and clarity about acceptable behaviours and values of team members were crucial (Goodrich & Cornwell, 2008). The term ward is a historical term and reflects a time when every patient was admitted onto a ward. However, places like A&E, AEC and AMU are known as units.

Wolf et al. (2012) referred to the everyday decision making in the emergency care context as ‘socially constructed games’ where hierarchy reduced patient-centred care and created a culture steeped in conflict. Therefore, highlighting the importance of any researcher entering the healthcare field to orientate his/herself to the boundaries that form the context, including relationships, systems and power differentials (Brown & McCormack, 2011, p.2). Thus, becoming accustomed to a practice context that “*…is a multi-layered construct that brings together issues of culture, leadership, behaviours, and relationships”* (Brown & McCormack, 2011, p.2).

3.7.3 Issues with setting up and sustaining the service

The review highlighted a paucity of research done in AEC settings in the UK and a lack of clarity of concepts. Furthermore, it highlighted a lack of consensus on recording acute assessment episodes, which appeared to be complicated by changes in policies and associated terms. An example is the meaning of the term ‘admission’ and its connotation. The policy language encouraged a move away from the term admission towards the language of assessment. Due to the speed of the changes, different terms continued to be used. In the studies in this review, paediatric assessment units were noted to be ‘admitting’ patients for two to four hours, whereas the A&E units were ‘holding’ children for up to 24 hours. However, if these terms are not universally agreed upon and used, it could lead to incorrectly recorded statistics. At the time of this study, the AEC network was working with organisations to address the inconsistent recording of activity measures.

3.7.4 Measuring experience

As a vital component of delivering high-quality care and an opportunity to measure person-centred care, patient experiences have become increasingly popular over the last decade (DH, 2008; De Silva, 2013; NHS England, 2014a). The literature review on experiences of patients, carers and staff included both national and international studies, including USA, Switzerland, Sweden and Australia (Considene et al., 2010; Luxford et al., 2011; Olofsson, Carlstrom, & Back-Pettersson, 2012; Petry, Steinbrüchel-Boesch, Altherr, & Naef, 2018). Furthermore, the review uncovered a body of work that consisted of a mix of quantitative and qualitative data that used semi-structured interviews and surveys to collect data about experiences in emergency departments and surgical day-care units (Gordon et al., 2010). However, that body appeared to be fragmented, and little evidence of how the findings were used to influence practice (Coulter et al., 2009; Coulter et al., 2014; Davies & Cleary, 2005; Goodrich & Cornwell, 2008).

Nevertheless, if measuring experience becomes just another policy to obey, there is a danger that both patients and healthcare professionals will see it as ‘rhetoric’ and disengage from any attempts to improve care (Redding & Hutchinson, 2017). In their study, Sheard et al. (2017) noted the difficulties NHS staff encountered when trying to make changes based on patient feedback due to structural issues such as lack of access to resources and senior managers' support. The importance of having commitment and support from senior managers is needed for change efforts to be successful (Gleeson et al., 2016; Redding & Hutchinson, 2017).

3.8 SUMMARY AND GAPS IN KNOWLEDGE

The literature review highlighted the dearth of studies on the experiences of patients, carers and staff in urgent and emergency care. Furthermore, most of the studies did not describe the methodology selected or the data analysis in detail, making it difficult to assess their findings' validity (Dixon-Woods, Booth & Sutton, 2007). However, the review provided valuable insights into patients and relatives' key concerns when they present to the hospital. Thus, one of the critical lessons of this review is the importance of choosing the most appropriate research design, including methodology and methods, to answer the research question/s and to be explicit about it in the final report.

The literature confirmed the concerted effort nationally and internationally to measure patients' experiences. Nevertheless, I could not find any evidence that the findings were used to improve services and given the longevity of some of the issues, it raised the question, "*are we researching just for the sake of it*?" The literature review highlighted the interwoven nature of experiences, person-centred care, and the organisation and practice area's culture. Despite the three papers on setting up ambulatory care services being from children services, the lessons learned aided this study. The review also emphasised the challenges patients, relatives, and healthcare providers face when navigating urgent and emergency care services.

Additionally, the review highlighted what the different groups viewed as essential for positive experiences. For patients and carers, it was the relational aspect, whilst staff, on the other hand, pointed out the roles played by resources, training and support, and patients' dependency levels. However, there was only a small number of studies that focused on the experiences of staff. The literature review thus highlighted the literature gap regarding the impact the introduction of AEC units has on patients, carers, and NHS staff's experiences. The first three chapter has situated the study in both local and national contexts. Chapter four will address the personal context.

CHAPTER FOUR LINKING PAST EXPERIENCES, WORLDVIEW AND PHILOSOPHICAL UNDERPINNINGS OF STUDY

4.1 INTRODUCTION

> *…we understand ourselves and others only when we transfer our lived experience into every kind of expression of our own and other people's lives. (Dilthey, quoted in Stake, 1995, p.36)*

The first three chapters explored the drivers and motivations for the study. Chapter one also briefly introduced the reader to the reasons for my interest in exploring people's experiences in AEC and involving patients, carers and NHS staff in shaping the unit to reflect the population's needs. Following on, this chapter sought to clarify the link between my interest in the research topic, the formation of personal worldview, the philosophical location of the study and the research design. In qualitative research, linking the potential impact of our beliefs and histories on decisions made regarding the chosen methodology and methods is vital. Otherwise, there is a danger of reflexivity becoming self-therapy, and any attempts to link experiences to knowledge production might fail.

> *To be reflexive is to be not only self-aware, but to be sufficiently self-aware to know what aspects of self are necessary to reveal so that an audience is able to understand both the process employed and the resultant product and to know that the revelation itself is purposive, intentional and not merely narcissistic or accidentally revealing (Ruby, 1977, p. 4).*

However, I must acknowledge the inherent tensions experienced whilst reflecting on my personal history and writing the chapter. These tensions were caused by the centring of myself, which felt oppositional to the study's ontological and epistemological foundations of inclusivity and cooperation. The focus on 'I' and 'me' caused moments of acute discomfort as too much introspection was not encouraged in my family or the wider community. Thus, reflected the ongoing strive to balance my ‘struggle for recognition’ and being viewed as self-centred. However, to understand the decisions made regarding the research focus, the methodology and the methods, transparency about personal values, beliefs and assumptions were necessary (Charmaz, 2017). Additionally, highlighting from the onset of the study my subjective knowledge of issues such as marginality, identity, subjectivity, and power and how it can influence experiences (Charmaz, 2017, p. 36).

Furthermore, during the study, events occurred that reminded me of how being ‘powerless’, ‘voiceless’, ‘unheard’ and ‘unseen’ felt. The incident reiterated the importance of allowing people to provide feedback on their experiences, to ‘tell their own story’. This ‘struggle for recognition’ and ‘being heard’ plays a crucial role in any intersubjective dialogue (Honneth, 2012) and, if lacking, can leave people feeling invisible and insignificant. The ‘struggle for recognition’ emphasises the acknowledgement *of* past influences on the formation of identities and experiences and the recognition *by* others of those experiences as valid (Edwards-Groves, Olin & Karlberg-Granlund, 2016).

As noted in previous chapters, the NHS underwent numerous restructuring of services by successive governments, leading to high-profile failures in delivering care and a demoralised workforce (Berwick, 2013; Francis, 2013). Thus, based on these previous experiences, people’s encounters on AEC are filled with preconceived notions, assumptions and anxieties, that they rarely express due to perceived time constraints as they assume their concerns and opinions are less important.

The significance of the 'struggle for recognition' in this study is that when patients, carers and NHS staff feel that others do not acknowledge their experiences or value their input, it can lead to scepticism about any service development effort (Green, 2007; Honneth, 2012). Moreover, the feeling of being 'powerless' or 'voiceless' may lead to perceptions that the environment is psychologically unsafe, consequently reinforcing the culture of silence as people who feel unsafe are reluctant to speak out (Brown & McCormack, 2011; McCormack & McCance, 2006; Titchen & McCormack, 2010).

The chapter is divided into sections containing reflections on critical periods in personal life and linking that to the formation of my worldview and the study's philosophical underpinnings. Also, it aimed to shed light on how those years contributed to my interest in exploring people's experiences in AEC and supporting them in using those experiences to improve the service. In writing the sections, I expressed my assumptions and beliefs about the role of values in research (axiology), the nature of reality (ontology) and what can be known about it (epistemology). I need to be clear from the outset that this chapter contains a personal perspective on experiences and do not purport to be an uncontested truth.

4.2 SECTION ONE THE FORMATIVE YEARS

> *For if we lived correctly and with frugality, looking both ways before crossing the street, then someday we would arrive back in the sweet place, back home (Lorde, 1982, p. 13).*

As children's developmental years are instrumental in shaping values, beliefs, and principles (Bennis & Thomas, 2002), this was the obvious starting point to consider how that period shaped mine. Being explicit about personal values from the onset of the study is a vital aspect of the research process as it can explain the motivation for why and how the study was done. Furthermore, how those formative years shaped my belief that people and events cannot be understood in isolation but needed to be situated in their social, historical, political and economic contexts to be fully understood. Thus, making case study an appropriate methodological choice.

My life journey started in Port Elizabeth, South Africa, as the third eldest of eight children born to Xavier and Kathleen Demingo, where my birth was recorded in the population register as a ‘coloured’ female per the *Population and Registration Act* of 1950. Therefore, I would spend the first half of my life “*in the framework of institutionalised separate development*” (Biko, 1987, p. 27), which was enforced by the National Party’s laws and extended through my culture and religion. Meaning my *being-ness* was bounded to *other-ness* from the onset through a legal, social, and educational framework. To survive meant understanding the constraints this created without being paralysed or controlled by it.

In the middle of the Northern Areas, we lived in a four-roomed house in a neighbourhood called Arcadia, the resettlement area for all ‘coloured’ people following the Group Areas Act’s legislation in 1950. This Act, introduced by the National Party as a means of segregation, gave the government the legal power to forcefully remove people from their homes, tearing communities apart in the process (Parry & van Eeden, 2015; Trotter, 2009). The displacement’s impact meant livelihoods, and any sense of shared community and culture were lost simultaneously.

The Act was part of a more extensive social engineering system steeped in racial segregation and led to hardship and feelings of uncertainty, anxiety, and resentment (Cochrane & Chellan, 2017; Trotter, 2009). The resultant entrenched poverty experienced by the Northern Areas communities was mirrored in similar displaced communities across South Africa (Cernea, 2004; Cochrane & Chellan, 2017; McDowell, 1995).

In line with the effects listed in the *model of involuntary risk and resettlement*, developed by Cernea in the 1990s (Dalton-Greyling & Greyling, 2007), the displacement led to joblessness, food insecurity, the fracturing of communities and marginalisation. Cernea (2004) also highlighted other consequences such as landlessness, homelessness, increased high morbidity and lack of access to amenities like water, sanitation, and electricity. The effects of that engineering are still evident in those communities today as some people continue to live in poverty without access to clean water, toilets, or electricity (Dalton-Greyling & Greyling, 2007).

The trauma of the displacement also left sociological and psychological scars and affected generations (Cochrane & Chellan, 2017), which most people in the affected areas still find difficult to discuss. Furthermore, it contributed to an environment steeped in cultural erosion, demoralisation, and dehumanisation. Consequently, filling some of the communities' adults with hopelessness, impotence, and rage. Therefore alcoholism, drug addiction and violence became interwoven into the fabric of the society I grew up in (Cochrane & Chellan, 2017; Fanon, 2001; Trotter, 2009).

My most vivid memory of the violence was being confined with the rest of the family and neighbours inside our houses for three days when I was eight years old. Trapped, as the two rival gangs fought whilst an injured teenage boy was laid in our backyard, bleeding to death. What stood out about that event was how the violence was normalised, and so life inside our homes continued as usual, and nobody expressed panic or anxiety. Also, the innovative and resourceful ways the adults found to meet everyone's physical and emotional needs.

According to Fanon (2001), the 'horizontal' violence experienced in these communities served simultaneously to avoid the impact of the displacement and to release their repressed emotions caused by it. 'Horizontal violence' refers to the direction of anger and frustrations at peers rather than real adversaries (Fanon, 2001). However, the ongoing violence also reinforced the neighbourhood's portrayal as unsafe and dysfunctional, where people were 'lazy', 'drunks' and 'just felt sorry for themselves'. Portraying the areas as 'unsafe slums' that required separation from others for safety reasons suited the narrative in support of the continual segregation (Biko, 1987; Trotter, 2009).

The cycle of violence, alcohol, drugs, and poverty became an intergenerational issue, still evident nearly thirty years after apartheid ended. Nevertheless, the people in these areas managed to survive under those circumstances, and some even thrived. So, despite the extreme poverty and an underfunded education system, through partnership-working, the community members, parents, and teachers helped shaped countless numbers of kids into thriving adults. Hence, giving meaning to the African proverb 'it takes a village to raise a child'.

4.2.1 Critical reflection on Section One

The establishment of racially segregated societies normalised and sustained marginalisation, and aided acceptance of it, a position further ingrained by our Christian faith (Biko, 1987; Fanon, 2001). To survive, we were actively discouraged from questioning our lives, displaying any dissent, or trying to protest the government. We had to remain within our communities or risk jail or worse, so we became ‘insiders’ within our neighbourhoods but ‘outsiders’ in white areas. However, some people worked as cleaners or gardeners in the prohibited areas, thus given temporary ‘insider’ statuses. They subsequently learned how to balance being an ‘outsider’ and an ‘insider’ to prevent being labelled ‘a sell-out’ and risk social exclusion. Thereby, learning to balance being submissive on the one hand and assertive on the other and in that space, the importance of developing adaptation skills needed for survival was born.

Reflecting on how the discourse impacted the formation of personal values, beliefs, and assumptions were difficult as I felt like I was questioning and disassembling my identity, which explained the intense discomfort experienced. Also, at times it was traumatic as the memories were painful and caused some nightmares and flashbacks. I wrote the diary entry below during one of those ‘uncomfortable’ days.

Research diary entry 23/2/2014

I feel like I was back in 1983. During my first year in high school (I was 13 years old), I first heard the story of the Soweto uprising of 16th June 1976. Hector Pieterson, a 13-year-old boy, died when a peaceful demonstration by school children turned in to a bloodbath when the Apartheid police started shooting indiscriminately at them. The image of an older boy carrying him, with his sister running next to them, with sheer terror on their faces gripped the world and caused outrage against the government.

While listening to these stories and chanting freedom songs, I felt that what I viewed as 'normal' was wrong, and for the first time, I looked at my parents' and grandparents' generations as weak and defeated. I felt robbed of my history and my heritage. I felt bitter as I saw the poverty we lived in and remembered the house on the hill my grandmother was born in that now belonged to a white family. It was a beautiful big house which she took us to see just once but often talked about with so much longing.

Yes, like most of my generation, I was angry and felt previous generations sold us out. When we sang "Senzeni na? (What have we done?) Isono sethu ubumnyayama (The only sin is the colour of my skin)", we were singing about the torture and massacres of innocent people like Hector and many others. We were singing about the pain and humiliation of being treated less than dogs, like the signs on the beach reminded us: "Only Whites and dogs allowed", just because we were the" 'wrong skin colour". I was unprepared for the extent of my anger and sadness when I realised how little our lives mean, how being "less than" seemed to be my future as I would always be a "non-white". Maybe it was because politics was a taboo subject in my house, and any act of resistance was forbidden, as my parents believed this was our burden given to us by God and resisting or moaning is disrespecting His plans for us.

So, when my mother found me boycotting at school, she was furious and punished me whilst asking, "Is this toy-toying going to educate you? Why do you want to put our lives in danger for a pipe dream? You shout, 'free Mandela', but you don't even know how he looks!" Later, when I stopped crying, she sat with me and told me she was sorry and that she was not angry at me but just scared of the dangers waiting for me. I will never forget the look of sadness in her eyes or the words she spoke: "I fear for you more than for any of my other children. You have that searching for something look in your eyes, and I know you feel like a caged animal at times. But this hand was dealt to us, and for now, the only way to find what you are looking for is through school, or you can give up now and become me. And never forget, we may be caged by the circumstances now, but staying locked in that cage filled with no hope is like throwing away the key. You may not feel like it now, but the power to change your life is within you. We all have some power, but we do not know it".

The incident stood out for me as it was the first time I questioned my life, my worth as a human being and most importantly, my parents and my upbringing. That scared me and made me feel disloyal. At that moment, I felt like I was seeing myself for the first time, exposed and vulnerable, which is what I am feeling now.

Extract from reflective research diary

Reflecting on the unease feelings with my critical friend and close relatives, I understood that it was not about being disloyal to my parents or the community members. Instead, it was a process enabling critical reflection on how those years shaped my view of myself and the world and how I make sense of my experiences. Examining and consciously acknowledging the assumptions and preconceptions I hold personally and professionally enabled a critical awareness of how viewing the data through a personal lens can shape the outcomes (Dwyer & Buckle, 2009; Maykut & Morehouse, 1994). Therefore, preventing any *"blind spots that come with unexamined views"* (Herr & Anderson, 2005, p. 440).

The critical reflection also highlighted the role social marginalisation, systemic violence, and othering played in forming the core personal values of caring, compassion, inclusivity, justice and self-determination and my ongoing struggle with feeling 'invisible' (Alford, 2001; Said, 1978). Hence, through re-engaging with my own life experiences as a child, I understood the reasons for my ongoing pursuit of self-actualisation, freedom and emancipation for myself and others and the role praxis played in that quest (Freire, 1996).

4.3 SECTION TWO THE IN-BETWEEN YEARS

My mother played a central role in these early years, imparting to me the importance of commitment, loyalty and caring for others. The daughter of alcoholic parents, she left school at the age of twelve to care for family and others in the community. Taking a tough stance on discipline, rules, and the necessity of an excellent education to prevent us from joining gangs or doing drugs. To reinforce her messages, we spend many days in her workplace, the hospital laundrette, witnessing manual labourers' life-world first-hand. The laundry was hot and stuffy, and the women looked sweaty, despondent, and tired. Nevertheless, they laughed, worked, talked, and shared their problems in that space, using their personal and practical knowledge to 'survive'.

She filled our home with books that we got from the junkyard, and so reading became my passion, the door to other worlds. Despite six children and a full-time job, she returned to night school for a high school certificate and got promoted to manager at the laundrette, where she worked since she was seventeen years old. Her relentless work ethic taught me about commitment to work and your colleagues. Furthermore, it taught me about the value of work (for the world and myself), and that opinions and meaning were co-constructed, so deserved equal attention.

Moreover, she taught me that we are active participants in creating multiple ways of knowing as beings-in-the-world. Also, everyone's opinion is valid. The passion and commitment displayed by my mother mirrored the informed, committed actions (praxis) that I espoused in this study. Situating my own and the participants' personal and tacit knowledge centrally meant accessing the necessary information about the study context and the factors that impacted participants' AEC experiences (Higgs & Titchen, 2001; Reason & Bradbury, 2006).

4.3.1 Critical reflection on Section Two

Reflecting on my mother's role in our lives and the community, I realised she saw *being* more valuable as *having* (Fromm, 1976) and caring for others as a way of *becoming*, of giving meaning to her own life (Frankl, 2006). Ultimately, transferring those principles of care and compassion onto me by modelling. Her assumptions were based on her beliefs that *to be* and *to know* were interrelated and inter-dependent, which shaped my ontological and epistemological views.

She advocated that learning from books will not suffice but must be supplemented by observing and interacting with other people. According to her, the aim was not to *never* make a mistake but to learn from every mistake made, as it was all sources of knowledge. A notion supported by McNiff and Whitehead (2009) and Winter (2006). Her emphasis on learning through doing, watching, and reading aligned with my drive to ensure a participatory approach remained central in this study. She also instilled in us the belief that no one is utterly powerless despite the constraints, but they just needed to learn how to use available tools, no matter how limited. Her teachings echoed Foucault's power-knowledge couplet (1998), which he pointed out, can have negative or positive impacts. Furthermore, she taught us how people's actions could cause them to become complicit in their oppression when they misuse their powers to oppress others (Somekh, 2006).

Reflecting on the influences of power on the study from the start and throughout the study was vital. When starting the ProfDoc programme, I subscribed to a view that service users and staff were powerless and needed empowerment. The position was reflected in the following extract from my first assignment: *"... to devolve power, status and hierarchy from senior management teams of hospitals to marginalised groups like patients and the workforce on the wards".* However, reflecting on my history and background enabled me to see this was a novice researcher's position heavily influenced by the literature that depicted power as a negative one-way process and people as helpless.

4.4 REFRAMING THE NARRATIVE

To further explore this view of people as helpless and powerless, I used Pierre Bourdieu's (1930-2002) constructs of 'habitus' and 'field' as a framework to re-vision my neighbourhood's people. Furthermore, to aid the shifting between distance and closeness needed to accommodate turning my history into an investigation object.

The 'habitus-field' relationship stemmed from Bourdieu's work on cultural re-production and analysing power relations in practice. He was interested in overcoming the objectivism-subjectivism divide and how people experience and negotiate structures (Bourdieu, 2004). Therefore, according to Bourdieu, through the 'habitus-field' relationship, it is possible to unpick the taken-for-granted things, such as the individual/society dichotomy and the embedded notion of the rational choice agent acting on his own. His theory also assisted in searching for an explanation for how people can resist power in one area (field) and yet appear to be complicit in their oppression in another (Moncrieffe, 2006).

According to Bourdieu (1986; 2004), society consists of several spaces and subspaces called 'fields' which refers to *"...a network, structure or set of relationships which may be intellectual, religious, educational and cultural"* (Navarro, 2006, p. 18). The 'fields' can be social groups, institutions, and workplaces where people's actions and behaviours produce and reproduce structures. An individual enters a 'field' with a 'habitus', which refers to the resources or 'capital' and skills accumulated by the individual (Bourdieu, 1986; Navarro, 2006). Their 'habitus' can be economical (money), social (your networks) or cultural (knowledge/skills/wisdom). During the 'field' interactions, all the different capital is transformed into 'symbolic capital' (status/recognition) and affects how much influence the individual has. 'Habitus' is social, transferable and durable and "*not fixed or permanent, and can be changed under unexpected situations or over a long historical period"* (Navarro, 2006, p. 16).

From the initial reading of my reflection, the impoverished 'habitus-field' relationship appeared to position people in the community as trapped in a 'culture of silence' (Freire, 1996, p. 12), hence weak, agency-less, despondent and ambivalent. However, using Bourdieu's theory, I reflected on the 'field' and the different skills and 'capital' (their habitus) the community had. The constructed meanings and truth were represented through a different lens and interpreted differently. Hence, enabling me to reflect on how the people, bounded by the system's laws and trapped in an impoverished society with no access to resources to change that, somehow managed to survive through generations.

Situating them in the Bordieuan' field' aided in representing them as active participants in their survival rather than as passive recipients. Consequently, revealing how their calls for community cohesion created active 'nodes of resistance' and the self-determination to keep fighting for their freedom. Thereby effectively rooting their praxis in the self-determination to decide which skills, strategies and knowledge were needed to survive in a 'field', whose initial creation was a measure to control and destroy them.

While the younger generation felt disillusioned and let down, the reality was that any 'war' required learning the strategy to stay ahead of the game, which included knowing the right time and space for these battles. Through the narration of stories and the resulting interpretation, the 'field' became infused with values, beliefs, situated knowledge and skills, which enabled the people in the community to continue to cope with the threat of the *"…unforeseen and ever-changing situations*" (Branson & Miller, 1991, p. 41). Supporting critical reflection using the habitus-field relationship revealed that what was interpreted in the past as a failure-to-act was an act-of-resistance as the community's people adapted to the socio-cultural milieu.

The reflection on my childhood reaffirmed my belief that whilst human action is bounded and inhibited by structural constraints, agency is still possible through active participation and reflexivity (Fanon, 2001; Gordon, 2011). Agency refers to people's abilities to make conscious decisions about their actions and thoughts. Furthermore, through agency and critical reflection, the hidden structures of oppression can be exposed.

4.5 SECTION THREE RESILIENCE

The resilience and resourcefulness demonstrated by people shaped how many of us deal with struggles and concerns. My parents were both manual workers with no education as the Apartheid regime declared that "natives" should not be educated as they were needed to do the manual work. They worked long hours, and as the eldest girl, I had to do all the household chores and look after younger siblings. From a very young age, I learned to be responsible, independent, and resilient, some of the traits that, according to Adair (1989), need to be present for practical leadership skills to develop.

4.5.1 Critical Reflection on Section Three

During one of the SKYPE sessions with the Living Theory Group organised by Jack Whitehead, I was asked: *"What is it that makes you keep going in the face of all the struggles you are facing?*" My response was, *"I just do"*.

Reflecting on that question revealed that I viewed these difficulties as part of life and often unconsciously used the survival skills I learned from a young age. Observing my mother and others taught me how to keep going and keep the set goals into moments of intense pressure. My view of resilience was echoed by one of the SKYPE group members when she quoted Angela Duckworth's work on 'grit'. According to Duckworth (2016), people with 'grit' demonstrate passion and perseverance, as well as a combination of resilience and determination. Linked with 'grit' is Carol Dweck's mindset theory (2012; 2016) which focuses on the reasons for people's reactions in certain situations.

According to the theory, people have assumptions about their abilities and invoke either a growth or fixed mindset (Dweck, 2017). However, she also pointed out that people have a mixture of both mindsets and used either of them as a coping strategy when required. People with fixed mindsets see "*failure-is-debilitating"* whilst those with a growth mindset see "*failure-is-enhancing*" (Haimoitz & Dweck, 2016, p. 866). Thus, we need to be aware of the language we use in practice and with our actions. It is also prudent that people know the situations where a growth mindset is necessary or when it can be unhelpful.

As the inappropriate use of "growth mindset" can be unhelpful and even destructive, as I learned when the unit closed unexpectedly during the data collection period. In the crisis of seeing the study 'fail', I unsuccessfully tried to find ways to 'fix' it. In this instance, my 'growth' mindset was unhelpful as I was trying to 'fix' a situation outside my control (Dweck, 2017). At that moment, I lost sight of the message I ofter reiterated to the staff on the unit about the importance of 'small changes' and 'small victories' when they talked about the futility of the change efforts. Thus, briefly overlooking the richness of the data already collected, the progress made, and the lessons already learned.

4.6 LINKING PAST EXPERIENCES WITH PERSONAL WORLDVIEW

Articulating and reflecting on personal core values was an essential part of the research process as it highlighted the assumptions that influenced how the study was executed and presented. Through reflexivity, I was able to balance the participants' concerns about being excluded from service development consultations on the one hand and using a participatory approach in an 'ever-changing' environment. However, failure to embrace a participatory approach in this study would sustain the 'never-ending' cycle of manager's establishing new services, people feeling disregarded, and resultant apathy about said service. Furthermore, ignoring participants concerns about feeling 'invisible' would be antithetical to my core values.

Reflexivity also aided ongoing awareness of the importance of considering how participants' values and previous experiences influenced their actions during the study. Furthermore, my core values reflected the centrality of interpersonal interaction with the participants and pointed to qualitative data collection and analysis methods as the most appropriate tools to collect information about their interpretations of their experiences.

Additionally, reflexivity highlighted the appropriateness of using multiple data collection methods from numerous sources to strengthen the findings.

Unpacking personal history illuminated my assumptions that people's views of their experiences are socially constructed and influenced by historical perspectives, culture, the environment, economic conditions, and power relations (Crotty, 1998). Consequently, their actions and behaviours were affected by the constructed 'truths', 'values' and 'realities' sustained and maintained by groups in the social setting. The socially produced behaviour, habits and traditions can then become entrenched and normalised by people (Bergman & Luckmann, 1991).

This study's overall purpose was to understand how people constructed their experiences and what meaning they attributed to those experiences (how they made sense of their experiences in the AEC unit). Hence, aligning with a social constructionist epistemology that viewed meaning-making as *"...constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context*" (Crotty, 1998, p.42).

As the reflections on my past experiences demonstrated, I believed that how people understand and articulate issues stemmed from their daily interactions and the traditions, relations, and communities they inhabit (Gergen, 2009). Thus, meaning-making is value-laden, fluid, and comes out of communal relationships. Therefore, the researcher who sets out to examine people's interpretation of meaning must obtain a shared agreement with them about how it will be explored (Gergen, 2009). Researching in a social constructionist vein thus, emphasise collaborative inquiry and practitioner-participants relationships.

The term social constructionism stems from Berger and Luckmann's *The Social Construction of Reality* (1967) and Karl Mannheim's work (1893-1947). Crotty (1998) noted that elements of constructionism could also be found in Karl Marx's writings (1818-1883), who was critical of how those with economic power controlled and determined the dominant discourses and thus people's views of their experiences. Furthermore, social constructionists acknowledge that due to the researcher's role in data collection and analyses, reflexivity and transparency about previously held assumptions, values, and beliefs were vital (Crotty, 1998).

The epistemology of social constructionism supported using an interpretive theoretical framework to explore the way participants made sense of their experiences. According to Crotty (1998), the interpretive approach "*…looks for culturally derived and historically situated interpretations of the social life-world"* (p.67). Interpretivism is linked to Max Weber (1864-1920) and his call for social scientists to focus on 'understanding' (*Verstehen*) and 'interpretation' (Crotty, 1998). Another influential philosopher is William Dilthey (1833-1911), who viewed human beings as active meaning-makers, whose motives and actions would be better understood if viewed within the context of their interpretations of events and the local circumstance of the events (Crotty, 1998). According to Dilthey, making sense and understanding people's experiences requires rationality, intuition, creativity, and imagination (Stake, 1995). Social constructionism and interpretivism revolve around the principle that human beings understand their society and actively create a culture based on these understandings.

4.7 SUMMARY

This chapter aimed to illustrate how my life experiences, culture and upbringing framed my axiological, ontological, and epistemological assumptions and the worldview that embodied them. Illuminating and clarifying these assumptions offers the readers insight into how I arrived at the chosen methodology and methods. Furthermore, transparency about the beliefs and remaining aware of their potential impact on every aspect of the study from the onset enhances the research quality and demonstrates trustworthiness.

My experiences' narrative demonstrated how the study's philosophical frame aligned with the research questions and its focus. The most suitable methodology was /case study as it supported the contextual situating of participants' experiences and linked the importance of understanding their experiences with praxis (action) and reflexivity. This chapter thus formed the philosophical foundation for the research strategy discussed in the next chapter.

CHAPTER FIVE RESEARCH DESIGN

5.1 INTRODUCTION

The previous chapters scrutinised the background to the development of AEC, including local and national policies and practices and reviewed the literature on the experiences of patients, carers, and NHS staff in acute services. Chapter 4 linked personal history with the underpinning research epistemology of constructionism and the theoretical perspective of interpretivism. Thus, the first four chapters provided the foundation for the study, whose purpose was to determine what people's perceptions of their AEC experiences were and contribute to developing the services and the AEC knowledge base.

Following on, this chapter provides the rationale for the selected research approach and methodology. Furthermore, the chapter contains a definition of the case and its boundaries (setting, population, sampling frame, recruitment) and discussing the steps I took to address rigour and ethics concerns. This chapter's challenge was to translate the philosophical assumptions and believes discussed in chapter 4 into a coherent and practical research design that answered the research questions.

However, the first step was to provide definitions for the concepts of research design, approach, methodology, and methods at the onset, as many authors use them differently (Jones & Lyons, 2004). Research design referred to the study's overall plan (framework) to answer the research questions (Flick, 2011). The essential elements of the design framework considered were the research approach, methodology, and data collection and analysis methods. Additionally, attention was given to define the case and establish the case boundaries (unit of analysis; setting; population and recruitment) and rigour and ethics issues.

The research approach referred to the primary research intent that shaped the methodology and methods chosen and involved analysing personal views, assumptions and beliefs that impacted the decisions (philosophical foundations) (Simons, 2009). The research methodology referred to the strategy underlying the selected methods and linking them to the study's desired outcomes (Crotty, 1998). Lastly, research methods referred to the data collection and data analysis techniques selected to answer the research questions (Crotty, 1998).

As all the research design components are connected, a lack of congruence between any components can lead to readers questioning the research's quality and soundness (Stake, 1995). Both Stake (1995) and Yin (2009) urged researchers to justify the chosen research design through an in-depth description of the decisions taken during the design phase and the steps followed during data collection and analysis. The 'research onion' developed by Saunders, Lewis, and Thornhill (2012) was adapted to address these concerns and to demonstrate how the design framework components were connected in this study. Thus, the 'onion' (see figure 5.1) is a visual depiction of the intersecting of the study's philosophical foundation and selected research approach, methodology, unit of analysis (case) and methods of data collection to answer the following research questions:

1. How did the introduction of a purpose-specific AEC unit influence patients, carers, and NHS staff's experiences?
2. What factors influenced their experiences?

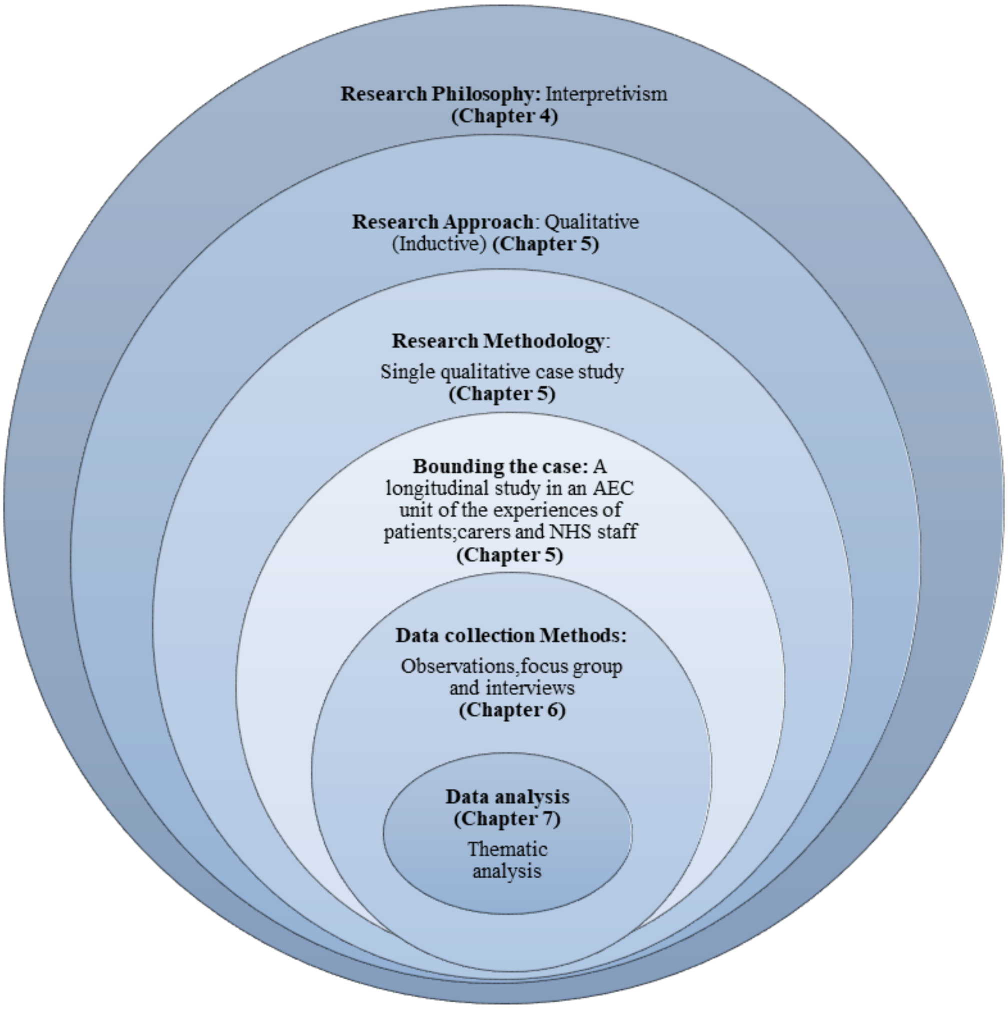


Figure 5. 1 The research onion (Saunders et al., 2012)

5.2 THE QUALITATIVE APPROACH

In social sciences research, the two main approaches are qualitative and quantitative (Creswell, 2003; Johnson & Onwuegbuzie, 2004). The research approach’s selection is influenced by the research question, the role of theory in relation to the research and the researcher’s philosophical assumptions (Bryman, 2008). A quantitative approach is warranted when the research question’s nature requires pattern finding, making predictions, or testing causal relations (Merriam & Tisdell, 2015). Additionally, the researcher is interested in theory testing, collecting numerical data and attaches importance to prediction, control, rationality, generalisations, and objectivity (Braun &

Clarke, 2013; Merriam & Tisdell, 2015). The researcher who uses this approach selects data collection methods that allow distance from the participants, such as surveys, questionnaires, or experiments (Bryman, 2008). Quantitative approaches are thus deductive and shaped by positivist philosophies (Bryman, 2008).

On the other hand, a qualitative approach is warranted when the nature of research questions requires exploration or understanding (Stake, 1995). Thus, the researcher's primary focus is on exploring and understanding how individuals experience and interact with their social world by collecting non-numerical data (Braun & Clarke, 2013; Bryman, 2008; Merriam & Tisdell, 2015; Stake, 1995). So, the researcher who uses this approach studies participants in their environment, uses data collection methods that are interactive (interviews and observations) and presents the findings in narrative (word) form (Bryman, 2008; Creswell, 2009; Robson, 2015). Theory and categorisation emerge out of the collection and analysis of data, and thus it is an inductive approach (Creswell, 2013; Merriam & Tisdell, 2015; Robson, 2015).

The qualitative researcher immerses themselves in the research settings and is the primary instrument for data collection and analysis (Merriam & Tisdell, 2015). Hence, the potential influences of subjectivity, values, beliefs and biases on the study design and findings must be acknowledged and monitored (Bryman, 2008; Creswell, 2013; Crotty, 1998; Robson, 2015). Therefore, the researcher must be transparent and reflexive about these influences throughout the study to ensure the research findings reflect the participants' experiences, thus emic and not etic knowledge (De Chesnay, 2017; Merriam & Tisdell, 2015). Accordingly, qualitative approaches are often shaped by interpretivism.

The study's focal point was gaining an in-depth insight into the research participants' experiences in an AEC unit. As highlighted in the literature review, experiences are complex and multifaceted and include features and factors that affect individuals differently, therefore calls for an inductive, flexible, and iterative research approach (Bridges, Flatley & Myer, 2009; Gordon, Sheppard & Anaf, 2010; Knowles, O'Cathain, & Nicholl, 2012; Merriam & Tisdell, 2015; Robson, 2015).

A qualitative approach would accommodate the exploring, documenting, and meaning-making process needed to understand those experiences, answer the research questions and meet the study's aims and objectives (Merriam, 2009; Patton, 2015). Thus, an inductive qualitative approach was selected as it provided the most appropriate vehicle for the contextualised exploration of the phenomenon (the experiences of patients, carers, and NHS staff in AEC) (Baxter & Jack, 2008; Flick, 2009; Merriam & Grenier, 2019; Robson, 2015).

5.3 RESEARCH METHODOLOGIES CONSIDERED

Once the decision about the research approach was made, the next step was to select a methodology that correlated with my primary interest in understanding the experiences of patients, carers, and NHS staff in an AEC unit. However, to make informed choices about the different research methodologies and their implementation, understanding how different philosophical worldviews aligned with them was vital (Merriam & Tisdell, 2015). Aligning with the philosophical frame of interpretivism and considered for this study was ethnography, grounded theory, participatory action research and case study, all of which have been used extensively by nurse researchers in recent years (Attree, 2001; Bailey, 2009; Mottram, 2011; Olthuis et al., 2014).

5.3.1 Ethnography

The roots of ethnography can be found in the tradition of anthropology and involve the researcher being immersed in the community under investigation to provide an in-depth description of the interactions of people and the culture of the society (Hammersley & Atkinson, 1995; Merriam & Tisdell, 2015). This qualitative methodology's central value is its ability to capture human behaviours that are covert and tacit, and it has been used to explore experiences in acute care settings (Huckstadt, 2002; Olthuis et al., 2014). Therefore, using ethnography as a methodology could have answered the research questions. However, it lacked emphasis on participation and catalysing of change and thus would not entirely meet the study's aims and objectives, so it was discounted.

5.3.2 Grounded theory

Grounded theory has its foundations in symbolic interactionism and perceives meaning as socially constructed, negotiated, and time and place dependent (Grbich, 2007). This methodology has been used in health-related research to examine patients experiences, where the focus of the study is on theory development (Attree, 2001; Mottram, 2011). Grounded theory would have been suitable for this study as there was little known about the phenomenon and would have supported the exploration of individual experiences and thus could answer the research questions. However, the study's impetus was understanding participants' experiences and contributing to the development of a service based on the needs of the population it served. Therefore, because grounded theory was more focussed on producing and constructing explanatory theories and lacked the emphasis on participation, it was deemed unsuitable for this study.

5.3.3 Participatory Action Research

In line with social constructionism, Participatory Action Research (PAR) was also considered. The methodology seemed appropriate to explore the experiences of patients, carers, and NHS staff in an AEC unit. PAR draws on other research methodologies such as case study, ethnography and phenomenology, and the methods most often used are interviews, observations, and document reviews (Khan & Chovanec, 2010; Waterman, Tillen, Dickson & de Koning, 2001). Action research has been used to explore people's acute care settings experiences (Dewar & MacKay, 2010; Spilsbury et al., 1999).

Tracing action research history is difficult due to its diversity, but most action research proponents start with Kurt Lewin and John Collier (Pasmore, 2006; Reason & McCardle, 2008). Kurt Lewin is widely recognised as the leading advocate of action research (Pasmore, 2006; Reason & Bradbury, 2006). Lewin was interested in finding ways to help solve social conflict and was driven by a desire to inspire research that could address poverty issues in marginal communities (Waterman et al., 2001). Thus, he proposed that co-operation between the researcher and the people affected was needed to promote social transformation, change and learning for everyone involved (Carr, 2006; Reason & McCardle, 2008).

The idea of interweaving action-for-learning, social improvement and democracy was consistent with other writers' thoughts in the early twenty-first century, such as John Dewey (Hart & Bond, 1995; Pasmore, 2006). However, critics of Lewin's work pointed out that participation is often seen as a tool to obtain workers' support rather than reflecting a collaborative culture (Carr & Kemmis, 1986). The criticism against Lewin reflected the NHS's current situation as the government's focus on improving patients' experiences appeared to be contrasted by the discourse at the periphery. Feedback received from patients, carers and NHS staff at the beginning of the study mirrored this when some of them verbalised that the study would be "*just another paper exercise*". Furthermore, the policy priorities did not appear to align with NHS organisations' capacity to successfully support and enable local developments to improve experiences, leading to criticism from the public and NHS staff.

Thus, to ensure participant's concerns were brought to the forefront, opening and maintaining a dialogue with them throughout the study was imperative (Koshy, Koshy & Waterman, 2011). However, while the study started as a PAR study, the complexity of the research environment and the urgent and emergency care division's unpredictable nature limited this strategy's potential to answer the research questions, aims and objectives. The two PAR elements that remained central throughout the study were *participation* and *transformation*, and linking these elements with case study research enabled balancing the drive to do meaningful research with doing rigorous research in an unstable environment (Argyris & Schon, 1996; McManners, 2015). Thus, I combined the participatory and change elements of PAR with a qualitative case study methodology.

5.3.4 Case study

The practice of case study research can be traced back to casework in social work and the Chicago School of Sociology (Hyett, Kenny & Dickson-Swift, 2014). Since then, case studies have become a well-established research methodology that has increased in popularity among qualitative researchers across different disciplines (Anthony & Jack, 2009; Creswell, 2013; Merriam, 2009; Robson, 2015; Simons, 2009; Stake, 1995; Yin, 2009). The use of case study research had also increased in nursing to produce in-depth and contextualised studies of clinical phenomena (Atwall, 2002; Colon-Emeric et al., 2010; Crowe et al., 2011; Martin; Jackson & Wright, 2018; McMurray & Wallis, 2010; Rycroft-Malone et al., 2009). Specifically, it is often used to explore peoples' experiences in acute care settings, and the conventional methods used are participant observations, interviewing and reviewing of documents (Baillie, 2009; Baillie et al., 2014; Bailey et al., 2016; Hancock & Algozzine 2006).

The leading proponents of case study research are Sharan Merriam (1998; 2009), Robert Stake (1995) and Robert Yin (2009), who all highlighted the importance of the in-depth exploration of a phenomenon (case) to get to the crux of the problem. Both Stake (1995) and Yin (2009) suggested that case studies are best suited to answer "how" and "why" research questions. They have written extensively about case study research but employed different methods for organising and conducting such research successfully, which appeared to be influenced by their philosophical worldviews (Baxter & Jack, 2009; Hyett, Kenny & Dickson-Swift, 2014; Merriam, 1998; Stake, 1995; Yin, 2009). The work of Stake (1995) and Meriam (1998) is situated in a social constructionist paradigm, whereas Yin (2009) approaches case study from a post-positive view (Baxter & Jack, 2009; Hyett, Kenny & Dickson-Swift, 2014).

Yin (2009) and Hancock and Algozinne (2017) pointed out that a case study methodology can be qualitative or quantitative. On the other hand, Stake (1995) focussed exclusively on a qualitative approach. A qualitative approach was utilised because it could clarify *what* was happening on the unit and *how* participants made meaning of those events and thus aligned with social constructionism and interpretivism that acknowledged participants interpretations of events. Utilising a qualitative case study enabled an in-depth contextualised description of participants' experiences and supported ongoing reflexivity about my assumptions and biases (Merriam, 1998; 2009; Stake, 1995; Yin, 2009). Thus, showing methodological integrity and candour valued in both interpretive research tradition and case study research (Wager & Kleinert 2010). Equally, using a qualitative case study supported my intent to discover communalities in experiences that may inform the set-up of other AEC services.

The defining features of case study research are the in-depth investigation of a complex, contemporary phenomenon (case) in its natural setting to understand the impact of behaviour and social interaction on it and using multiple sources of data to do so (Anthony & Jack, 2009; Flyvbjerg, 2011; Merriam, 2009; Robson, 2015; Stake, 1995; Yin, 2009). The case can be an individual, a group, a setting, or an organisation (Robson, 2015; Stake, 1995; Yin, 2009). This study was concerned with exploring participants' experiences and facilitating their participation in actions that would improve the AEC environment and, consequently, people's experiences.

Thus, based on the complex phenomenon of interest (the experiences of participants in AEC) and the lack of available evidence about how the introduction of these services influenced the experiences of the people who used them, case study methodology was selected. Additionally, the lack of clarity and research evidence about the relationship between the contextual factors (historical, social, political, and economic) and these services' ability to function effectively and meet the desired outcomes (improving patients' experiences) also made the methodology an appropriate choice (Stake, 1995).

Stake's approach to case study research (1995) was congruent with the study's social constructionist stance and adopted to frame this case study. His case study approach enabled an exploration of the complexities that shape participants' experiences within an AEC and obtain insight and a holistic understanding of their perceptions and meaning-making of their experiences. Stake (1995) identifies three types of case studies: intrinsic, instrumental and collective. An intrinsic case study is when the researcher has a fundamental interest in learning about the case itself (the case is the focus). An instrumental case study is when you study a case to understand a broader phenomenon of interest (the phenomenon is the focus). However, he warns that sometimes the distinction between the types is not very clear (Stake, 1995). My interest, in this case, was rooted in a desire to improve the practice arena for patients and staff and contribute to AEC services' knowledge base. The case was thus predetermined as I was committed to undertake context-directed research, which refers to "*...the research carried out in a particular context because we are interested in effecting changes in that context…*" (Taber, 2013, p.126). Thus, this was an intrinsic case study as it would support the probing of relationships and issues pertinent to the case.

There are several advantages and limitations of case study research (Merriam, 2009; Robson, 2015). The researcher's role is to rationalise the methodology's selection and be familiar with the associated strengths and weaknesses (Meriam, 2009). The strengths of case study research aligned with the reasons it was selected as a methodology. Case study methodology enables the in-depth investigation of a complex phenomenon within a real-life context, bounded by time and place.

One of the core methodological advantages of case study research is using multiple sources of data to enhance the quality of the findings. The context’s complexity is explored, and the findings are described in detail for the reader's benefit. By using multiple sources of evidence, the findings can be linked and verified, thus evidencing the study's audibility. The in-depth description of the context and the findings would allow readers to interpret the findings in relation to their context and judge the applicability. Thus, insights gained may be beneficial for others in similar contexts, and simultaneously it can address the issue of generalisability, which is seen as a limitation (Merriam, 2009).

A limitation of case study research is that the call for in-depth, thick descriptions, analyses, and report writing can be time-consuming, which can be exacerbated if the researcher has limited experience using the selected data collection and analysis methods. The issues with generalisability, rigour, and the subjectivity of the researcher have frequently been highlighted as limitations, and that is why the case study researcher must ensure issues such as biases are discussed from the onset and decisions regarding methodology and methods are described systematically (Flyvbjerg, 2006; Merriam, 2009; Robson, 2015; Stake, 1995; Yin, 2009).

Case study research has been described and defined widely in the literature (Cohen et al. 2003; Yin 2009; Gillham 2000; Gomm et al. 2000; Bassey 1999; Merriam 1998; Stake 1995). The most common definitions come from the work of Merriam (1998; 2009), Robson (2015), Stake (1995) and Yin (2009). For the present study, I drew on the work of Stake (1995) to frame this qualitative case study as a

> *research methodology that supports an in-depth investigation of a single complex phenomenon bounded by time and place using multiple sources of evidence and multiple methods of data collection.*

5.4 BOUNDING THE CASE

A vital question in case study research is: "*What is the case*?" (Taylor, 2013, p.4). Merriam (1998) remarked that "*the most single defining characteristic of case study research lies in delimiting the object of study, the case*" (p. 27). A case (unit of analysis) is a bounded context used to analyse a particular phenomenon such as an organisation, a class, a policy, or a person and is determined by the study's focus and research question/s (Merriam, 2009). By defining the case's boundaries, the study's scope was considered and included decisions regarding the setting, study population, sample size and the time I needed to spend in the field (Merriam, 1998).

In this thesis, the case selected for inquiry (unit of analysis) was that of the experiences of patients, carers, and NHS staff in ambulatory emergency care. The case was bounded by place: the AEC unit in an NHS Trust in the North-West of England and time: the period from referral to the AEC unit until discharge home or admission to a ward. The planned time scale of the study was twelve months.

5.4.1 Setting

The first step involved the clarification of the location where the selection of the participants would take place. The research site was an AEC unit based in an NHS

Foundation Trust in the North-West of England, as described in chapter one. The unit operated five days a week between 08.00 am and 10.00 pm, and an average of forty patients per day were seen. The unit's patient population included medically stable adults over eighteen years of age who were deemed suitable by the referring practitioner to be assessed, treated, and discharged on the same day and could be accommodated in the waiting room. The sample was drawn from the above patient population, their carers, staff (working in the unit) and GPs/ANPs (referring patients to the unit) to support my aim of gaining a multi-stakeholder perspective. For this study, carers were defined as someone who identified themselves as providing care to patients.

5.4.2 Study population

The second step was defining the target population, guided by my insider knowledge (Robinson, 2014). The paradox of this insider knowledge is reflected throughout the study, and potential biases and conflict were acknowledged to augment transparency. As a healthcare team member, I knew the workforce and patient population, so I framed the initial sample based on the inclusion and exclusion criteria in table 5.1.

Participants	Inclusion criteria	Exclusion criteria
Patients	Treated in the AEC according to AEC Policy	Patients who are not medically stable Patients under 18 years of age Patients who cannot consent
Carers	Accompanying patients treated in the AEC and identified themselves as their care provider (s)	
Staff	All staff working in the AEC	Staff working outside the clinical service area
GPs/ANPs	Referring patients to the AEC	GPs outside the hospital catchment area (access to unit based on funding criteria of CCG)

Table 5. 1 Inclusion and Exclusion Criteria

5.4.3 Sampling approach

The selection process of participants was another essential aspect to consider. At the onset of the study, purposive sampling was deemed most appropriate and refers to the logical and non-random selection of research participants to achieve a goal (Silverman, 2010). My goal in choosing purposive sampling was to seek out information-rich cases (Johnson & Waterman, 2004, p.124), and this was grounded in my knowledge of the unit and the judgement and selection of suitable participants based on their experience and knowledge of care in the AEC (Robson, 2003; Robinson, 2014; Schwandt, 2007). The aim was to generate data that would reflect a detailed account of participants' experiences in the AEC unit and identify the barriers and enablers in the system and strategies for improvement.

5.4.4 Sample size

After constructing the sample population, the next consideration was how many participants to interview in both one-to-one and group interviews. There is no consensus in the literature about the appropriate sample size for qualitative studies (Boddy, 2016), but, some authors link the minimum sample size with the study design as per Table 5.2.

Research design	Minimum sample size
Case Study	4-5 participants (Creswell, 2013)
Narrative	1-2 (Creswell, 2013)
Phenomenology	>6 (Morse, 1994); 5-25 (Polkinghorne, 2005)
Ethnography	30-50 interviews (Morse, 1994); 1 cultural group (Creswell, 2013)
Grounded Theory	20-30 (Creswell, 2013)

Table 5. 2 Minimum Sample size in Qualitative Studies. Adapted from Onwuegbuzie and Collins (2007).

The literature review supported collecting data until saturation, referring to when any further data collected does not contribute new information to the research topic (Silverman, 2010). According to Guest, Bunce and Johnson (2006), whilst saturation occurs in twelve interviews, basic themes are already present after six interviews. The use of saturation was deemed appropriate for the study, and I anticipated that eight to ten one-to-one interviews would ensure the generation of data that reflects the in-depth views of participants. In line with the DProf framework and qualitative research, the sample size was continuously monitored and adapted as needed in response to practical issues and findings of early data analysis (Silverman, 2010). Practical issues included constraints on time and resources, which affected the availability of the participants.

5.5 ETHICAL APPROVAL

Full ethical approval was sought and granted from the University of Salford and the National Research Ethics Service (NRES), the central NHS research body, in advance of the study (Appendixes 1 and 2). Both committees requested minor adjustments to the forms and some clarification before approval was issued (Appendixes 1 and 2). In January 2016, I applied and was approved a substantial amendment from both ethics committees as outlined in the appendices (Appendixes 3 and 4).

5.5.1 Negotiating access

Consent for the study and access to the unit was negotiated through the organisation's R&D process. I approached the R&D lead, who advised me to write to the Chief Executive, the Director of Nursing, and Acute Medicine Directorate's leadership team to request permission for the study was granted. I also met with the Ward Manager of the unit and obtained a formal agreement from her.

5.6 RECRUITMENT

Participants were recruited through posters, leaflets and by staff in the unit. The posters were displayed in different hospital areas and some GP surgeries and contained information about the study and my contact details. As I was also planning to do observations in the unit, which would potentially affect patients, carers and staff, the planned observation was highlighted on the poster (Appendix 7). Leaflets regarding the study were also placed in the waiting room in the unit.

The divisional manager of unscheduled care and the unit's ward manager was approached in advance of the recruitment phase to obtain approval for the study and access to the unit. Before starting the study, a briefing session was held with staff to explain the project and discuss the purpose, data collection methods, time commitments, potential risks and benefits, anonymity and privacy, and answer any questions.

Information regarding the study was only given to patients and carers after the nursing staff's initial assessment to ensure patient safety was maintained. In line with the Mental Health Capacity Act (2005), acutely ill patients and patients unable to consent on their behalf were excluded. An interpreter service was available if needed. All medically stable patients and any accompanying carers were screened using the inclusion and exclusion criteria.

If inclusion criteria were met, they were given a brief verbal explanation about the study and handed the study information pack that contained the invitation letter (Appendix 8), information leaflet (Appendix 9) and consent form (Appendix 14) by the assessment nurse. If interested, they were requested to return the completed reply slip at the bottom of the invitation letter to a staff member before leaving the unit. They were then informed to expect a telephone call from the researcher after one week. This decision was based on my intention to ensure they had adequate time to read the leaflet and think about the study before making a final decision regarding participation.

The study information packs for staff, containing the invitation letter (Appendix 10), information leaflet (Appendix 11) and consent form (Appendix 14), were also given to staff members before the start of the study. They were informed to return the reply slip at the bottom of the invitation letter to me directly or place it in the locked box marked ‘reply slip’ in the ward manager’s office if they were willing to participate in any of the focus groups. The planned focus groups’ dates were displayed in the staff office, and staff were informed to write suitable dates on the reply slip. An agreement was reached with the senior area business manager of the CCG that she would distribute the study information packs for GPs containing the invitation letter to participate in focus groups (Appendix 12), information sheet (Appendix 13) and a consent form (Appendix 14) to the appropriate practices. The information was emailed to her and the GP practices and was followed up with a telephone call.

All the participants who filled in a reply slip were contacted after one week to introduce myself, discuss the study, answer any questions they had and arrange interview dates if appropriate. A few needed more time to consider, so we agreed on a suitable date for the next phone call to discuss if they were happy to return for interviews. No financial incentives were offered to participate.

5.6.1 Patients/carers

Sixty information packs were handed to patients and carers, of which thirty-six reply slips were returned, reflecting a sixty per cent response rate. The reasons people offered for non-participation included anxiety, distrust of the NHS, not interested in taking part and busy schedules. As voluntary participation was central to the study, “self-selection bias” (Costigan & Cox, 2001, cited in Robinson, 2014, p. 11) was inevitable as some people choose not to participate. Twenty participants were purposively selected (ten patients and ten carers) to account for attrition. They all agreed to participate, but two patients became very unwell and subsequently died, and I felt it was inappropriate to approach the relatives at this stage. A further six participants (two patients and four carers) withdrew, citing busy schedules. The final sample of ten participants (six patients and four carers) consisted of four males and six females, ranging between 28 and 88.

Due to the ward closure and office space loss, a substantial amendment to change telephone interviews to face-to-face interviews was submitted and agreed to by both university and NHS ethical committees (Appendixes 3 and 4). Telephone contact was made with the patients and carers who agreed to participate but were still awaiting interviews to inform them of the study’s changes. They all agreed to face-face interviews.

5.6.2 Staff

All staff in the unit agreed to participate in the study and returned the signed consent forms. However, only six could attend the first focus group due to competing work schedules, holidays and gaps in the rota. Six staff members agreed to be observed and were subsequently interviewed following the observations. Four senior managers, influential in the unit's introduction, having championed innovation and working at the Foundation Trust, CCG and AEC Network, respectively, were approached by me and agreed to be interviewed. Three were face-to-face semi-structured interviews, and one was a telephone interview. A substantial amendment to do the interviews were submitted to both ethical committees and approved (Appendixes 3 and 4).

5.6.3 GPs/ANPs in primary care

Initially, invitations to participate in focus groups were emailed out to this group, but no responses were received despite several follow up emails. In discussion with my supervisors, it was agreed that telephone interviews might be more appropriate, and I applied for a substantial amendment to both university and NHS ethical committees (Appendixes 3 and 4). At this point, I emailed the invitation letter to participate in telephone interviews (Appendix 12), a copy of the information sheet (Appendix 13) and a consent form (Appendix 14) to all appropriate GP surgeries. Two GPs and two ANPs agreed to telephone interviews.

Method	Participants	Characteristics	Number of participants	Average time
Observations	Patients/carers/ AEC staff	Male/female All ages All ethnicities Reflecting AEC population Varied reasons for presence in the AEC (assessment, treatment, or		4/7 per week over 4/52 approximately one hundred and fifty hours.
Interviews	Patients/carers	Male/female All ages All ethnicities Reflecting AEC population Varied reasons for presence in AEC	Ten patients and ten carers	One interview per person lasting twenty to thirty minutes
Focus Groups	AEC Staff	Male/female All ages All ethnicities Cross-section of employees Differing lengths of	Ten per focus group	Three lasting forty-five minutes per session
Focus Groups	GPs/ANPs	Male/female All ages All ethnicities Differing lengths of experience	10 per focus group	Three lasting forty-five minutes per session

Table 5. 3 Sampling frame and planned data collection methods

5.7 RIGOUR: ENSURING A RIGOROUS PROCESS

The criticism raised about the quality of case study research includes subjectivity, small scale, anecdotal, not generalisable and lacking scientific and methodological rigour. This case study's purpose was to provide an in-depth description of the experiences of patients, carers, and NHS staff within the AEC context. Thus, objectivity and generalisation were not primary; instead, the focus was on providing a detailed report of the study and the findings to enable other researchers to judge the potential influence of the findings on their study (Robson, 2015).

Andrews and Halcomb (2009, p. xvi) define rigour as *"[t]he thoroughness, accuracy, confirmability, and ethical soundness of all aspects of a study's design [and reporting of the findings]".* The concept of thoroughness aligned with Yin's call for case study researchers to clearly describe the logic behind the research design and process and present the findings in a systematic way (Yin, 2009). In this case study, both the study's design (including the methodological foundations), data collection process and the findings are described in detail. Thus, providing the reader with sufficient detail to understand the rationality behind the design and the findings (Hallberg, 2013; Morse, 2011). Furthermore, the detailed description provided an account of the ever-changing context within which the research occurred and how those changes influenced the study's approach.

The concept of accuracy supported the study's intention to exhibit 'truth-value' and 'trustworthiness' when reporting the findings of participants' experiences in the AEC unit. The qualitative term 'trustworthiness' is akin to the terms 'reliability' and 'validity' and refers to the confidence that the research findings are a trustworthy representation of the data collected about participants experiences (Guba & Lincoln, 1985). The steps I took to ensure trustworthiness included extended periods of observations and participation in the field to ensure those aspects that impacted participants' experiences were captured. Additionally, every individual who was contacted was given time to consider whether they wanted to participate in the project to ensure participation was voluntarily and information was offered freely.

Another method used to enhance trustworthiness was triangulating the data methods and sources, aligning with the calls for case study researchers to use multiple evidence sources

(Stake, 1995). Triangulation refers to *“the use of more than one method or source of data in the study of a social phenomenon so that findings may be cross-checked”* (Bryman, 2008, p. 700). One method's results shaped the next steps in the research process and adjusted some research tools through triangulation. Also, it enabled scrutiny of the data from the various sources and enabled me to consider alternative interpretations and conclusions, thus, strengthening the findings (Stake 1995). Hence, supporting the goal of seeking an in-depth understanding of participants’ experiences whilst simultaneously leaving room for expression and acknowledgement of differences (Silverman, 2010; Stake, 1995; Winter & Munn-Giddens, 2001).

Confirmability is one of the criteria a qualitative researcher uses to establish trustworthiness and refers to the level of certainty that the study’s findings are based on the participants’ narratives and words rather than shaped by the researcher’s potential biases. In qualitative studies, audit trails and reflexivity are often used to demonstrate confirmability. In this case study, confirmability was enhanced by carefully describing the steps taken to collect the data in field diaries and using raw data examples such as participants’ quotes.

These quotes were carefully selected to reflect various participants’ views and not only the most sensational quotes or overly draw on any one quote. The detailed description of the data collection process, data analysis, and data interpretation in the field diaries, therefore, provided an audit trail. Additionally, by recording any unique topics or findings during the data collection process and any thoughts I had about coding, I aimed to provide the reader insight into how codes emerged from the data and the meaning of the themes.

Reflexivity is a crucial element of rigour in qualitative research, and through reflexive journals, it remained central during the study as I challenged my own biases and perspectives. As discussed in chapter one, reflexivity referred to an ongoing process that was both reflective and recursive as I continually reflected on how both my own and participants' actions and behaviours in the AEC setting shaped the study's outcomes (Hibbert, 2010). Reflexivity supported the continuous questioning and articulation of the influence of my background, position, views, attitude, assumptions, perspectives, and beliefs on choices made during the research process and the resultant consequences. Thus, the reader will follow the logic for the choices made at each stage of the research process. The included journal extract from my reflexive journal is an example of ongoing reflexivity.

Research diary entry 23/5/16

Met with supervisor today. We discussed the AEC unit's sudden closure and its new function as a MAU and what my options were. As I have completed most of the planned data collection, we discussed the possibility of writing the study up as a case study. Whilst I was initially up for the challenge, I am starting to question if I wanted to do this. I was prepared that this may happen as it is common in the NHS, but I didn't anticipate changing my focus from action research to a case study. It just won't feel like my study anymore, just something I wrote to comply with academia's rules. I feel stuck as I am trying to unravel what I already have and still need, but afraid to move forward or backwards.

It feels like the time I learned to knit when I was ten years old. The teacher gave each of us wool (mine was purple, my favourite colour), knitting needles and a pattern. Excitedly I started, only to drop a stitch resulting in it unravelling and starting over again. When I handed it in 6 months later, the jumper was black with big holes in it, and I was put off knitting for the rest of my life. Not only did I fail, but my favourite colour turned into the colour I disliked the most. My teacher said I did not follow the pattern or her instructions, so I failed miserably as effort is not enough. I was crushed as I tried really hard, knitting every night, trying to follow the pattern, palms sweating from the frustration of having to pull it all out and start over again. And whatever I did, it just didn't look like the picture I had. It ended in the bin as it was not usable unless you liked big holes in your jumper, and I never really learned to knit.

Extract from reflective research dairy

My interpretation of the teacher's message was that I would not fail again if I do as I am told. I wrestled with the instructions from my supervisor until my critical friend said: "*what your teacher did was offer you suggestions of different ways to get it right, just like your supervisor is doing now. You just took it as a blueprint to follow to the letter".* After the discussion, I reflected on my reluctance to change things and realised my 'paralysis' stemmed from the fear that if I do not follow 'instructions', my study will turn out 'unusable' or 'broken' by the imprints I left as I tried to save it, just like that jumper. I also realised that it was not about 'saving the study', but about being honest about the 'messy-ness' of the study and how it impacted my development as a practitioner-researcher whilst ensuring the study report reflected participants' experiences.

5.8 ETHICAL CONSIDERATIONS

The study's design and execution were rooted in personal values and the NMC *Code of Conduct* (NMC, 2018). As a registered nurse, I have a duty to myself and the profession to ensure all patients receive harm-free care and are treated with dignity and respect (NMC, 2018; Winter, 2015). These professional and personal values were linked to my researcher role during the study. Situating the research in an ethical and transparent framework, I espoused to adhere to the following four principles:

- *Non-maleficence* - to cause no harm to participants.
- *Beneficence* - to carry out research that can be beneficial to participants.
- *Autonomy or self-determination* - to respect the rights, decisions and values of others.
- *Justice* - to treat others fairly.

5.8.1 Informed consent

Informed consent refers to the assurances that participants had adequate facts with enough time for queries and can absorb and retain the information given. One of the problems brought to my attention during the recruitment phase was that participants felt the participant information sheet was long-winded and thus off-putting. Their feedback was in line with that received during the design stages when people verbalised it should be more user friendly and shorter. However, I was bounded by the information required by both ethical committees regarding the information the leaflet must contain to ensure informed decision-making. To offset the likelihood that participants did not read the leaflet, I reiterated the pamphlet's information at the interview stage again.

Using a reflexive approach, my manager and I discussed the appropriateness of interviewing patients whilst they were still on the unit. I also reflected on these concerns with the R&D lead, and we agreed that the patients and carers might feel pressurised to participate whilst they were on the unit. Additionally, the unit was extremely busy at times, and as my priority was to ensure patients were seen and assessed in a timely matter, the data collection could be affected. The decision was taken to do the planned interviews later and give the participants a week to consider the information and make an informed decision regarding participation.

5.8.2 Data protection

All study data were anonymised and coded with a research code to ensure privacy and anonymity. Furthermore, the data was stored in line with the Data Protection Act (1998). The Act states that anyone who collects personal data must be clear about the intended usage, who will have access to it and how long the data will be stored. In line with the Act, I took the following steps:

- Any information about the study that was transferred electronically was encrypted as per the NHS Encryption Guidance.
- The data was stored on the office's computer, which had a door code that was not written down or shared unnecessarily.
- The password-protected databases were only accessible by me.
- The list of participants was kept separate from their data.
- All data was kept in a locked cabinet, where a door code was in operation, and the codes were not written down.
- Study data was to be stored for five years after the publication of the results to enable verification of data if challenged. After this time, it will be shredded and disposed of appropriately.

5.8.3 Anonymity and confidentiality

As an NHS employee, I am bounded by the standards set out in *Confidentiality: NHS Code of Practice* (DH, 2003), the NMC Code (2018), and has to attend annual mandatory training updates. The concerns regarding anonymity and confidentiality remained a central concern throughout the study. While steps were taken to protect the participants' identity, the remaining dilemma was that concealing the staff's identities would be difficult due to the unit's size. I was open with the team regarding the concerns, and they still agreed to participate. Therefore, to reduce the risk, information about age and gender was omitted in describing the sample characteristics.

5.8.4 Risk/benefit

There were no expected physical risks. However, as participants discussed their experiences during the interviews, I anticipated that it might be emotional or upsetting. A risk management plan, which included monitoring for any upset or if anyone wanted to take a break, was prepared. None of the participants became emotionally distressed during the interviews. When the interviews were at participant’s homes, my contact details and information regarding an interview’s expected duration were given to a colleague. Furthermore, my mobile remained switched on, and I contacted the colleague after completing every interview in line with the University’s Lone Researcher Policy.

5.8.5 Conflict of interest

As I worked in the unit, there was a possibility that my ANP duties might clash with the researcher role. However, as a registered nurse, I was bound by the NMC Code (2018) to act if unsafe or unethical behaviour was seen. Thus, I was clear with participants about my roles and responsibilities as a registered nurse and researcher. During one of the interviews with a carer, he raised an issue about a senior staff member’s behaviour that caused the family distress, and I informed the ward manager about their concerns. I reflected on the event and resultant consequences for the patient, their family and the study in chapters seven and eight.

5.8.6 Complaints

Any complaints raised by patients or carers were handed over to the ward manager or team leader of the day. Additionally, the leaflet “*How to complain*” and the liaison team’s contact details were given to them. During the study, I received two complaints from relatives, both about the time their relative had to wait for CT scan results which I handed over to the ward manager.

5.9 SUMMARY

This chapter linked the underpinning research epistemology of constructionism and the theoretical perspective of interpretivism with the assumptions and characteristics of a single qualitative research strategy to answer the research questions. As the study aimed to understand the phenomena of participants' perceptions of their experiences on AEC, a single intrinsic case study was selected. The case and its boundaries were identified, and participants' recruitment, negotiating access, and ethical approval was explained. Additionally, the techniques used to ensure the research design framework was rigorous and ethically sound were discussed. In chapter 6, the selected data collection methods and the data analysis process are outlined. The challenges that occurred and the steps to overcome those challenges are discussed.

CHAPTER SIX METHODS

6.1 INTRODUCTION

The two previous chapters introduced the reader to three of the research design elements: the philosophical perspective, the qualitative research approach, and case study methodology. In this chapter, the fourth element of the research design, data collection methods, is described, and the rationale for their selection provided. As discussed in chapter 5, it was imperative to demonstrate the link between the research questions, interpretivism, qualitative case study and the selected methods. Thus, whilst the research design elements are presented in separate chapters, it is vital to remember that the design frame elements were not separate entities in this qualitative case study research but signified an iterative and recursive process.

In this chapter, the data collection instruments' design process is described, and a summary of how the research objectives were linked to the selected methods are provided. The data collection process is described in detail, and the selected methods' potential limitations and how these limitations were minimised during the fieldwork are explained. Finally, the techniques and procedures utilised to ensure patient and public participation are discussed.

6.2 RATIONALE FOR METHODS

Methods refer to the data collection techniques used to generate knowledge about the experiences of the care of patients, their carers, and NHS staff (Bryman, 2008; Crotty, 1998; Mason, 2018). The use of the word 'generate' rather than 'acquire' was in line with the epistemological position taken during the study that viewed knowledge creation as an active and interactive process between researcher and participants (Mason, 2018). However, the decision of which methods to use was also a pragmatic one and affected by real-world limits like my experience as a researcher and practical issues like resources, time, place, and availability of participants as often expressed by other researchers (Brown & McCormack, 2011; Flick, 2015; Patton, 2014; Silverman, 2010; Winter & Munn-Giddens, 2001). Thus, the decision-making process regarding methods' suitability was practical, dynamic, and adapted to participants' feedback and events that affected the study context. Furthermore, the approach to methods selection and the design of research tools were transparent, reflexive, and iterative, as displayed in Figure 6.1.

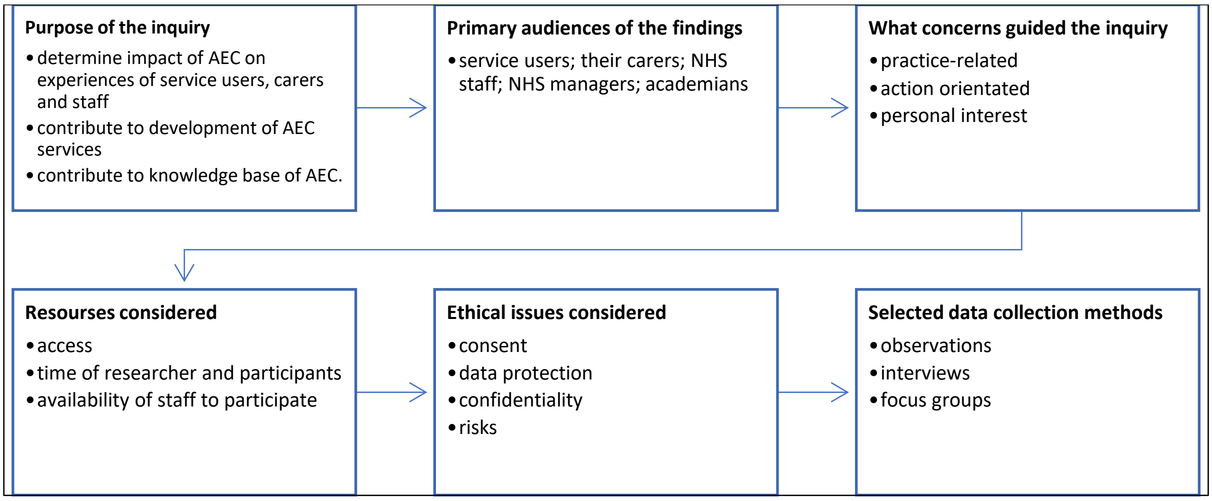


Figure 6. 1 Guiding questions for reflection on methods. Adapted from Patton (2014, p. 21).

Following the multiple sources of evidence concept associated with case study research, multiple data collection methods from multiple sources were utilised to explore participants' experiences. The triangulation of data collection methods supported and enabled the attaining of depth whilst simultaneously leaving room for expression and acknowledging differences (Silverman, 2010; Winter & Munn-Giddens, 2001). The data collection methods considered were observations (including informal conversations), semi-structured interviews and focus groups. Table 6.1 contains a summary of how the selected methods were linked to the study's objectives and included the questions about the methods considered during the planning phase and throughout the study

Objectives	Research Method	What type of information can you gain?	Advantages	Challenges
To critically explore the experiences of patients, carers and NHS staff in AEC	Observations	Access to non-verbal communication.	Flexible (Mack, Woodsong, Macqueen, Guest & Namey, 2005; Mason, 2018)	Challenges with managing the observations process, including documentation (Flick, 2014).
To determine which areas of the patient journey through AEC needed improvement or reinforcement		Will allow comparison between what was said in interviews and focus group and what happened in reality.	Serve as a check against participants' reporting of what they believe and do against reality (Mack et al., 2005).	Issues with acceptance of the researcher and the dilemma between participation and maintenance of distance (Flick, 2014).
To implement required changes to the AEC service by working with staff, GPs, and managers		Information about the interplay between the perspectives of participants and the context.	Collect data in a naturally occurring environment, giving insight into interactions (Mack et al., 2005; Mays & Pope, 1996; Mulhall, 2003).	
		Can allow the researcher who is an 'insider' to view interactions from an 'outsider' perspective and vice versa.	Illustrates the whole picture-physical, social and cultural contexts (Mack et al., 2005; Mays & Pope, 1996; Mulhall, 2003).	

		Can shape the questions needed for interviews and focus groups.	Situates observed behaviour in context (Mays & Pope, 1996; Somekh & Lewin, 2011).	
		Gives first-hand perspectives of participants.	Can support or inform other data collection methods (Mack et al. 2005; Polkinghorne, 2005; Robson & McCartan, 2016).	
To critically explore the experiences of patients, carers and NHS staff in AEC	Interviews	Provides individuals' perspective of experiences of care.	Flexible (Mack et al., 2005; Mason, 2018)	Time-consuming (Polkinghorne, 2005).
To determine which areas of the patient's journey through AEC needed improvement or reinforcement		Both the interaction and encounter can provide insight into the experiences of care.	Useful for eliciting individual experiences (Mack et al., 2005; Mason, 2018).	Quality of data depends on the skills of the interviewer (Polkinghorne, 2005).
		Gives researcher access to body language and gestures.	Gets at interpretive perspective, i.e., the connections and relationships a person sees between particular events, phenomena, and beliefs (Mack et al., 2005).	Data is dependent on the responses from the participants and the ability of participants to express themselves (Cohen, Mannion, & Morrison, 2007; Mason, 2018; Patton, 2014).

			Elicits in-depth responses, with nuances and contradictions (Mack et al., 2005; Mason, 2018).	Can be difficult to arrange due to people’s time schedules (Creswell, 2007).
			Access to non-verbal communication (Onwuegbuzie et al., 2010)	Challenges with conducting the interviews-(Creswell, 2007).
			Informal (Mason, 2018).	Problems with power imbalances (Anyan, 2013).
To critically explore the experiences of patients, carers and NHS staff in AEC	Focus groups	Gives insight about the dynamics of the group and the ‘mini-culture’ on the unit	Good for eliciting group norms (Mack et al., 2005)	Data quality depends on the skill of the facilitator (Mason, 2018).
To determine which areas of the patient’s journey through AEC needed improvement or reinforcement			Faster and economical (Onwuegbuzie et al., 2010).	Focus groups are not fully confidential or anonymous because the material is shared with the others in the group. (Morgan, 2002).
To implement required changes to the AEC service by working with staff, GPs, and managers			Increase number of participants (Onwuegbuzie et al., 2010)	Power differences between the participants may prevent people from speaking out or lead to one person dominating the group (Creswell, 2014; Mason, 2018).

			Elicits information on a range of norms and opinions quickly (Mack et al., 2005).	
		Provides a group perspective of experiences of care	Creating a space where staff can express views, and clarify the difference in understandings (Hennick, 2007, p.7; Kitzinger, 2005).	
			Group dynamic stimulates conversation, reactions (Mack et al., 2005).	

Table 6. 1 Critique of suitable methods. Adapted from Mason (2018).

6.3 DEVELOPING INSTRUMENTS AND COLLECTING THE DATA

Data collection commenced on the 11th of March 2015 over fourteen months and was completed in May 2016 as per Table 6.2.

Method	Number of participants	Dates	Time of activity	Transcribed	Records
Observations (Plus informal discussions with ten patients and carers)		March - April 2015	100 hours	No	Fieldnotes and Hand-written notes in a research diary
Semi-structured face-to-face interviews with AEC staff	Six	March-April 2015	10-15 minutes per participant	No	Audio recording, fieldnotes and hand-written notes in a research diary
Semi-structured face-to-face interviews with patients	Six	March 2015-April 2016	40 -60 minutes per participant	Yes	Audio recording, fieldnotes and hand-written notes in a research diary
Semi-structured Face-to-face interviews with carers	Four	March 2015-April 2016	40-60 minutes per participant	Yes	Audio-recording, fieldnotes and hand-written notes in a research diary
Focus Group with AEC staff	Six	May 2015	60 minutes	Yes	Audio recording, fieldnotes and hand-written notes in a research diary
Semi-structured Telephone Interviews with GPs/ANPs	Four	April 2016	20-30 minutes per participant	Yes	Audio recording, fieldnotes and hand-written notes in a research diary
Semi-structured interviews with senior managers (Two telephone and two face-face)	Four	May 2016	20-30 minutes per participant	Yes	Audio recording, fieldnotes and hand-written notes in a research diary

Table 6. 2 Summary of completed data collection methods

6.3.1 Observations

Observations are frequently used in case studies where the research focuses on understanding the participant's perspectives of an issue and how the cultural, physical, and social context influenced their perceptions (Merriam, 2009; Stake, 1995; Yin, 2009). My decision to use observations as a data collection tool stemmed from an interest in people's actions and interactions in real-time social relations to understand what was happening (Holstein & Gubrium, 2008; Ledderer, 2011). By observing the participants in the AEC unit, their actions, roles, and behaviours and how they interpret and respond to situations were contextualised (Dixon-Woods et al. 2012; Flick, 2015; Maben et al., 2012a, 2012b; Walshe, Ewing & Griffiths, 2011). According to Bryman (2008), during observations, the researcher *"…immerses him or herself in a group for an extended period of time, observing behaviour, listening to what is said in conversations…, and asking questions*" (p.402). Thus, according to his definition, observations involve observing and clarifying observed behaviours through follow-up interviews or reviewing documents (Bryman, 2008).

There is an ongoing debate amongst researchers about whether observations and interviews should be viewed as mutually exclusive methods or if there is room to use elements of both (DeWalt & DeWalt, 2011). Whilst I view them as distinctive methods, I agree with the latter that there is room to use elements of both to support or clarify what you saw or hear. Using informal or formal interviews as an adjunct to observations is a valuable tool to avoid misunderstanding about practices and behaviours that are witnessed (Agar, 1996; Bryman, 2008; Ledderer, 2011). As I was interested in understanding the meaning of actions from the participants' perspectives, interviews were used to gather and verify the information collected. Other researchers have used informal conversations and follow-up interviews to substantiate their data (Mead, 1930; Ledderer, 2011).

The use of observations in nursing studies can be traced back to Jeanne Quint's study *The Nurse and the Dying Patient* in 1967 (Morse, 2013). Since then, other nurse researchers have used it as a data collection method, specifically in studies looking at the experiences of patients, carers, and nursing staff (Atkinson, 2013; Baillie, 2009; Gerrish, 2003; Maben et al., 2012a, 2012b; Vasey, 2015). Thus, in line with the study's first objective, "*To critically explore the experiences of the patients, carers, and NHS staff",* observations enabled me to not only explore their experiences but also to 'see the whole picture' of how those experiences were shaped by the physical, social and cultural contexts.

Additionally, observations enabled me to follow the patient's journey through AEC from referral to discharge and uncover the areas that needed improvement. Thus, meeting the second objective of the study: "*To determine which areas of the patient's journey through the AEC unit needed improvement".* The decision to use observations also aligned with the participatory approach often associated with case studies as it enabled participants to implement changes needed and thus contributed to the meeting of the third objective of the study "*To implement required changes to the AEC service by working with staff, GPs, and managers".* Furthermore, the contextualisation of actions and behaviours aligned with the study's interpretive frame and the selected qualitative case study design.

6.3.1.1 Role of the researcher

The researcher's role has been conceptualised differently in the literature (Creswell, 2013; Flick, 2006; Bryman, 2008). For this study, I followed the typology by Gold (1958), who described it based on the extent of involvement with participants in setting, ranging from the complete participant; the participant-as-observer; the observer-as-participant and the complete observer (Creswell, 2013; Bryman, 2008; Flick, 2006). However, whilst the decisions regarding my level of involvement started early in the study, it was not a "*once and for all decision*" but one that required ongoing reflexivity and flexibility and was also affected by my current role as an ANP on the unit (Mason, 2018, p. 151; Pope, 2005; Somekh & Lewin, 2011).

In this study, the decision to use 'non-participant' (complete observer) observations as a method was made during the planning phase and included in the ethical approval applications. The decision was based on my concerns that the AEC unit's high activity levels would affect the data quantity and quality. However, reflecting on the decisions made in the planning phases, it became clear that some of those decisions were influenced by the thinking of a relative novice researcher who was still learning about the importance of aligning components of the research design. Thus, I did not question whether this type of observation fitted the study's philosophical frame. Additionally, the very essence of my role as an ANP on the unit meant I could never be a complete observer as I was already part of the group I wanted to study and, thus, a participant observer.

6.3.1.2 Planning the observation phases and the development of associated tools

During the planning phase and before entering the field, extensive thought was given to observations' practicalities, such as recording the observations. The decisions included whether to make notes during the observation sessions or to write fieldnotes afterwards. A lightly structured format was used for an audit trail and served as a memory aid (Bryman, 2008).

Observations in the unit were divided into two distinct phases: the first phase focused on the activities from referral to the unit until discharge and how that affected participants and was structured and focused. The second phase included selective observations on the unit and was framed by a lightly structured topic guide. Both phases focused on obtaining the information needed to address the objectives, as outlined in table 6.1.

For the first stage of the observations phase, a mapping tool was adapted (Appendix 15). The tool was developed by the NHS Modernisation Agency (2005) and used at AEC service improvement workshops held by the NHS Institute for Innovation and Improvement. The information acquired from this tool included a patient details section where details such as age, gender, referral date and time, the reason for attendance, key symptoms, and the referral pathway were recorded. Additionally, the tool contained a table that enabled the chronological recording of each step in the care pathway and any issues, as demonstrated in table 6.2. The term ‘stage‘ refers to an aspect of their care pathway (referral, assessment, treatment and discharge). The plan was to observe ten patients and their carers from referral to discharge for five days.

Stages (from referral to discharge	**Description of Action**	**By Whom?**	**Time started**	**Time completed**	**Comments (any problems or comments by staff/patients/ carers)**
Referral	Referred to unit	GP	09.00	09.08	GP reports a long wait for the call to be answered by switchboard.

Table 6. 3 AEC Patient mapping tool from admission to discharge (adapted from the NHS Modernisation Agency, 2005).

For the second stage of the observations phase, a topic guide (Appendix 16) was developed from two sources: the reviewed literature and the informal conversations with staff, patients and carers in the unit during the planning phase. The topic guide consisted of a table that included five areas: communication and information; waiting times; the environment and facilities; staffing and patient/family & friends involvement. The plan was to do observations on the unit over three weeks.

6.3.1.3 Collection of data

Observations were undertaken over four weeks. I attended the unit dressed in uniform with a visible identification badge and liaised with the nurse in charge (co-ordinator) to inform her of my presence and to determine if there was anything I should be aware of, such as unwell patients or areas that should be avoided due to infection. During this observation period, there were no issues highlighted regarding possible infections or unwell patients. At the start of each observation period, I introduced myself to the patients and carers on the unit and explained my purpose briefly and obtained their verbal consent.

In the first phase of observations, ten patients referred to AEC were observed from referral to discharge, between 08.30 and 20.00 for five days (O=38.5hrs), for a period of up to eight hours to follow them through the stages of care they received. When GPs called the unit, they were informed about the observations and asked to inform the patients and carers. When the patients arrived on the unit, the admission nurse completed their initial observations, and if they were stable, she informed them again about the observations and gave them a copy of the poster about the study. At that point, I introduced myself and explained the study's purpose briefly and obtained their verbal consent to be observed for the duration of their stay.

The observations were documented on a patient mapping tool (Appendix 15). Other observational data such as facial expressions, gestures, tone of voices and the physical environment (noise and activity) were also recorded on the same form. This approach allowed for recognising the different people involved in the patients' care and why and identifying any duplication in procedures. Moreover, the tool enabled me to compare their care journeys and experiences and ascertain how much impact healthcare staff's actions and behaviours and the practices on the unit had on it. The mapping tool's use also aided the construction of a visual presentation of a patient's journey through the AEC from referral to discharge (Appendix 17), which I completed soon after every observation.

Additionally, I had informal discussions with the ten patients and accompanying carers during and after the observations. The initial observation phase provided insight into the patient's journey through the AEC from referral to discharge and identified those issues that needed further exploration. An example was a delay in the referral phase caused by the long waiting time GPs experienced for their calls to be answered by the hospital switchboard, which was addressed by installing a direct GP referral telephone line.

The second part of the observations included the observations of members of the AEC team using the topic guide (Appendix 16). Over two weeks, six different members of the team were observed on different days (O=24hrs) and included a healthcare assistant (HCA), registered nurse (RN), receptionist, consultant, registrar, and junior doctor. Follow-up interviews were done and deemed appropriate as they would allow participants to explain the actions observed in practice. During these sessions, I noted the arrangement of physical space and the people within that space, the activities on the unit, and the interactions between people (verbal and non-verbal, including facial expressions, voices and gestures).

A further week was spent in the patient's waiting area and the unit's reception area, enabling me to focus on the observable (both directly and indirectly), including perceptions about the use of the physical space, noise, and activity levels (O=37.5hrs). These observations added additional information about what happened in the unit and any challenges patients, carers and staff encountered.

During the observation period, rough fieldnotes of observations were made and later transcribed into the fieldwork diary. The notes' outline included references to the physical environment's design and how it was navigated and utilised by service users, carers, and staff. I also looked at how people worked, noting any challenges in the patient's journey and its impact on experiences. The hours spent on the unit as a participant-observer enabled me to experience the events from an outsider's perspective and record them as they transpired in the context of the unit itself and the rest of the hospital (resources available, environment, activity levels in A&E).

The fieldwork diary and fieldnotes became part of the study's audit trail, as they contained descriptions of critical events as they occurred chronologically within the context. In this qualitative case study, the in-depth description of the participants, location, data collection, analysis, decisions taken, interpretations made and my views, beliefs, biases and assumptions held in the field diaries were imperative. Therefore, providing a decision trail that the reader can follow and then judge the study's quality, transferability, and worth. Thus, aligning with the study's ethical and transparent framework and contributing to its quality framework.

6.3.1.4Reflection on issues encountered in the field

Wearing a uniform was a requirement from the NHS ethics committee which I thought would positively impact people's acceptance of my new role as a practitioner-researcher; thus, overcoming the dualism of being a team member yet a professional stranger. Personally, the uniform also served as a comfort blanket and symbolised an expert clinician whilst hiding my inexperience as a researcher. In other words, I associated the wearing of a uniform (my appearance) with people's perceptions of my professional identity and competence (Stone, 1962).

Unfortunately, wearing the uniform also signalled 'a pair of hands' to staff, managers and other service users, and I was frequently asked to do things or advise on things in the middle of an observation, which caused me anxieties as I feared I would miss something or not document enough. The issue of note-taking during observations (*how much, where, what*) and the struggle to balance immersion in a setting and writing notes is recognised by others (Emerson, Fretz & Shaw, 2007; Mulhall, 2003).

The unit’s ‘busyness compounded my anxieties regarding documenting observations’, as I was concerned about how that would impact the collected data’s quality. Despite doing most of the observations in my own time, I felt guilty watching staff struggle during busy times and, coupled with my frustrations with frequent interruptions, led me to end the observations early on a few occasions to help in the unit. As a staff member, I knew which times of the day were the busiest but avoiding the unit at those times was not an option as it would not give the real-life insight that was needed. Similar issues were experienced by other researchers studying their workplace (Atkinson, 2013; Griffiths, 2010). However, my ‘insider’ knowledge of the setting prepared me to an extent for the issues mentioned above, so I used a topic guide to ‘structure’ my note-taking and supplement that with notes in the research diaries.

As an ANP who worked on the unit, my biggest challenge was overcoming the issues of familiarity, being taken for granted and over-identification with the staff, which could impact the quality of collected data (Adler & Adler, 1994). However, I found that the physical act of observation allowed me space to emotionally disengage from my ANP insider role and view the AEC milieu as an observer. When immersed in the workday, my focus is on providing treatment to patients and problem-solving, thus narrow and focussed. As an observer, whilst sitting with patients and relatives in the different areas of the unit, my focus expanded to the unit and everyone within it. I saw a hectic, at times even chaotic and noisy unit, but noted the small efforts staff made to ensure patients’ comfort (every patient was offered a cup of tea on arrival). The intersecting relationship between the situation (the specific set of circumstances and my position within it), the context, research participants, and me were highlighted through ongoing reflexivity. Thus, situating me on both sides of the practitioner-researcher hyphen enabled me to adjust the lens (from narrow to more expansive) depending on the situation and afforded me the balance between strangeness and familiarity.

Practical issues such as ‘misplaced notes’ and the frustrations it caused for staff and the resultant delay in the patient’s journey were also highlighted. The team addressed the issue by fixing labelled boxes (nurse assessment, medical assessment (clerking), treatment, discharge) to the unit’s reception desk, and staff were instructed to place notes in the appropriate box once they have used it. For example, once the assessment nurse completed the assessment, he/she would place the notes in the medical assessment box.

6.3.2 Interviews

Qualitative interviews are viewed as a conversation between researcher and participants and commonly used to explore participants’ perceptions, beliefs, and views that surveys and questionnaires cannot capture (Polkinghorne, 2005; Rubin & Rubin, 2012; Seale, 2004). In healthcare research, interviews are a popular data collection method, especially when exploring sensitive topics or when one wants to understand an issue such as experiences from the participants’ perspectives (Clements, 2012; Luxford et al., 2011; Luxford & Sutton, 2014) or the ‘relational’ aspects of experiences (Mason, 2018; Tsianakas et al., 2012). Yin (2009) viewed interviews as one of the most important data collection methods in case study research, and he ascribed the appeal of interviews to their interactive nature and flexibility. Thereby, aligning with social constructionism interviews offer participants the opportunity to tell their constructed story of their experiences (their reality) (Crotty, 1998Spradley, 1979). Thus, meeting the study’s first objective “*To critically explore the* *experiences of the patients, carers, and NHS staff"*. Additionally, interviews shed light on the areas that needed improvement, thus meeting the study's second objective: "*To determine which areas of the patient's journey through the AEC unit needed improvement"*.

During the study's design phase and throughout the study, consideration was given to the different variables that would affect the outcome and the interview data's quality. These included the type of interviews, the interviews' location, whether to use topic guides, how to record the interviews and how I would impact this process. Additionally, steps were put in place to address ethical concerns regarding informed consent, participants' well-being, and anonymity.

6.3.2.1 Types of interviews

Qualitative interviews take on different forms depending on the structure and can be placed on a continuum. The structured interview is where questions are delivered in a pre-determined order; the semi-structured interview uses open-ended questions based on the research focus, and the unstructured interview is comparable to a free-flowing conversation (Fontana & Fray, 2008; Robson, 2011). Interviews can be done face-to-face or over the telephone, in groups such as focus groups or with individuals (Creswell, 2014; Rubin & Rubin, 2012), and each type has its advantages and drawbacks, as outlined in table 6.1.

Telephone interviews are the preferred option when access to participants is problematic, but the literature highlights disadvantages such as no access to non-verbal cues and cost (Creswell, 2014). When interviews were considered, I was aware that they were time-consuming (they can take between 30 and 90 minutes to complete, and transcription can take up to ten times the interview length). I also considered whether to record interviews or write notes and concluded both would be useful, depending on the context and situation (Petty, Thomson & Stew, 2012). Semi-structured telephone interviews were deemed appropriate for this study as they would offer non-intrusive and practical ways to explore participants' experiences and highlight the areas they felt needed changing or re-enforcing. Thus, meeting the first two objectives, as noted in table 6.1.

Due to the loss of office space, the interviews with patients and carers were changed to face-to-face interviews, as discussed in chapter 5. Some interviews were conducted telephonically, some at people's home or offices and some on the unit. Whilst patients and carers were offered a choice about where they wanted to be interviewed, the other participants' decision about interview location was pragmatical and based on their availability and schedules and whether there was a room available. That said, all participants' interviews ultimately occurred where they felt comfortable and at ease (areas that were 'their own territory'). Furthermore, during this case study, the data collection process was rigorous and iterative, and interview data was not viewed in isolation but alongside data collected from observations and focus group.

However, remaining aware that the variation in settings can lead to differences in responses and concerns about rigour and ethics was crucial. Thus, steps needed to be taken and documented clearly to address those concerns and protect the data's quality. The data collection process was described in detail. All interviews were audio-recorded, and additional hand-written notes were taken. The steps took to address ethical concerns regarding informed consent, the participant's well-being and anonymity were the same regardless of the venue of the interviews (see chapter 5).

6.3.2.2 Planning the interviews and topic guide

One-to-one semi-structured interviews guided by a topic guide were planned (Appendix 18) to strengthen, compliment or extend findings from observations and focus groups. The interview guide was developed from themes highlighted by the literature review in chapter three. Additionally, the interview guide supported the use of both open and closed questions, which offered participants the opportunity to expand or provide more information. My reasoning for using a semi-structured interview approach with an interview guide was to allow the participants to talk freely as per Yin (2009), but simultaneously due to the topic's nature, I believed that the participants might require prompting.

6.3.2.3 Collection of data

6.3.2.3.1 Semi-structured interviews with staff

I interviewed the six staff members I observed in practice after each observation session in an office just off the unit to ensure they remained in the clinical area. All of the participants consented to be interviewed and signed the consent form (Appendix 14). The interviews lasted between ten to fifteen minutes. Their goal was to clarify and verify events and actions that occurred during the observations and allow the participants to elaborate on their actions and thoughts during the observations. Due to time limitations, questions were focused on their behaviour or experience, opinions or beliefs, feelings, knowledge, and sensory experience (Coffey & Atkinson, 1996; Emerson, 2001; Patton, 2014).

Anticipated issues included interruptions and time limitations due to the environment’s nature, which occurred as anticipated. One of the issues was documentation of the interview, and the decision was made to audio-record the interviews and transcribed them verbatim. Separate rough fieldnotes were also kept for each participant, and this was later transcribed in the fieldwork diary. The documentation included key phrases and body language such as pauses, tone of voice and gestures, which was highlighted with different coloured marker pens (this was done for all interviews done during the study).

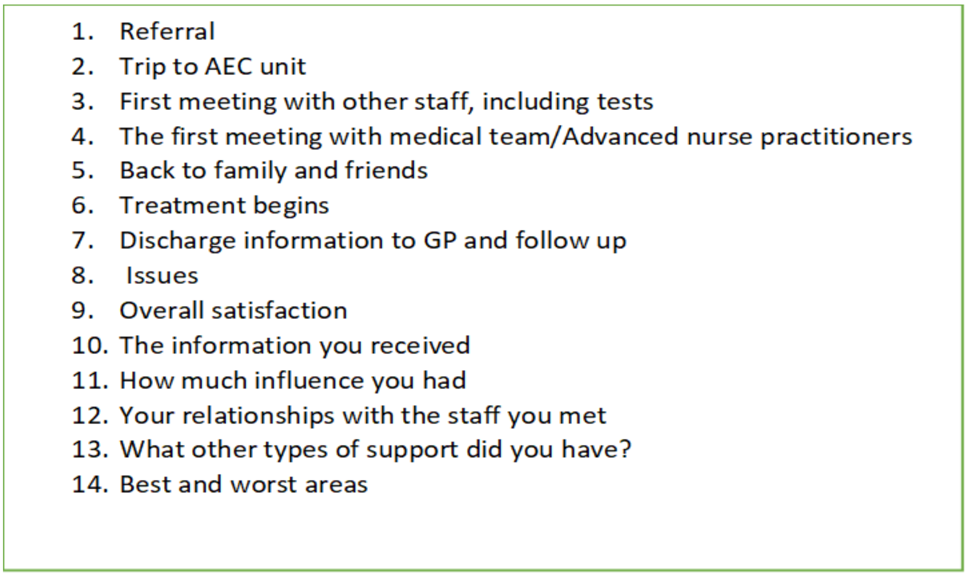
6.3.2.3.2 Semi-structured interviews with senior managers

Interviews, structured by a topic guide (Appendix 20), were held with a sample of four managers at a time and place convenient for them and lasted between twenty to thirty minutes. Before starting the interviews, I determined if they had read the information sheet (Appendix 11) and had any concerns or issues they wanted to clarify. We discussed the purpose of the study and my role and clarified their expectations. I reviewed the consent form (Appendix 14) again and confirmed that they were happy to proceed with the interview.

During the two face-to-face interviews, I paid attention to their body language and non-verbal signals, which I noted down. During the telephone interviews, I noted any non-verbal signals such as tone and speed of voice, laughter, pauses, sighs, or groans in the fieldwork diary. When appropriate, communication tools, such as nodding agreement, semi-verbal cues like ‘uh-huh’ or repeating statements as a question were used to encourage participants in all the interviews. Further details were obtained by asking for examples (this was also applied to the other interviews). Interviews were audio-taped with permission from the participants and transcribed verbatim. I also made rough fieldnotes about the interview setting and any non-verbal signals such as tone and speed of voice, laughter, pauses, sighs, or groans and transcribed it later in the fieldwork diary.

6.3.2.3.3 Individual interviews with patients and carers

Semi-structured interviews were held with a sample of six patients and four carers in their own homes and lasted between forty and sixty minutes. Before starting the interviews, I determined if they had read the information sheet (Appendix 9) and had any concerns or issues they wanted to raise. We discussed the purpose of the study and my role and clarified their expectations. I reviewed the consent form with them again and confirmed that they were happy to proceed with the interview. A topic guide (Appendix 18) served as a guide only, and questions were adapted according to the participant's characteristics and how much probing was needed. Table 6.4 contains a summary of the key questions in the guide. Interviews were audio-taped with permission from the participants and transcribed verbatim. I also recorded rough hand-written fieldnotes about the setting and verbal and non-verbal gestures and later transcribed them in the fieldwork diaries.



1. Referral
2. Trip to AEC unit
3. First meeting with other staff, including tests
4. The first meeting with medical team/Advanced nurse practitioners
5. Back to family and friends
6. Treatment begins
7. Discharge information to GP and follow up
8. Issues
9. Overall satisfaction
10. The information you received
11. How much influence you had
12. Your relationships with the staff you met
13. What other types of support did you have?
14. Best and worst areas

Table 6. 4 Summary of the main questions in the topic guide

6.3.2.3.4 Telephone interviews with primary care practitioners

Two GPs and two ANPs were interviewed at a time convenient for them, and the interviews lasted between twenty to thirty minutes. Before starting the interview, I determined if they had received the study information pack emailed to them and if, after reading the information sheet (Appendix 13), they still had any concerns or issues they wanted to raise. We discussed the purpose of the study and my role and clarified their expectations. I also reviewed the consent form (Appendix 14) with them and confirmed that they were happy to proceed with the interview and noted the consent in my fieldwork diary. Interviews were audio-taped with permission from the participants and transcribed verbatim. I also made rough fieldnotes about the interview setting and any non-verbal signals such as tone and speed of voice, laughter, pauses, sighs, or groans and transcribed it later in the fieldwork diary.

6.3.2.4 Reflection on issues encountered in the field

An issue identified was related to my concern that participants might adapt their answers to fit with what they think I wanted to hear, which Mercer (2006, p. 7) refers to as "*informant bias*". As a senior member of the team, participants might have believed that I just wanted to hear good or bad stories, so it was vital that I ensured participants understood the reasons for doing the study and its purpose.

A further issue was member checking to enhance rigour. Member checking refers to the researcher returning either verbatim data or interpretations to the study participants to confirm or refute the information and narrative account (Boblin, Ireland, Kirkpatrick & Robertson, 2013; Stake, 1995). Initially, I planned to give participants a copy of the transcript as advocated by the literature (McNiff, 2013) but was asked by the NHS ethics committee not to do that. Upon further reading, I noted Kvale (1996) also warned about potential issues with returning transcripts, such as distress when participants felt it portrayed them as unintelligent or foolish. This issue was highlighted in a study by Dearnley (2005) as well. I decided to summarise the main points of the interview and returned these to participants for verification, as suggested by (Kvale, 1996).

All the participants were happy with the summaries of their interviews. My reasoning for returning a summarised version of the interviews was twofold. Firstly, it was based on my commitment to carry out collaborative and participatory research. Secondly, I believed that the summary would still entail the essence of the story they told and thus offer them the reassurance that the representation of their reality was fair and authentic, and thus rapport and trust between the participants and me were maintained.

6.3.3 Focus groups

Focus groups are a valuable method to follow up on the insights gained from other methods and allow the researcher to obtain multiple viewpoints quickly. As focus groups were historically challenging to organise for busy practitioners, individual interviews for GPs/ANPs and staff on the unit would be arranged if needed. The focus groups' primary aim was to draw on the array of experiences, feelings, and attitudes of participants to provide an in-depth understanding of their perspectives and those of patients and carers experiences. Additionally, focus group would identify those areas in a patient's journey through the AEC that needed improvement and enable the implementation of identified changes required. Thus, meeting the three objectives of the study.

6.3.3.1 Planning of focus groups

Planning the focus groups was an essential aspect of research design as clarity about the planning phase's choices contributes to enhancing rigour and quality (Ryan et al., 2014). Consideration was given to the number of focus groups needed, the size and composition of the groups, each session's length, venue, selection of participants, and my role as moderator and data analysis (Doody, Slevin & Taggart, 2015; Ryan et al., 2014). Three focus groups for GPs/ANPs and three for AEC staff members were planned.

None of the GP/ANP focus groups took place. Only one of the three focus group sessions that were arranged with AEC staff took place. The focus group was arranged in the staff's lunchtime so they could attend the session without feeling pressurised about taking time out of their work schedule. It lasted sixty minutes, and lunch was also provided. The event, facilitated by me, was held in an A&E seminar room which I arranged in a circle to capitalise on the face-to-face contact. At the start of the focus group, I checked that everyone had read the information leaflet (Appendix 11) and that the consent forms (Appendix 14) were signed. The purpose of the focus group was explained. Ground rules to optimise equal participation and boundaries for confidentiality were agreed upon by the group during this session.

The anonymity and confidentiality issues were discussed, and I informed them that as the focus group was an open forum and whilst the discussions and disclosures were confidential, I could not guarantee absolute confidentiality. I explained that the focus group's data would be transcribed by me, and access to fieldnotes and dairies was restricted. All data would be anonymised during transcription. We discussed my role as facilitator and the issue of repercussions if contentious issues were raised. As others did not view the data, and I was the only one that gathered, handled and stored data, this was unlikely. The transcripts would only be seen by the supervisors and me, and all data would be destroyed after completion of the study.

The first focus group was attended by six staff members, including two registered nurses, two healthcare assistants, a ward clerk and a student nurse. Unfortunately, none of the medical staff attended and cited ‘pressures on service’, despite being arranged at lunchtime. The focus was specifically on the different stages of the patient’s journey through the AEC, identifying areas of concern and excellence. The visual map of a patient’ ‘journey’ from admission to discharge, constructed during the observation phase, was used to structure group discussions (see figure 6.2). Additionally, the focus group was steered using a semi-structured interview guide (see table 6.5).

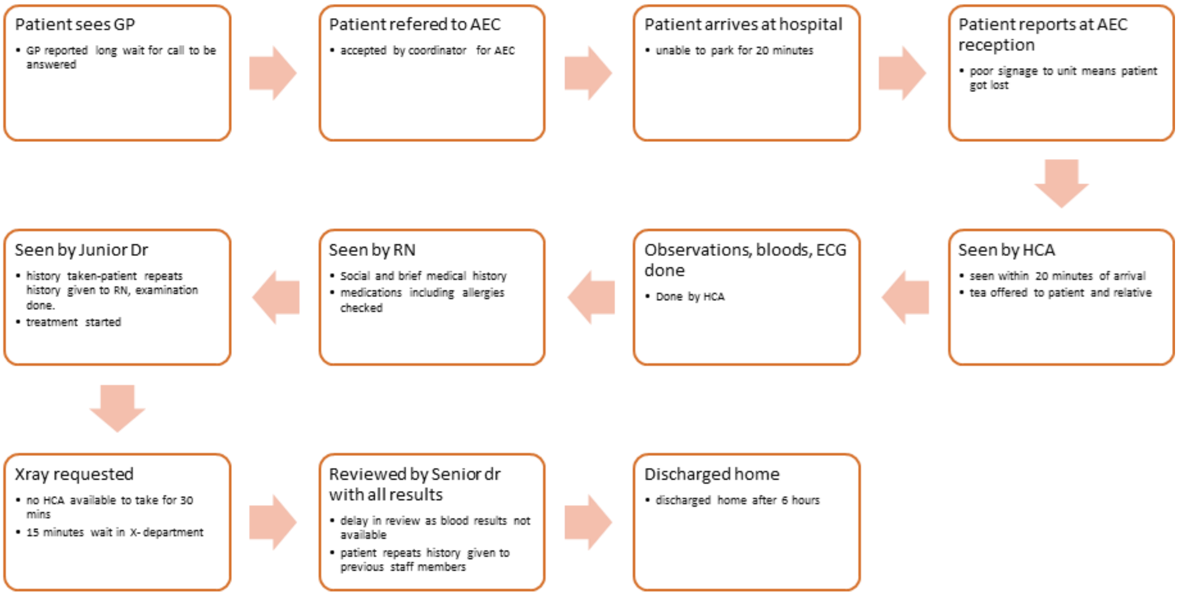


Figure 6. 2 Visual map of a patient’ ‘journey’ from admission to discharge

Context	**Historical issues relating to the unit**	**Implementation and communication**	**Evaluation**	**The physical space**
Tell me about the unit and the patients you provide care for	Tell me about how the unit was established	Where you involved in implementation	Has implementation worked	Any comments about the layout of the unit
Do you routinely collect feedback about experiences from patients/carers/ colleagues	Were patient groups involved in planning	How were you informed about the implementation of the unit	Is it safe	Any comments such as facilities
If you collect feedback, how is it recorded and actioned	Where any of you involved in planning, decision making	Were patient groups involved in implementation	Any concerns	Is the unit conducive for privacy/dignity
Is there any avenues to raise concerns			Is it an effective use of resources	

Table 6. 5 Interview guide for focus group

Issues that possibly affected the patients' experiences were identified, and actions were agreed on. Some staff members volunteered to help with them and provide feedback about any issues encountered and resolved in the next staff meeting. The other two planned focus groups were cancelled due to 'extreme pressures' on the service.

6.3.3.2Reflection on issues I encountered

As a senior member of the team, I attempted to minimise my influence on the discussion and maintain a balance between steering and directing. Furthermore, using the map of a patients' journey was an additional measure to maintain focus and direction. During the initial few minutes of the session, my efforts to put staff at ease and boost morale involved me over-emphasising to staff the vital role they played in this study, affectively given the impression that the organisation was listening when truthfully, I had no proof that they were, which Krueger warns against (1994, 2006).

I was also tempted to participate as I wanted to put staff at ease and build rapport with constant smiling and nodding. On reflection, I wondered if staff might have construed this as my concurrence, which may have influenced the rest of the session. I shared the session's transcript with my supervisors to shed light on this as suggested by Mercer (2006) and discussed whether to abandon the focus group due to my perceived influence or retain it for data analysis. I decided to keep it as part of the data collection as it offered valuable insight into how staff members perceived a patient's journey through the unit.

Overshadowing by one participant was an issue initially, as she was keen to make all of her opinions known and used the forum to do it. Whilst allowing her space, I continued to bring others into the conversation, and she settled halfway through the group. I noted that one participant was not participating despite all of my efforts to involve her; however, I knew she was shy, so I was mindful not to put too much pressure on her to speak. At the end of the focus group, she approached me and offered to write down her opinions which she handed to me later the day. The focus group session was audio-taped and transcribed, and as with the interviews, I gave participants a summary of the main points we discussed, and the action plan agreed.

6.3.4 Research diaries

Research diaries were identified as a suitable secondary data collection method to supplement data obtained from primary data. The decision was taken to use fieldwork diaries to document issues and encounters in the field and personal reflections during the study. The diaries had a dual role: acting as an audit trail and cross-checking information during data analysis and report writing.

6.4 PATIENT AND PUBLIC ENGAGEMENT

It was vital to ensure that the people who used the service, such as service users, carers, staff, and patient representative groups, were heard. With a hospital volunteer's help, a dialogue was opened with service users and carers who attended AEC. The discussions centred on the preferred topics to be researched, preferred data collection methods and the most suitable recruitment strategies.

The volunteer was a young college student allocated to the AEC by the hospital volunteer services, so she had clearance to deal with patients. She was invited to the first meeting regarding the study by the unit manager, who felt it would be beneficial for her to hear about the study, and afterwards, she approached me for more information. We discussed the next steps of the study and the comment cards currently used to obtain information from patients and carers, and she agreed to assist me with handing them out to people in the waiting room when she was in the unit.

Over the next two weeks, the comment cards were handed out, and feedback was obtained from about fifty people. At the end of the period, the volunteer fed back to me about her experience and admitted that she just handed out the cards during the first few days as she did not feel confident to speak to people. However, as time progressed, she found herself talking and interacting with people in the waiting room, and her family and college staff have commented on how much she had grown in confidence in the two weeks. She also informed me that the experience allowed her to start her UCAS application to apply to university to become a medical student.

The issue highlighted by patients, carers, and the staff was the importance of their experiences during hospital visits as negative experiences leads to reluctance to seek medical input in the future. When asked about the preferred data collection methods and appropriate timing, some verbalised a preference for filling in questionnaires whilst in the AEC, and others stated they preferred individual interviews. There was also a difference in opinions about timing. Some people preferred it done whilst in the AEC as they could ask for help if needed, addressing concerns regarding participation in the study.

Others wanted time between the AEC visit and the interview/questionnaire to allow them time to reflect on their experience and decide about participation in the study without feeling pressurised. During this stage, it became evident that most people believed that their input would be of little value and was possibly ‘tokenistic’, an issue also raised in the literature (Dewar, 2005) and recurred during the interviews well. This issue is revisited in the discussion chapter.

Conscious that the patients seen in the AEC unit were part of a wider community who also may use the service at some point, I also spoke with people with the same characteristics as the AEC population, such as neighbours, family, and friends. They were asked the same questions about the prospective study, and the feedback received from them related to the importance of building rapport with people, especially the elderly community, to encourage participation in the study. I attended a few coffee mornings at our local centre to discuss the study, and again the opinions regarding preferred data collections methods varied, but most felt interviews either over the phone or face-to-face would be preferred. This process was clearly outlined in my ethical application forms to the university and NRES, the NHS research body.

The invitation letter, participant information leaflet and consent form were adapted after feedback from service users and staff. An open day was held in July 2014 and was attended by members of the public. Some staff members volunteered at the AEC stall, and they answered questions and displayed patients stories to demonstrate what happens on the unit. A few people asked to be taken around the unit and gave suggestions to make the waiting room more user-friendly, such as rearranging the chairs so people do not sit facing a wall.

I regularly attended the A&E/AEC patient representative group, delivered a presentation about the study's aims and objectives, and obtained feedback about the ward leaflet and suggestions about distributing the study results. I also took some of them around the unit and introduced them to the staff on duty. I spent extensive time in the field before the data collection and found this period crucial for laying the groundwork for this qualitative case study to ensure its sustainability. However, I agree with other writers that this area of the research process is often neglected in the literature and rarely is the researcher's emotional and psychological impact during this time acknowledged (McNiff, 2013; van Lieshout, 2016).

6.5 SUMMARY

This chapter discussed the data collection procedures in detail, including how any issues were managed whilst ensuring the ethical framework was maintained. The chapter also demonstrated the attempts at ensuring that quality, rigour, and transparency remained central to the study. Furthermore, the importance of involving patients and other members of the public in the initial discussions about the research topic, data collection tools and timing and location of interviews is clarified. In the next chapter, the data analysis process is discussed in detail.

CHAPTER SEVEN DATA ANALYSIS AND INTERPRETATION

7.1 INTRODUCTION

The previous chapter described the data collection process in detail. This chapter describes how collected data was analysed and synthesised to answer the research questions. While the chapters are written separately, data collection, data analysis and report writing were not separate but interrelated and sometimes overlapped during the research process (Creswell, 2014, Stake, 1995). This recursive and iterative approach imbued the research process from the problem identification phase to the final report's writing. The case study aimed to provide empirical and holistic data and thus offer the reader the opportunity to experience the unit vicariously and get an in-depth understanding of how AEC's introduction impacted participants' experiences (Stake, 1995).

Data was collected from various sources and various methods (observations, interviews, and a focus group) to gain insight into participants’ experiences. Triangulation of sources and methods can either corroborate (Yin, 2009) or negate (Stake, 1995) the information collected. I used it for both purposes and to decide if more data was needed and from which sources. An example of how triangulation contributed to the development of the data corpus was when emergent data from observations and the focus group highlighted the absence of senior management voices. The decision was taken to arrange semi-structured interviews with four managers. Furthermore, the follow-up interviews with AEC staff after the observations was used to corroborate or dispute what I observed. Consequently, the data analysis process was inductive, recursive, and interpretive, consistent with the study’s philosophical frame and Stake’s case study approach.

Data analysis refers to examining the collected information and translating it into coherent findings (Creswell, 2014, Stake, 1995). The data analysis strategies most used in qualitative studies are thematic analysis, grounded theory, Interpretive Phenomenological Analysis (IPA), discourse analysis and narrative analysis (Braun & Clarke, 2006; Creswell, 2014; Savin-Boden & Howell, 2013; Stake, 1995). Despite the variety of qualitative data analysis methods, the starting point for all of them appears to be the engagement with the data to explore or uncover the underlying *“essence, meaning, norms…rules, structures”* (Rapley, 2016, p. 332; Stake, 1995).

Thus, qualitative data analysis's main steps involve preparation and organisation, familiarisation, forming initial codes, amalgamating codes into themes, and presenting the findings in narrative form or graphs (Creswell, 2014; Miles & Huberman, 1994). Both Stake (1995) and Braun & Clarke (2006) highlighted the importance of ensuring that the selected data analysis technique is flexible enough to be modified to fit the research questions and the data collected.

According to the literature, thematic analysis is one of the most widely used data analysis methods for novice researchers. Thematic analysis refers to “*a method for identifying, analysing and reporting patterns (themes) within data”* (Braun & Clarke, 2006, p. 79). Thus, it is viewed as the foundational data analysis method for most qualitative studies as it *“... provides core skills that will be useful for conducting many other kinds of analysis”* (Braun & Clarke, 2006, p. 78, 2013; Sandelowski, 2010). The approach to data analysis has been used widely in health care studies exploring patients and carers experiences (Attree, 2001; Kieft et al., 2014; Moss, 2014; Tsiakanas et al., 2012).

Hence, it was deemed a suitable technique to analyse the data in this study that focused on participants' experiences (Wilkinson, 2016). The data analysis approach appeared to fit in with my interpretive worldview and drive to adopt a holistic approach to study how participants' experiences were shaped by the unit, the hospital and the broader policy context (Willig, 2014). Furthermore, the approach's inductive, recursive, and interpretive nature was in line with my ongoing interrogation of the data and the questions I asked myself during the research process (Stake, 1995) "*how is this part related to that part*?" (p.71) and "*what did that mean*?" (p.78). This ongoing interrogation and documentation during the data collection process were essential elements of the study's quality frame as it enhanced the trustworthiness and confirmability of study findings. For example, during observations, I made notes in the observation guide's left-hand margin about the interactions I observed, any questions raised, and my initial thoughts and interpretations.

Stake (1995) sees case study data analysis as starting from the moment you enter the setting, and "…is *a matter of giving meaning to first impressions as well as final compilations" (p.71).* Furthermore, he sees analysis as an intuitive and sense-making process where data and thoughts must be deconstructed (taken apart) and then synthesised into meaningful parts. Hence, *"...analysis should not be seen as separate from everlasting efforts to make sense of things* (Stake, 1995, p. 72) instead, the researcher should rely on intuition and sensing in their search for meaning-making, which aligned with thematic analysis (Savin-Boden & Howell, 2013). However, as a novice researcher, I quickly felt overwhelmed by the data, especially given all the data collection methods. Thus, by combining the structure of thematic analysis with Stake's data analysis techniques, I aimed to balance immersing myself in the data to the extent that I start to understand which parts contain the case's essence while still following a rigorous, analytical process (Stake, 1995).

7.2 ALTERNATIVE DATA ANALYSIS METHODS CONSIDERED

IPA and grounded theory was considered initially to address the research questions. IPA was considered as it would offer insight about participants' experiences on the unit (Braun & Clarke, 2006) and has been used in health care research where the emphasis is on exploring how participants experience and make meaning of the world (Braun & Clarke, 2006). IPA was deemed unsuitable as it required intensive analysis of each transcript, so it is a lengthy process and would work better with a smaller sample (Smith, Flowers, & Larkin, 2009).

Grounded theory (Charmaz, 2006) was also considered as it has been used within some qualitative studies to analyse patients' experiences. For example (Kihlgren et al., 2004; Olthuis et al., 2014) used this approach to explore the patients' perspective of their experiences in emergency departments, and Mottram (2011) used it to explore the perspectives of patients of their experiences in day surgery. However, the approach was disregarded because it focused on theory generation rather than meaning-making of individual experiences and minimised the researcher's influences, which was oppositional to this study's interpretive frame (Braun & Clarke, 2006).

7.3 THE DATA ANALYSIS PROCESS

I followed thematic analysis as described by Braun & Clarke (2006), combined with the analytic strategies of classification and interpretation advocated by Stake (1995) as outlined in table 7.1. Thus, the data analysis process I followed started with a description of the case (study context and participants characteristics) and a systematic process of data organisation and familiarisation with the data (the foundational steps of TA). Furthermore, I used categorical aggregation and direct interpretation to extract themes from the data and naturalistic generalisation to move the interpretation of data findings from understanding to abstraction (Creswell, 2014; Stake, 1995).

	Thematic analysis	**Case study**
Phase one-Describing		Describe the case and its context
Phase two (managing data)	Data managing	Create and organise files for data analysis. Verbatim transcriptions of interviews and focus group.
Phase three (reading and notating)	Familiarising yourself with the data	Read through texts, made margin notes and highlighted texts that are interesting and repeating themselves.
Phase four (form initial codes)	Search for potential codes	Potential codes identified
Phase five (Classifying)	Classifying the data into codes and themes	Use categorical aggregation and direct interpretation to establish themes.
Phase six (interpreting)	Interpreting the data	Develop naturalistic generalisations of what data was relaying.

Table 7. 1 Summary of the data analysis process

7.3.1 Phase one description of setting and participants

The first step in analysing the data entailed a detailed description of the study’s context and a summary of the research participants' characteristics in tables. This phase was important for this case study as it contextualised the data and offered the reader the opportunity to experience the unit ‘vicariously’ through in-depth descriptions.

7.3.1.1 The setting:

The AEC was a hybrid unit and had some similarity with the AMU and general medical wards in terms of design, outline, and routines such as mealtimes. However, in contrast to the AMU and general medical wards, the unit did not cater for patients who needed to be cared for over several days. The unit was initially used as an ‘overflow’ area for A&E patients with five enclosed bays of 4 beds with a reception desk in the middle. When it was transformed into an AEC unit, the first two enclosed bays with four beds was allocated to A&E, and the two bays on either side of the reception desk were furnished with four recliner chairs and four trolleys. The bay with the toilet and bathroom facility became the waiting area. The unit’s layout meant people used it as a through-way to get outside or to the A&E/X-ray department, which was adjacent despite signs telling people to use the hospital’s main entrance.

The unit's daily staffing levels included a receptionist, two ANPs, two RNs (band 5), two HCAs, an RN coordinator (band 6), a consultant, a registrar, and a junior doctor. The clinical lead was the consultant, and the ward manager was the administrative lead. The consultant and RN coordinator acted as gatekeepers to the unit. The HCAs did the initial assessment, which consisted of checking patients' identification details and doing a set of observations (later, they were trained to take blood and do ECGs by the ANPs). The RNs took a brief history, including any medical problems, medication and social history. Risk assessments such as fall risk assessment and a property inventory were also done at that time. The assessment was completed by taking blood and doing an ECG.

The ANPs/junior doctors were responsible for taking a complete medical history, examining the patient and devising a treatment plan, including ordering a chest x-ray and prescribing medication. The registrar and the consultant reviewed the patient after all results were available and decided whether to admit or discharge. Completing the discharge letter was assigned to the ANP or junior doctor on the unit at the time of the patient’s discharge. The receptionist was responsible for welcoming patients, answering the telephones, ordering stationery, admitting and discharging patients on the IT system and in the admission and discharge logbooks.

As most of the staff came from AMU/A&E/general medical wards settings, those routines were adopted most of the time, despite patient populations’ differences and the faster turnover of patients in AEC. The unit coordinator liaised with the nursing staff regularly during the shift regarding the patients’ diagnoses and management plans. The coordinator’s job was to liaise with A&E and AMU regarding transfers in and out of the unit. Nurses spent significant periods completing various documentation and following procedures inherited from AMU and medical wards such as admission proformas, risk assessments, and nursing records to ensure all patients on the unit were ‘processed’ (‘admitted’). The ‘admissions’ process involved having various blood test obtained, an ECG recorded and often a chest x-ray performed. Thus, while the unit's function was to establish a culture of assessment rather than admissions, the daily activities and practices remained rooted in admissions discourse.

As the unit had no dedicated porter, most of the times, the HCA’s were taking patients to and from other departments. The unit had no office space for medical or nursing teams, so most of the documentation and all telephone calls were done from the reception desk.

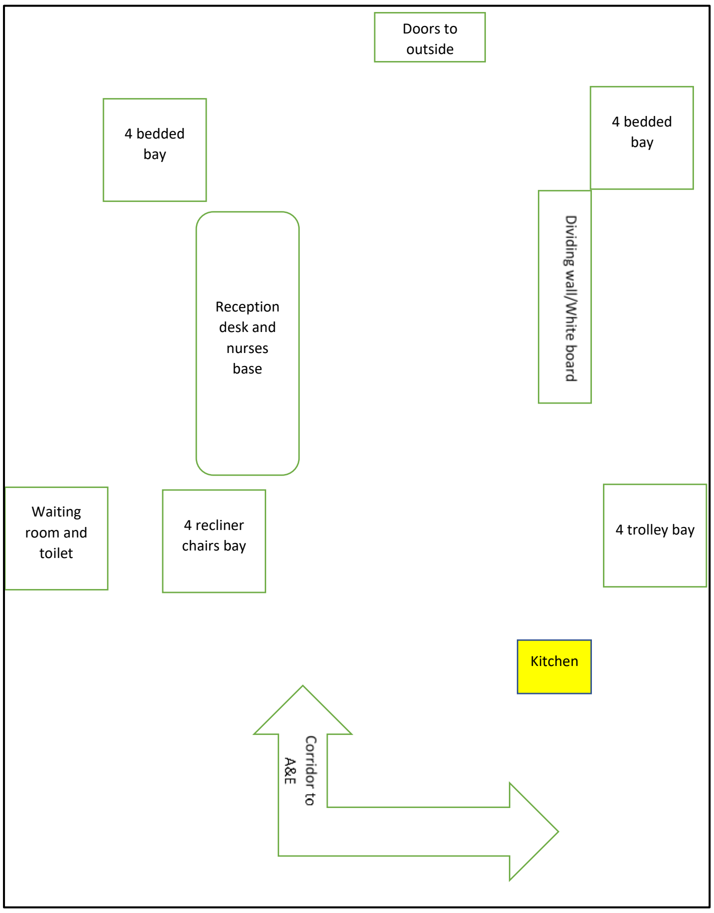


Figure 7. 1 Layout of the AEC unit

7.3.1.2 The Participants

The tables containing information about the participants' characteristics is contained here to enable cross-reference with the different data sets quickly. An example is whether a staff member's length of experience had any potential bearing on what was observed or heard in practice. Additional notes such as the length of time working on AEC was part of my fieldnotes.

No.	Name	Gender	Age	Method	Reason for being on the unit
1	Paul	Male	42	Observations	Insertion of an ascitic drain
2	Pam	Female	40	Observations	Paul’s carer
3	Barry	Male	60	Observations	Shortness of breath
4	Susan	Female	60	Observations	Barry’s partner
5	Vera	Female	72	Observations	Possible PE
6	Maggie	Female	48	Observations	Vera’s daughter
7	Harry	Male	80	Observations	Chest infection
8	Sally	Female	50	Observations	Harry’s daughter
9	Brenda	Female	84	Observations	Possible DVT
10	Peter	Male	86	Observations	Brenda’s Husband
11	James	Male	72	Observations	Chest pain
12	Ivy	Female	70	Observations	James’ wife
13	Christine	Female	50	Observations	Insertion of an ascitic drain
14	Maureen	Female	64	Observations	anaemia
15	Kerry	Female	38	Observations	Maureen’s daughter
16	Deborah	Female	58	Observations	Possible DVT
17	Chloe	Female	32	Observations	Deborah’s daughter
18	Sandra	Female	44	Observations	Cellulitis
19	Jackie	Female	83	Interviews	Cellulitis
20	Steven	Male	80	Interviews	Jackie’s husband
21	Adam	Male	16	Interview	Headache, need lumbar puncture
22	Denise	Female	44	Interviews	Adam’s mom
23	Hazel	Female	80	Interviews	Possible UTI
24	Raymond	Male	78	Interviews	High Calcium levels
25	Sarah	Female	24	Interviews	Chest pain
26	Michelle	Female	48	Interviews	Sarah’s mom
27	Penelope	Female	74	Interviews	Pneumonia and confusion
28	Dana	Female	44	Interviews	Penelope’s daughter
29	Mrs Smith	Female	58	Narrative	Possible PE
30	Dane	Male	22	Narrative	Son of Mrs Smith
30	Mr Kay	Male	75	Narrative	Shortness of breath
31	Jane	Female	38	Narrative	Daughter of Mr Kay
32	Mr Thompson	Male	73	Narrative	Monitoring kidney function
33	Kay	Female	44	Narrative	Daughter of Mr Thompson

Table 7. 2 List of participants (patient and carers)

No	**Name**	**Job role**	**Gender**	**Length of experience**	**Method**
1	Bashir	Registrar	Male	Five years	Interview
2	Roman	Consultant	Male	Two years	Interview
3	Debbie	Registered nurse	Female	Two years	Interview
4	Eva	Junior doctor	Female	one year	Interview
5	Eunice	Healthcare assistant	Female	Five years	interview
6	Adele	Ward clerk	Female	Four years	Interview
7	Henna	Staff nurse	Female	Three years	Observations
8	Peter	Junior doctor	Male	Two years	Observations
9	Delia	Staff nurse	Female	Four years	Observations
10	Katie	Junior doctor	Female	Two years	Observations
11	Henry	Staff nurse	Male	One year	Observations
12	Amina	Staff nurse	Female	Three years	Observations
13	Marlena	HCA	Female	Two years	Observations
13	John	HCA	Male	Two years	Observations
15	Sally	HCA	Female	One year	Observations
16	Amanda	Junior doctor	Female	One year	Observations
17	Dr Hall	Consultant	Female	Six years	Narrative
18	Nurse Tate	Staff nurse	Female	Eight months	Narrative
19	Nurse Frey	Staff nurse	Female	Six years	Narrative
20	Dr Grant	Registrar	Male	Four years	Narrative
21	Dr Franks	Consultant	Male	Twenty-one years	narrative
22	Jenny	Staff nurse	Female	six months	Focus group
23	Penny	Staff nurse	Female	Two years	Focus group
24	Paul	HCA	Male	One year	Focus group
25	Steph	HCA	Female	One year	Focus group
26	Beverley	Ward clerk	Female	Three years	Focus group
27	Mimi	Student nurse	Female	N/A	Focus group
28	Saad	GP	Male	Ten years	Interview
29	Stuart	GP	Male	16 years	Interview
30	Nicholas	ANP	Male	Two years	Interview
31	Leigh	ANP	Female	Six years	Interview
31	Tessa	Manager (NHS Trust)	Female	Eight years	Interview
32	Heidi	Manager (CCG)	Female	Two years	Interview
33	Heather	Manager (AEC Network)	Female	12 years	Interview
34	Stephen	Manager (AEC Network)	Male	Ten years	Interview

Table 7. 3 Profile of Participants (NHS staff)

7.3.2 Phase Two Data management

7.3.2.1 Fieldnotes

The writing and storing of field notes and fieldwork diary was part of the data organisation. During the observation periods, rough fieldnotes containing information about the date, time and location of the observation and my perceptions of what was happening at the time were noted. The fieldnotes also contained information about the day-to-day interactions in the unit, perceptions about the environment (noisy, hectic, or calm) and non-verbal responses like facial expressions and body language. The rough notes were transcribed in more detail in the fieldwork diaries within six hours of the observations. Fieldwork diaries started in 2010 and contained detailed fieldnotes under three separate headings, namely *events* (what happened), *reflections* (about the day and any significant events) and *relevance* (what does it mean).

Fieldnotes from interviews and focus group that contained information about the context of the interviews, reflection, relevance, and any non-verbal communication were transcribed into fieldwork diary immediately after the interviews and focus group. The fieldnotes and the fieldwork diaries were all photocopied as I was concerned that the continual handling caused by repetitive reading might ruin them, and the original notes, the fieldwork diaries and the photocopies were stored in a locked cupboard. Confidentiality was maintained by giving participants pseudonyms. Below is an example of one of my fieldnotes written after an observation session.

Date	Events	Reflections	Relevance
Thursday 11/6/2015 *AEC assessment area*	*Observed 'Paul' (Male, 42, British) referred by GP for symptomatic ascites and needed a drain inserted.* *Referred yesterday and arrived this morning at 10 am. Consent obtained to observe.* **10.15 HCA** *comes to do an initial assessment (check basic details and reason for coming to the unit today), took observations recorded and stable. Tea and biscuits supplied and explained that the nurse would be with him shortly. Also explained dr. Abdul is aware he is on the unit but currently seeing other patients in A&E.* **11.00 Staff nurse** *comes to do nurse assessment (check details, medical history, medication), took blood, offers him analgesia and a trolley bed which he declined "recliner chair is much more comfortable" (laughing but grimacing at the same time). She informs him that one doctor on the unit is currently trained to insert an ascitic drain, but junior doctors can also do it under observation. However, Paul declined and stated he wants dr. Abdul today, as the juniors can cause him pain when they do it and today he is already in pain. The nurse reassures him that is ok and ask him to tell her if he needs stronger analgesia* **11.30 ANP** *comes to 'clerk' (take his medical history, examine him, obtain consent for the procedure and order albumin). She informs Paul that once Albumin is ready and his blood results are back, he will be placed on a procedure trolley. "Has the hospital changed the procedure regarding albumin collection yet as in Leeds the nurses can collect all four bags at the same time, but at this hospital, they have to collect one at a time "absolutely bloody ridiculous when you guys are so busy anyway. Anyway, today is a good day so far as I have not had to wait for a free chair or for my bloods to be taken! Some days it can be hours before a space is free for me to be seen. And do not get me started on the nurses who do not want to take my referral and says I have to go to gastro when they all know I only let dr. Abdul put a drain in!"* *Whilst waiting for his blood results, Paul tells me he prefers coming to AEC for his drains as dr. Abdul does it quickly and pain-free, the nurses, always offer him warm drinks and meals and everyone is friendly (winking at me when he says it). He has come to GPAU/AEC to have the drain inserted every eight weeks now for a few years and refuse to take up the offer of having the procedure done somewhere more suitable.*	*Met Paul previously so good rapport.* *Unit not busy* *The first two staff members asked Paul similar questions* *HCA aware Paul is 'frequent attender' and knows the procedure but explained the next steps to him in detail.* *Basic needs are seen too very quickly.* *Three people have now seen Paul, who is a semi-elective patient (booked in yesterday). 2 separate sets of documentation completed-one for nurses and one for the medical team. Why can't they use one form and one nurse/doctor do everything? I have looked after Paul, and other patients like him several times and have never really questioned how we do things until today.* *Paul appears to trust the dr. Abdul which explain why he is refusing to have the procedure done on the ward.* *Wondering why blood results still not back at noon.* *Policy in place stating only one blood product can be collected at a time. A patient needs 100 ml of 20% HAS for every 3 litres of ascites drained.*	*Duplication of information seeking/work* *Levels of information given* *Comfort and empathy* *Duplication* *Waiting time for results an issue* *Frustration with policy and procedure* *Variation in service* *Trust in medical professional* *No agreed protocol for day attenders*

Example of a Fieldnote (observations)

7.3.2.2 Transcription and data management

Interviews and the focus group session were recorded on a hand-held Dictaphone and transcribed verbatim by myself as I wanted to become familiar with the data. I also wanted to pick up on verbal and nonverbal cues such as tone of voice or silence. By doing the transcribing myself, I negated the problem of confidentiality and other ethical issues. All interviews and focus groups were transcribed within twenty-four hours to maintain my familiarity with the data. Transcription of each interview and the focus group took roughly six hours each to type verbatim and amounted to twenty to twenty-five single space pages per transcription.

Once interviews and the focus group were transcribed, the transcript was exported onto a word document and stored in an electronic folder that was password protected. Confidentiality was maintained by giving each transcript a unique identification number system and pseudonyms replaced names. The paper copies of transcribed interviews were stored alphabetically in an A4 file and together with the fieldnotes and fieldwork diaries (copies and originals) kept in a locked cupboard. Whilst the interviews and focus group's transcription was a part of the data management phase, it also supported familiarisation with the data through the repeated listening to the audiotapes and typing it up verbatim.

7.3.3 Phase three familiarising myself with the data

Phase three consisted of familiarisation with the empirical data through reading and re-reading each data item individually, as a data set and then as a data corpus, adding comments and looking for any repetitions or interesting segments (Braun & Clarke, 2006). During this phase, I revisited the observation data first. The photocopied fieldnotes were read and compared with the entries in the fieldwork diaries about the observations. Care was taken to ensure the field notes were fully transcribed in the diary. Each fieldnote was stapled to the back of the relevant diary entry. Any missing information (body language or facial expressions, or comments about the environment) and annotations about initial ideas or potential patterns were added to the photocopied diary entry's left-hand margin.

The field diaries’ photocopied entries of six AEC staff interviews and the relevant photocopied fieldnote were read to ensure the fieldnotes were fully transcribed in the diary. Each fieldnote was stapled to the relevant diary entry. Any missing information (body language or facial expressions, or comments about the environment) and annotations about initial ideas, or potential patterns, were added to the photocopied diary entry’s left-hand margin.

Photocopies of transcripts of the nineteen interviews (including the focus group) were stapled to the relevant copy of the fieldnotes and fieldwork diary entry. First, each transcript was read individually and then compared with the accompanying fieldnotes and fieldwork diary entries to ensure all the relevant information about the individual interviews were contained in the transcript. Annotations were added to the transcripts' left-hand margin, such as body language or facial expressions, comments about the environment, initial ideas, or potential patterns. Then I re-listened to all the nineteen audio files and added any missing information.

Each data set was initially read as described above (observations followed by the interviews and focus group) and then as a whole (data corpus). This repeated process of reading, listening and annotating within and across the data sets supported immersion and familiarisation with the data and the development of interpretive skills needed for qualitative case study data analysis (Braun & Clarke, 2006; Stake, 1995).

During this phase, I noted down any thoughts, observations and reflections I had while reading the textual data. These notes included any repeated expressions or words and any questions I had about what was happening. These annotations were done on the left-hand margin of the transcripts and a copy of fieldwork diary entries. Texts that were repeating themselves or interesting were highlighted with different colour highlighters.

7.3.4 Phase four generating initial codes

Phase four required assigning initial codes to the data. Codes refer to the descriptive labels (categories) applied to sections of a transcript. Coding the transcripts involved me trying to make sense of what participants were saying or doing and then labelling the specific phrase, word or whole paragraph of text where information relating to a specific point was included. During this phase, I repeatedly asked myself, "*how are the parts related*" and "*what does this mean*"?

Coding was done manually, as I felt that data analysis software packages like NVivo would interrupt the connection I had with the data and would not account for the contextual issues that were an integral part of the data. Manual coding also enabled me to continuously interrogate the data and visualise the relationships between data sets and compare and contrast the information gathered. The initial coding process involved moved from reading and analysing transcripts line by line, then paragraph by paragraph, then the whole transcript. The 'progressive focusing' notion of data analysis permitted me to focus on the issues as they emerged (Stake, 1995).

Each transcript and all the field diary entries were re-read in search of a pattern during this phase. Three large wall charts (one for each data collection method) were placed on a wall in my study with columns for data tracts, initial codes and contextual issues. Extracts of the data were cut and pasted onto the appropriate wall chart (interviews, focus group and observations). Each data extract was re-read, and initial codes were written next to it. From this process, more than two hundred initial codes were identified, as outlined in Appendix 23.

The transcripts and field diary's contextual notes were noted on the charts to ensure the data was analysed in context. The process was not linear but iterative as every time a new code was identified, I re-checked all transcribed data to check whether it was missed. Once all the transcribed data was coded, I re-read all the transcripts and the field diary to ensure all the data was coded and checked for repetitions, similarities and differences. This process was very time-consuming but also very satisfying as by using raw data examples such as participants' quotes, I kept them at the centre of the study. Table 7.4 contains examples of how data extracts from the data sets were coded.

Data type	**Respondent**	**Data extract**	**Initial codes**
Statement made by the patient during observations.	Paul Patient	*"Has the hospital changed the procedure regarding albumin collection yet as in Leeds the nurses can collect all 4 bags at the same time but at this hospital, they have to collect one at a time which is absolutely bloody ridiculous when you guys are so busy anyway. Anyway, today is a good day so far as I have not had to wait for a free chair or for my bloods to be taken! Some days it can be hours before a space is free for me to be seen. And don't get me started on the nurses who do not want to take my referral and says I have to go to gastro when they all know I only let Dr. Abdul put a drain in!"*	Frustration with policy and procedures Staff are busy External factors concern and empathy for the nursing staff. busy periods in unit. frustration with variations in service. Shortage of space
Statement made by the carer during observations.	Pam Carer	*"Everyone is always so busy but always keeps us up to date and we get regular cups of teas"*	Acknowledges busy unit Displayed empathy with staff Satisfied with levels of information giving comfort

Statement made by nurse during focus group	Jenny Staff nurse	*"Dealt with a very angry GP yesterday who was furious because he was on hold for a long time and then he got further annoyed as the patient was inappropriate for the unit, so I had to put him through to bed managers. He shouted at me about his busy surgery!"*	Frustrations Competing demands Unclear referral guidelines Ineffective communication Feeling stuck in the middle
Statement made by ward clerk during focus group	Beverly Ward clerk	*"There was probably no one at the desk as I was running around trying to find notes for a patient who came for a review. Just this morning I had to go to records to find a set of notes, which left the telephones and desk unmanned for more than 30 minutes."*	Issue with notes Inadequate communication Competing demands Lack of support
Statement made by registrar during interviews	Bashir Registrar	"*I have just seen a patient referred by A&E as a DVT of the hand, which is not a medical patient. Now I will have to spend hours trying to convince Ortho's to see patient. Why don't people know the protocol?"*	Unclear referral procedure Lack of communication Frustration Time (busy) Lack of training
Statement made by GP	Stuart GP	"*I once tried to get through to AEC for thirty minutes, so I decided to just send the patient up to the unit."*	Referral process Issues with contacting unit Inappropriate action The patient becomes stuck in the middle
Statement made by NHS manager	Tessa Manager (NHS Trust)	"*From the feedback, we got from the executive team. One of them commented that we spend too much time acquiring patient and staff experience feedback, giving a platinum service when we really can afford silver only. And another one said 'stop with the navel-gazing and get on with it'."*	Disinterest in evaluation Conflicting agendas Whose interest?

Table 7. 4 Initial coding of data extracts

7.3.5 Phase five search for initial themes

In phase five, the data sets on the wall charts were reviewed in search of patterns or similarities across them (Braun & Clarke 2006). This process was not a passive process of 'waiting for the themes to emerge'; instead, identifying the themes was an active construction process. The initial codes and the corresponding data abstracts with shared meanings or features were clustered together using categorical aggregation. Using this technique enabled me to identify those instances in the data where issue-relevant meanings emerged, establish patterns and look for a correspondence between the themes and sub-themes (Stake, 1995). As the focus of this intrinsic case study is on understanding the case, the three data sets were revisited, alongside the three families' narratives and analysed using direct interpretation, which enabled me to look for meaningful single instances (Stake, 1995).

To differentiate themes, I adopted the framework used by Overcash (2003), who suggested a theme is identified through repetition and perceived as necessary by the participant. Table 7.5 contains an example of how I used categorical aggregation to clump initial codes into themes using inductive analysis (Patton, 2014) and a constant comparative approach, looking for different meanings.

The process of grouping similar codes in larger chunks and then breaking it down (deconstructing) into themes and sub-themes assisted with meaning-making and provided structure to the process (Braun & Clarke 2006; Stake, 1995). The wall chart was revisited, and the newly formed themes and subthemes with extracts were pasted onto it. Ten main themes and eighty-three sub-themes were constructed as outlined in Figure 7.2.

Initial codes	**Sub-themes**	**Theme**
No information given to patient or carer Nurse did not attend as arranged Waiting for results without explanation Told story to five different people Unmanned reception desk Missed scan due to unmanned desk Long wait for results Given wrong information by GP Expected to have scan done today Kept on hold for 30 minutes Transfer call back to switch as inappropriate patient Nowhere to give bad news Variation in access to unit Doctor made time to explain to me Doctor made eye contact during conversation Explanations given Reassurance given Empathy Warmth nurse has a blank stare staff speaking in raised voices no eye contact made difficulty to hear in loud unit The doctor spoke to me in a kind voice and he held my hand	Repetition Disconnection Disengagement Variations Omissions Lack of information Varied approach	Communication

Table 7. 5 Example of categorical aggregation of codes into sub-themes and theme

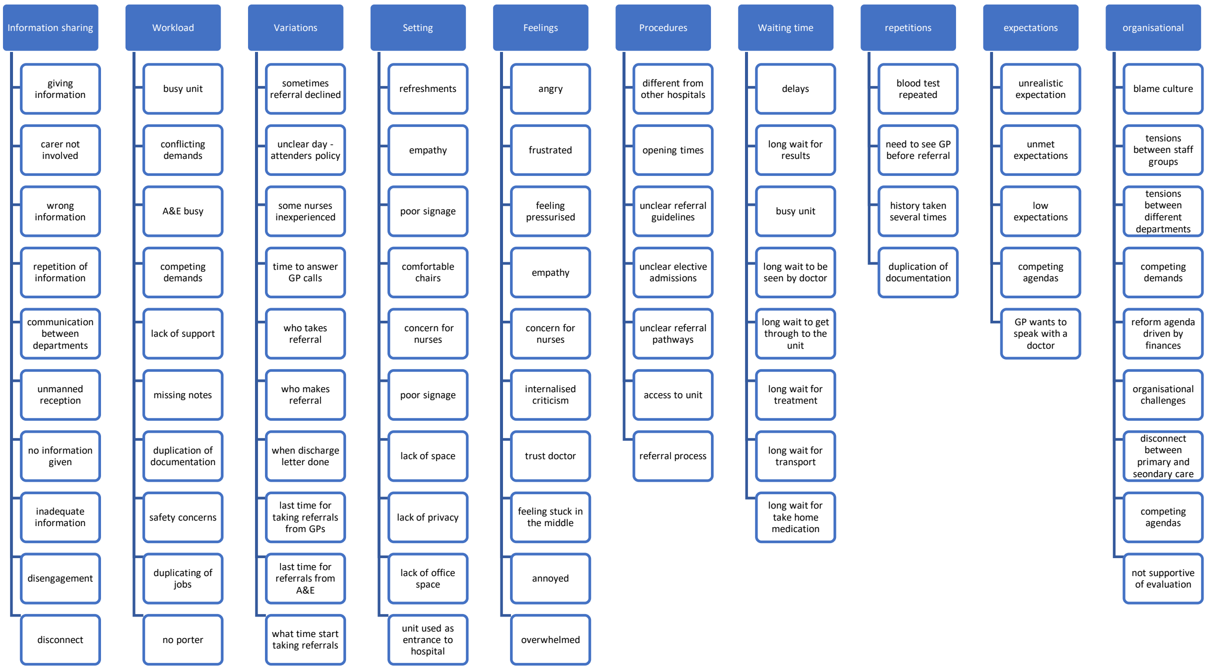


Figure 7. 2 Initial themes and sub-themes

7.3.6 Phase six: interpretation and abstraction

The thematic map in Figure 7.2 was reviewed and refined after re-reading the data set transcripts and field notes. This phase required back and forth movement between the data set, the data codes and themes to see if the themes represented what the participants told me. From the refinement, four main themes and sixteen sub-themes were identified as outlined in Figure 7.3. The themes and sub-themes in figure 7.3 were further deconstructed and synthesised using naturalistic generalisation. The process supported active interaction with the data, questioning and clarifying the uncovered data and thus increased the level of abstraction (Stake, 1995). The finalised thematic map (figure 7.4) captured the data's essence in each theme (Braun & Clarke, 2006). By continually comparing the codes, sub-themes and themes across all three data sets with my transcripts and fieldwork diary, I was assured that the emerging themes and sub-themes represented the participants' views.

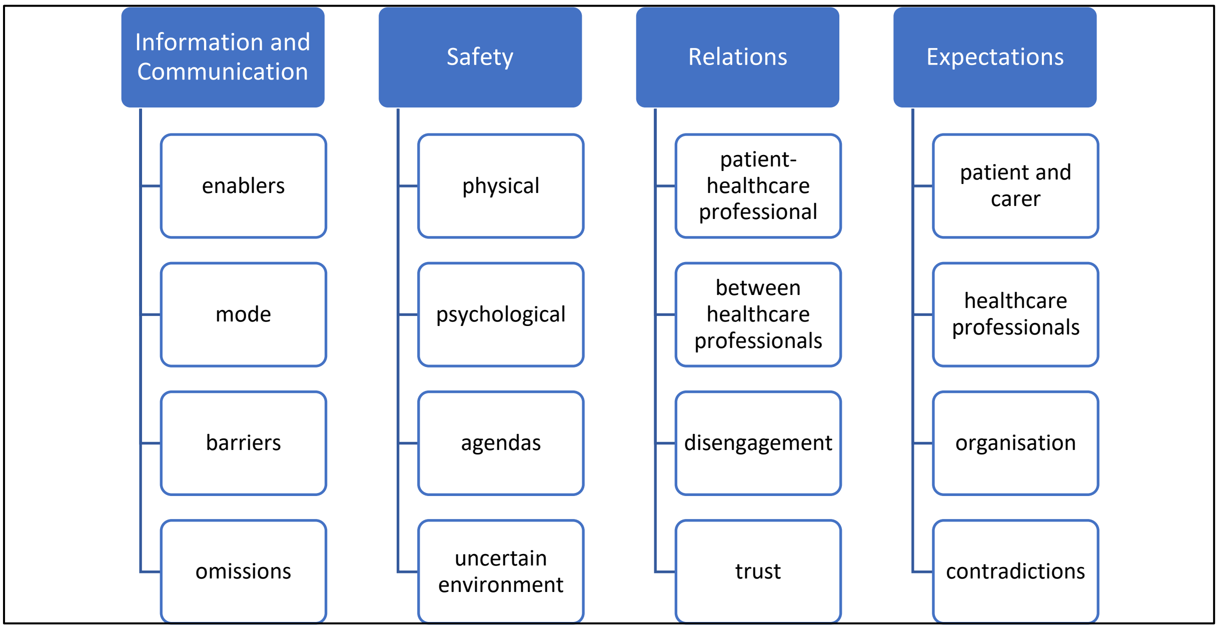


Figure 7. 3 Thematic data map

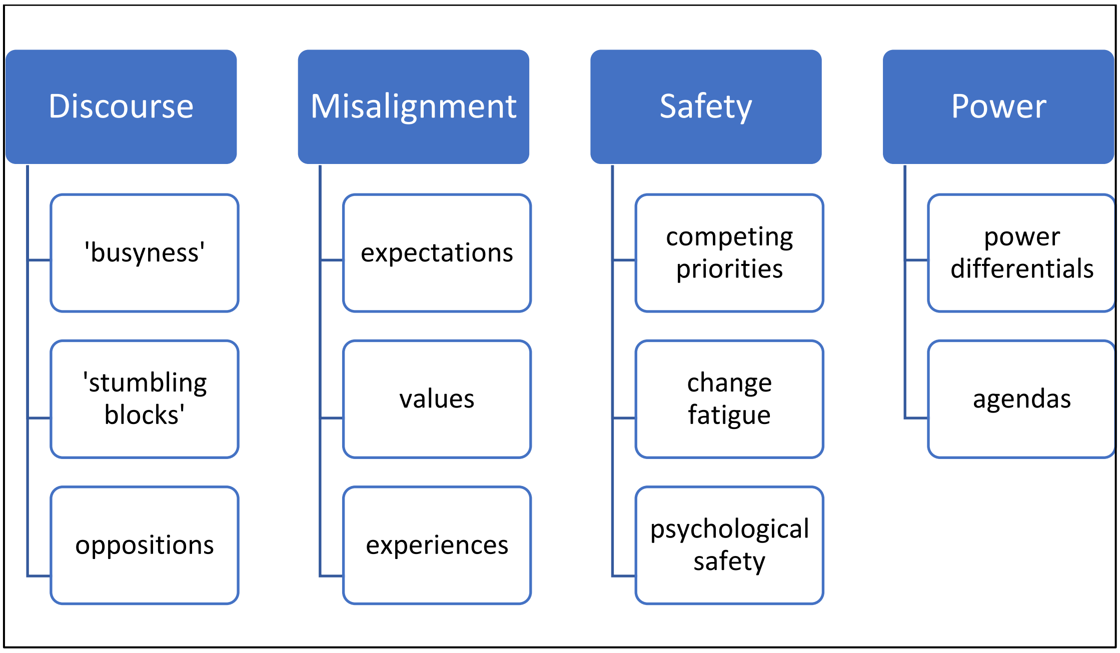


Figure 7. 4 Finalised thematic data map

7.4 SUMMARY

The data collected from the participants during the observations, interviews and focus group identified the issues that influenced the experiences of patients, carers and NHS staff on the AEC unit. The data was deconstructed and synthesised through the recursive movement between the data sets, the codes, themes, and the setting until final themes were formed. Using Stake's (1995) analytic strategies (categorical aggregation and direct interpretation), I was able to look for meaning in single instances and repetition of phenomena. These strategies, along with naturalistic generalisation, supported exploring the relationship between the meanings participants attached to their experiences (the study's essence) and the contextual complexity. Overall, combining the broad principles of Braun & Clarke's (2006) thematic analysis approach to data analysis with Stake's (1995) approach provided a sound, systematic method of data analysis.

Data analysing also enabled the movement from raw data to more abstract themes and concepts and supported the gradual explanation building advocated by Stake (1995). In doing so, I found that compiling different themes meant I had to interpret the thematic data, so I began a simultaneous analysis and interpretation process. However, I answered the study's central question and sub-question in Chapter 9 (Discussion) for clarification reasons. In the next chapter, the findings are presented as an in-depth picture of the case using narrative, tables and figures.

CHAPTER EIGHT FINDINGS

8.1 INTRODUCTION

This case study aimed to consider how the introduction of AEC impacted patients, carers, and NHS staff' experiences and to identify the factors that influenced their experiences and find ways to improve the service and make it sustainable. Participants' experiences on AEC was understood as a social process situated in a highly complex and changing health and social care system, shaped by national policy and local circumstances. Case study research offered me a way to understand participants' meaning-making of their experiences; that is, how they made sense of their world and the experiences they have in the world (Crotty, 1998; Stake, 1995). By asking *how* AEC influenced their experiences rather than *what* their experiences were, I pursued to disrupt the idea that there was a singular way of describing experiences and instead aimed to draw attention to the multiple ways in which experiences can be expressed and known (Stake, 1995).

The previous chapter described how the collected data was analysed, and the main themes and sub-themes extracted from the data were identified. In this chapter, the findings, encapsulated as themes and sub-themes that defined and delineated patients, carers and NHS staff' experiences, are presented in the form of narratives, tables and graphs and described in detail. The findings presented here are a synthesis of the analysed data from different sources and methods, using excerpts from the transcripts of the interviews and focus group and the observations' field notes. The findings will be presented for ease of navigation under the four main themes: 'understanding the prevalent discourse', 'misalignment', 'safety' and 'power'.

8.2 FINDINGS

8.2.1 Observations

Some of the issues highlighted by participants are outlined in Table 8.1. The main issues highlighted centred on a lack of information about the unit resulting in uncertainty about waiting times and what would happen whilst in the unit, but overall, patient and carers felt happy with the care they received. Staff expressed concerns about competing and sometimes conflicting demands, staffing issues and inappropriate use of the unit.

Respondent	**Data extract**	**Coded for**
Paul Patient	"*Has the hospital changed the procedure regarding albumin collection yet as in Leeds the nurses can collect all 4 bags at the same time but at this hospital, they have to collect one at a time which is absolutely bloody ridiculous when you guys are so busy anyway. Anyway, today is a good day so far as I have not had to wait for a free chair or for my bloods to be taken! Some days it can be hours before a space is free for me to be seen. And don't get me started on the nurses who do not want to take my referral and says I have to go to gastro when they all know I only let dr. Abdul put a drain in!*"	Frustration with policy and procedures concern for the nursing staff. busy periods in unit. frustration with variations in service.
Pam Carer	*"Everyone is always so busy but always keeps us up to date and we get regular cups of teas"*	Acknowledges busy unit Displayed empathy with staff Satisfied with levels of information giving comfort
Barry Patient	*"It would help if this unit is clearly signposted. Took me half an hour to find it. Nobody in this hospital seems to know what AEC is?"*	poor signage Time wasted due to getting lost Frustrated
Vera Patient	*"The nurses are always smiling and explained everything to me. They put me at ease as soon as they put me in that big blue chair."*	Care Empathy
Maggie Carer	*"This is unacceptable. My mother had her CT scan at 11am. Whilst the staff on here have explained to me as soon as we arrived that it is a long time for results, I feel we should have been told about this by A&E last night. That way I could have sorted out transport. Its 6pm and still no report."*	Time-delays waiting for results Frustration No information given disconnect between departments Lack of involvement of relatives from onset
Sally Carer	*"Can someone please explain to me what my dad is waiting for now? I have sat with him all day and no one has told me anything!"*	Frustration Lack of carer involvement No information given Issues with communication and information
Harry Patient	*"I was told in A&E I am just coming here for a scan of my leg, which is why my GP send me to A&E, but now that I arrived on the unit I'm told that I needed to have blood taken, wait for the results and then come back for my scan in four days."*	Poor communication Frustration/anger Unrealistic expectations Lack of clarity about pathways Time (busy)

Brenda Patient	*"The district nurse never came to give my injection yesterday so I asked my husband to bring me here as I know you will sort it out. Why didn't the nurse arrive?"*	Poor communication Patient safety issue Disconnect between primary and secondary care
James Patient	*"I have told five people my story now. First my GP, then the two nurses and then the two doctors. I understand it is needed to give me the right treatment but five times?"*	Repetitive nature Inappropriate communication
Christine Patient	*"I do not understand why I have to be seen by my GP first before I can come in for a drain. It is ridiculous and a waste of time."*	Unclear pathway Duplication Frustration
Kerry Carer	*"My mother has been told the results take 2 hours, but we have been waiting for three hours now?"*	Waiting Delays
Chloe Carer	*"I was told by A&E to bring my mother here for a scan of her leg. There was no one at reception, so we just sat down in the waiting room. Then after sitting in the waiting room for 30 minutes, we were told she should have gone to another department first then come here. She has missed her scan now, and I have to take another day off on Thursday to bring her back."*	Unmanned reception Poor communication Frustration Time waiting
Peter Staff nurse	*"What time do we stop taking referrals? ED wanted to send down a DVT patient at 8 pm. I said we closed as the ANPs and the junior doctor was not on unit anymore, so there was no one to clerk patients. The nurse was not happy with me."*	Workload pressures Conflicting demands Unclear procedures Feeling pressured
Henna Staff nurse	*"The place is bursting, and I am still expected to take new patients when I have not even done all the other patients' paperwork."*	Workload pressures Conflicting demands Difficulties Busy Feeling pressured
Delia Staff nurse	*"Can someone please sort the long waiting times for CT/VQ reports? Patients and relatives are giving us the evil eye and more over it!"*	Waiting Delays frustrations internalise criticism

Table 8. 1 An extract of initial codes from observations in the AEC

As part of the study's participatory element, actions were planned and carried out to address the issues highlighted. Table 8.2 depicts an extract of the action plan.

Issue	**Key extract**	**Actions done**	**Lead**
Delay in the processing of blood samples caused a delay in patients' management.	"My mother was told it takes two hours for the blood results, but we have been waiting for more than three hours now?	One of the ward staff and I met with the Pathology department head to discuss the concerns. It transpired AEC samples were processed with the rest of the wards as they were unaware it is a day service. Agreement reached to process the samples within the same timeframe as an outpatient clinic.	ANP (supported by two RNs who volunteered and the clinical lead of acute medicine).

Table 8. 2 Example of an issue identified and addressed

8.2.2 Focus group

One focus group was held with AEC staff, as outlined in chapter six. The focus group's starting point was the issues highlighted by participants and the visual map in chapter six (Figure 6.2) guided discussions. The key issues raised were categorised into initial codes, as demonstrated in Table 8.3.

Respondent	Data extract	Initial codes
Jenny Staff nurse	*"Dealt with a very angry GP yesterday who was furious because he was on hold for a long time and then he got further annoyed as the patient was inappropriate for the unit, so I had to put him through to bed managers. He shouted at me about his busy surgery!"*	Frustrations Competing demands Unclear referral guidelines Ineffective communication Feeling stuck in the middle
Steph HCA	*"Some days, there is nowhere to do the patients' bloods or give them their treatments."*	Lack of space Competing demands Lack of support Busyness
Beverly Ward clerk	*"There was probably no one at the desk as I was running around trying to find notes for a patient who came for a review. It needs sorting please as it has been going on for months! Just this morning I had to go to records to find a set of notes, which left the telephones and desk unmanned for more than 30 minutes."*	Issue with notes Inadequate communication Competing demands Lack of support
Paul HCA	*"I feel like the HCAs are expected to do several jobs at the same time. We do the initial observations, bloods, ECGs for all the new patients and then are also expected to take patients to other departments like X-rays, which is why people are waiting."*	Competing demands causing tensions Lack of support Ineffective communication
Penny Staff nurse	*"How do I manage to get the patients directly into AEC with the demands from A&E to take the GP patients from there first. "The other day, I was told by an A&E nurse that their corridors are full of 'my' patients! And she wanted to know what I was going to do about it as if I am the show master."*	Tensions between AEC staff and A&E staff Frustrations Poor communication blame Competing demands Lack of support
Jenny Staff nurse	*"If I refuse to take a patient due to the current pressures on the ward, such as staff shortages or no areas to assess patients, I am called obstructive."*	Pressurised Organisational challenges Unrealistic expectations Lack of support Conflict Being labelled
Penny Staff nurse	*"I was told off by the ED doctor yesterday for refusing to sort out Clexane for a DVT patient. I explained that if the patient comes to AEC and needs medication prescribing, the protocol states the patient will need to be clerked first, duplicating work. It is better if these patients come straight to us to prevent this."*	Tensions between AEC staff and A&E staff Frustrations Poor communication blame Issues with pathways Lack of support Feeling like stuck in the middle
Jenny Staff nurse	*"I feel like a lot of my time is spent asking the questions the doctors will also ask. The current booklet takes 30 minutes to complete, and a lot of the information is unnecessary. It is the same booklets they use on the wards and not suitable for a day unit."*	Frustrated Time wasting Duplication Inappropriate documentation

Table 8. 3 An extract of initial codes from a focus group with AEC staff

The main concerns highlighted in the focus group were communication between departments, the pressures and the impact of competing demands, perceived lack of support from management and how the staff dealt with what they viewed as unrealistic demands. As part of the study's participatory element, actions were planned and carried out to address the issues highlighted. Table 8.5 depicts an extract of the action plan.

Issue	Key extract	Actions done	Lead
Availability of notes	"Can we sort out the notes issues for patients coming to us for review? Yesterday I had to go to records to find a set of notes, which left the telephones and desk unmanned for more than 30 minutes."	The ward manager emailed all the medical wards who refer patients to the unit, informing them of the procedure they need to follow if they return to AEC for follow up.	Unit manager and the receptionist

Table 8. 4 An extract of an issue and actions taken

8.2.3 Interviews

Face-to-face individual interviews and telephone interviews were conducted, as described in chapter six. The interviews were steered by the guides and adapted to answer any questions raised by the observations and focus group's initial findings. The key issues raised were categorised into initial codes, as demonstrated in Table 8.6.

Respondent	Data extract	Initial codes
Bashir Registrar	*"I have just seen a patient referred by A&E as a DVT of the hand, which is not a medical patient. Now I will have to spend hours trying to convince Ortho's to see patient. Why don't people know the protocol?"*	Unclear referral procedure Lack of communication Frustration Time (busy) Lack of training
Debbie Staff nurse	*"Two patients are still waiting to be clerked, but the doctors and the ANPs have all gone to teaching. And one of my nurses has just been moved to A&E as they are short-staffed."*	Staffing issues Competing demands Communications Busy
Eva Junior doctor	*"I have nowhere to see the patients so I think you should stop taking patients we cannot care for."*	Anger/frustration Safety concerns Problems with space busyness
Roman Consultant	*"A&E is heaving, so now we have been told to create another assessment space to take more patients.*	Problems with space Problems with staffing

	Everyone is already cramped together and can probably hear each other's thoughts by now. Plus, who will see these extra patients as I do not see any extra staff."	Problems with communication Problems with privacy and dignity busy
Eunice HCA	*"There is no ward clerk on duty today…so guess who is going to have to answer all the calls and do my job…well no time to talk today I suppose."*	Difficulties Staff shortage Busy Annoyed
Adele Ward clerk	*"A patient has arrived for follow up and guess what…no notes again!!!"*	Procedures inadequate Frustration Time wasting
Stuart GP	*"I once tried to get through to AEC for thirty minutes, so I decided to just send the patient up to the unit."*	Referral process Issues with contacting unit Inappropriate action The patient becomes stuck in the middle
Stuart GP	*"It is not that we did not want to be involved with the service, but you have to understand some of us are single-handed GPs and really busy."*	Busy Workload
Saad GP	*"We GPs had nothing to do with the setup of the unit and to be honest, I do not see why we should as it is run by secondary care."*	Disconnect disengagement Whose interest? Competing agendas
Leigh ANP	*"I do not know what the referral protocol is, but there is one nurse in particular who refuses to take a referral from me and insists I get a GP to ring back. It is ridiculous."*	Communication issues Variation in practice Frustrated Unclear referral guidelines
Nicolas (ANP)	*"I always find them very helpful except when it is after 5 pm. Do not know why."*	Variation Communication
Tessa Manager (NHS Trust)	*"From the feedback, we got from the executive team. One of them commented that we spend too much time acquiring patient and staff experience feedback, giving a platinum service when we really can afford silver only. And another one said 'stop with the navel-gazing and get on with it'."*	Disinterest in evaluation Conflicting agendas Whose interest?
Stephen Manager (AEC Network)	*"At the moment, the main focus unfortunately for NHS Trusts is on closing the financial gap and looking at different ways to save money."*	Financial agenda Conflicting agendas
Heidi Manager (CCG)	*"To be honest, the setup of AEC, as well as its survival, is not an issue we in the community are concerned about. If it fails, it may mean we get a go at setting up a similar service in the community."*	Competing Agendas Us vs them Power
Heather (AEC Network)	*"For AEC services to succeed, there must be close working between the CCG, the organisation and all staff involved, from board to floor."*	Cooperation Contrast with reality Time? For cooperation
Jackie Patient	*"Dr * made an appointment to see me again on the unit after three days to see if my leg is better. And I was given a card with the number of the ward and told to ring if I feel unwell or my leg gets worse, or I was unsure of something. I told me I do not need to go to my GP or A&E if I feel worse but just come straight back. I liked that you know."*	Communication Care Follow up Information given
Raymond Patient	*"I was in that unit for a long time. Luckily they have nice comfy recliner chairs, and you get food and drink."*	Comfort Wait
Penelope patient	*"I was scared when I came into the unit, having spent a few hours on A&E corridor made me lash out at the staff. But the girls just listened to my outburst and then sat with me until I was calmed down. I was never judged or ignored because of that. And the lovely doctor reassured me. That is all I wanted, someone to listen to me."*	Safety Communication Empathy

Stephen Carer	*"Wonderful care. Staff explained things very clearly. And you even get fed and watered."*	Information given
Denise Carer	*"My son has just recently turned 16, so I was worried about bringing him there, but the nurses made him feel at ease, and the doctor talked to him about his favourite football team."*	Caring At ease Appropriate communication Reassuring
Michelle, Carer	*"My daughter has special needs and hates hospitals, but thanks to nurse… she did not even cry when they took her blood. The ward manager allocated the same nurse to look after her whilst she was on the unit, which is very important as she gets unsettled by too many strangers."*	Caring Patient-focused Needs-based care Reassuring
Dana Carer	*"After the events of the past I was very reluctant to bring my mother here, the newspaper articles frightened me. The staff explains everything to you from the minute you walk in, they did not ignore me, as the carer, as people sometimes do but made sure I understood as well. The doctor has the most gentle bedside manner, kneeling to be at the same level as my mother when he spoke to her. I will be writing to my MP to tell her how wonderful the staff are."*	Reassurance Caring Carer involvement Communication Excellent Bad press
Raymond Patient	*"Why must we go to the GP who will take bloods, wait 24 hours for results and then be referred to AEC? And when we arrive here, you retake bloods, and we have to wait a few more hours before I can have my treatment."*	Unnecessary steps Duplication Frustration

Table 8. 5 An extract of initial codes from interviews with patients, carers, staff and senior managers

As part of the study's participatory element, actions were planned and carried out to address the issues highlighted. Table 8.7 depicts an extract of the action plan.

Issue	Key extract	Actions done	Lead
An issue with the referral process: GPs reports difficulty in getting through on AEC telephones.	"I once tried to get through to AEC for thirty minutes, so I decided to just send the patient up to the unit."	A dedicated GP referral line installed, and a coordinator role implemented to take all the GP calls. Standard operating policy (SOP) for AEC introduced in order to streamline the referral process. Self-referral policy implemented**.**	Acute physician, ward manager and an ANP

Table 8. 6 An extract of an issue and actions taken

8.3 THEME ONE UNDERSTANDING THE PREVALENT DISCOURSE

The prevalent discourse on experiences in the unit was rooted in the notions of ‘busyness’, ‘stumbling blocks’, and ‘oppositions’. The discourse in the unit, the hospital itself and the wider community mirrored the NHS's discourse, that of ‘a system-in-crisis’. The dominant discourses offered reasons for the reported variations in experiences and demonstrated why there is ongoing reluctance to get involved with setting up and sustaining new services.

8.3.1 The language of ‘busyness’

While none of the participants was explicitly asked about the unit's activity levels, the patients and carers were asked about waiting times and their impressions of the unit during their interviews. Additionally, waiting times and the environment and facilities were on the observations topic guide.

> *“My mother has been told the results take 2 hours, but we have been waiting for three hours now?” (Observations, Kerry, Carer).*
>
> *“Some days, there is nowhere to do the patients’ blood or give them their treatments.” (Observations, Steph, HCA)*
>
> *“I was in that unit for a long time. Luckily, they have nice comfy recliner chairs, and you get food and drink.” (Interview, Raymond, Patient).*

The concept of ‘busyness’ was raised during the first observations when the patient remarked:

> *“Anyway, today is a good day so far as I have not had to wait for a free chair or for my bloods to be taken! Some days, it can be hours before a space is free for me to be seen”. (Observations, Paul, Patient).*

His partner concurred with him regarding the unit's activity levels but quickly pointed out the nursing staff's positive attributes.

> *"Everyone is always so busy but always keeps us up to date, and we get regular cups of teas" (Observations, Pam, Carer).*

During the observations and interviews, patients, carers and NHS staff often situated their experiences within the context of the 'busyness' of the unit or the staff. Most of the patients used the concept to rationalise waiting time and empathise with the pressures staff faced. Whilst none of the staff during the observation phase mentioned being busy, the unit looked busy on most days.

> *"The nurses are always smiling and explained everything to me. They put me at ease as soon as they put me in that big blue chair." (Observations, Vera, Patient).*
>
> *"Wonderful care. Staff explained things very clearly. And you even get fed and watered." (Interview, Stephen, Carer).*

This perception of busyness could be attributed to the unit's open-plan layout, as described in chapter seven. Thus, the staff had to walk from one end of the unit to the other to find equipment or speak to other staff members. Furthermore, the reception desk was in the middle of the unit and presented a hub of activity, where telephones were continually ringing. The desk was also the area where staff gathered to complete their paperwork or discuss patients (there was no office for medical staff). Due to the unit's nature, there was also constant activity as patients were admitted, discharged, or taken to other departments for investigations. One of the patients picked up on the non-verbal cues of busyness.

> *"The place was really busy with everyone just rushing around. I was dying for a drink, but I didn't want to disturb them." (Interview, Hazel, Patient).*

However, during the interviews, NHS staff and carers linked the notion of ‘busyness’ with time pressures on them, as illustrated in the quotations below.

> *“Luckily, I took the day off work to go with my mom as we were there a few hours.”* (Observations, Maggie, Carer).

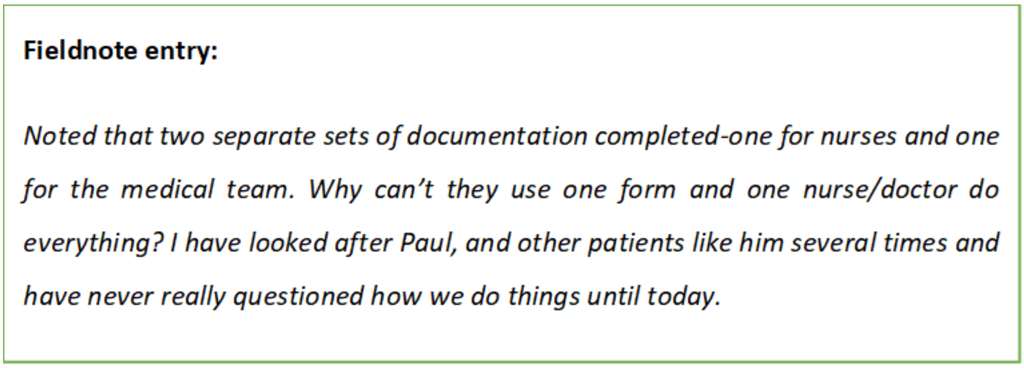
> *“I told switchboard I needed to refer the patient for admission but was put through to AEC then told to go back to switch. This was in the middle of a busy morning clinic.”* (Interview, Saad, GP).

> *“I once tried to get through to AEC for thirty minutes, so I decided to just send the patient up to the unit.”* (Interview, Stuart, GP)

Linked to the time pressures was the issue of duplication highlighted by patients and carers during the interviews and noted during observations.

> *“I told my story to five different people today First my GP, then the two nurses and then the two doctors. I understand it is needed to give me the right treatment but five times?”* (Observations, James, Patient).

> *“I do not understand why I have to be seen by my GP first before I can come in for a drain. It is ridiculous and a waste of time.”* (Observations, Christine, Patient).



Fieldnote entry:

Noted that two separate sets of documentation completed-one for nurses and one for the medical team. Why can’t they use one form and one nurse/doctor do everything? I have looked after Paul, and other patients like him several times and have never really questioned how we do things until today.

Example of a field note entry

During interviews and observations, NHS staff also highlighted the duplication of documentation.

> *"I feel like a lot of my time is spent asking the questions the doctors will also ask. The current assessment booklet takes 30 minutes to complete, and a lot of the information is unnecessary. It is the same booklets they use on the wards and not suitable for a unit whose patients are sometimes discharged within two hours." (Focus group, Jenny, Staff nurse).*

Furthermore, if a patient was seen in A&E and sent to AEC, the whole assessment process started again, causing frustration for patients and healthcare providers.

> *"I was told off by the A&E doctor yesterday for refusing to sort out Clexane for a DVT patient. I explained to her that if the patient comes to AEC and needs medication prescribing, the protocol states the patient will need to be clerked first, which is a duplication of work. It is better if these patients come straight to us to prevent this." (Focus group, Penny, Staff nurse).*

'Busyness' also impacted communications and the sharing of information. The issue of inadequate communication and a lack of information featured strongly in the fieldnotes, observations and interview transcripts. There appeared communication problems between departments, leading to patients arriving in the unit without being expected, as one patient expressed in her interview. "*They did not know I was coming from A&E*", which often led to conflict, "*the nurse was shouting at the A&E porter*" or inappropriate use of language about the patient. "*I heard her say patients are being dumped on her*."

Most often, the reason given for this inappropriate communication was, "*we are swamped."* Also, 'busyness' was often aligned with the notion that there is no time to support or question decisions without appearing obstructive or problematic.

> *"It is not that we did not want to be involved with the service, but you have to understand some of us are single-handed GPs and really busy." (Interview, Stuart, GP).*

> *"The place is bursting, and I am still expected to take new patients when I have not even done all the other patients' paperwork." (Observations, Henna, Staff nurse).*

> *"Two patients are still waiting to be clerked [assessment by doctors], but the doctors and the ANPs have all gone to teaching. And one of my nurses has just been moved to A&E as they are short-staffed." (Observations, Debbie, Staff nurse).*

8.3.2 The language of 'stumbling blocks'

This sub-theme concerned the perceptions of NHS staff of all the perceived problems and barriers that prevent them from delivering the care they espoused. Staff were keen to point out how staff shortages meant they had additional workloads and felt it affected their ability to give patients the care and attention they needed.

> *"There is no ward clerk on duty today…so guess who is going to have to answer all the calls and do my own job…well no time to talk today I suppose." (Observations, Eunice, HCA).*

> *"A patient has arrived for follow up and guess what…no notes again!!!" (Interview, Adele, Ward clerk)*

Whilst highlighting their frustrations to each other, the nurses rarely escalated them to the senior managers. However, the medical team were very vocal about their frustrations and often acted on them by speaking to a manager themselves or asking a senior colleague to do it.

> *"I have nowhere to review the patients so I think you should stop taking patients we cannot care for." (Observations, Eva, Junior doctor).*

The medical team recognized the issues were outside the nursing team's control, but the nursing staff then expressed that they *"had to answer for everything"*. Nurses also verbalised that they had to constantly juggle the unit's demands with the demands of A&E, and some struggled with prioritising.

> *“How do I manage to get the patients directly into AEC with the demands from A&E to take the GP patients from there first? The other day I was told by an A&E nurse that their corridors are full of ‘my’ patients! And she wanted to know what I was going to do about it as if I am the show master.” (Focus group, Penny, Staff nurse).*

A further stumbling block highlighted by all participants was the lack of consistency and clarity about day attendees' procedures. The problem extended to the management of those patients in the community whilst awaiting further investigations. Often patients were referred to district nurses to administer blood thinning injections. However, a few returned to the unit to have the injections reporting that “*The district nurse never came to give my injection yesterday, so I asked my husband to bring me here as I know you will sort it out.” (Observations, Brenda, Patient).*

Patients who frequently attended the unit to monitor their bloods or have fluid drained off their abdomen did not understand why they had to see a GP before they could be referred to the unit. Both they and the GPs pointed out the duplication this caused.

> *“Why must we go to the GP who will take bloods, wait 24 hours for results and then be referred to AEC? And when we arrive here you take bloods again, and we have to wait a few more hours before I can have my treatment?” (Interview, Raymond, Patient).*

> *“I do not understand why I have to be seen by my GP first before I can come in for a drain. It is ridiculous and a waste of everybody’s time.” (Observations, Christine, Patient).*

Frustrations were also compounded by the nursing staff's acceptance of inappropriate patients, which increased tensions between staff groups.

> *“I have just seen a patient referred by A&E as a DVT of the hand, which is not a medical patient. Now I will have to spend hours trying to convince Ortho’s to see the patient. Why don’t people know the protocol?” (Observations, Bashir, Medical Registrar).*

8.3.3 The language of difference

This sub-theme ties in with both the previous sub-themes and reflect how participants viewed the impact the perceived inconsistencies had on their experiences. Mainly, participants expressed how these differences led to variations in their care and, consequently, left them frustrated and sometimes led to tensions and conflict.

> *"Why is it that some days I can speak directly to the consultant for advice and other days I cannot?" (Interview, Saad, GP).*

> *"What frustrates me most is the fact that I can speak to someone today who would be happy to take a patient that may not one hundred per cent meet the guidelines with great outcomes. But when I try to refer a similar patient and speak to a different staff member, I get told 'sorry the patient does not meet the guidelines.' I get why there is a need for guidelines, but I have the patient in front of me. Does the fact that I ring the unit not indicate I have considered suitability already? Guidelines are just a guide, but certain people on that unit follow it too rigidly. That is why I started insisting on speaking to the consultant or registrar, but even then, the outcome of the call depends on who the person is. No wonder my colleagues get frustrated and send the patients to A&E." (Interview, Stuart, GP).*

> *"I have been seen quickly by the nurse but waited over two hours to be seen by a doctor, only to be told I have to wait for another doctor to decide if I can go home." (Observations, Barry, Patient).*

> *"If I refuse to take a patient due to the current pressures on the ward such as staff shortages or no areas to assess patients I am called obstructive." (Focus group, Jenny, Staff nurse).*

> *"I always find them very helpful except when it is after 5 pm. I Do not know why." (Interview, Nicolas, ANP)*

The comments pointed to the variability in the referral process, which caused conflict between the AEC staff and the referrers. The AEC model followed in the unit depended on the lead clinician of the day and the unit's shift coordinator and varied from accepting all clinically appropriate referrals to accepting only patients who met the pathways or criteria.

The GPs mostly were unhappy about the lack of clarity, and nurses found it difficult to handle the conflict.

> *"Dealt with very angry GP yesterday who was furious because he was on hold for a long time and then he got further annoyed as the patient was inappropriate for the unit, so I had to put him through to bed managers. He shouted at me about his busy surgery!" (Focus group, Jenny, Staff nurse).*

Staff also raised the issue about taking on extra workload as a hindrance to delivering the care they espoused too. The HCAs were trained to take blood and do ECGs to support the RNs and address the long waiting time. However, they expressed frustration with the extra workload. Other members of the team expressed similar concerns.

> *"I feel like the HCAs are expected to do several jobs at the same time. We do the initial observations, blood, ECGs for all the new patients and then are also expected to take patients to other departments like X-rays, which is why people are waiting." (Focus group, Paul, HCA).*

> *"There was probably no one at the desk as I was running around trying to find notes for a patient who came for a review. Just this morning I had to go to records to find a set of notes, which left the telephones and desk unmanned for more than 30 minutes." (Focus group, Beverly, Ward clerk).*

8.4 THEME TWO MISALIGNMENT

During the study, it became evident that there was a misalliance between patients, carers, and NHS staff's values, expectations, and experiences. Furthermore, there was a misalignment between the expectations of managers and those of the staff. The Cambridge Dictionary (n.d.) [online] defines misalignment as: "*An arrangement in which the parts of a …system do not fit together correctly, so they do not work well together".*

8.4.1 Expectations

This sub-theme dealt with a mismatch between participant expectations and reality. Staff verbalized that patients' expectations are based on what they are told by GPs or A&E staff which made things difficult for them. Most of the expectations were based on wrong, inadequate or no information, as evidenced by the excerpts below.

> *"I was told in A&E I am just coming here for a scan of my leg, which is why my GP send me to A&E, but now that I arrived on the unit I'm told that I needed to have blood taken, wait for the results and then come back for my scan in four days." (Observations, Harry, Patient).*

> *"What time do we stop taking referrals? ED wanted to send down a DVT patient at 8 pm. I said we closed as the ANPs and the junior doctor was not on unit anymore, so there was no one to clerk patients. The nurse was not happy with me." (Observations, Peter, Staff nurse).*

However, some of the findings also pointed out the differences between patients expectations of their experiences and what staff presumed they expected. The narratives of the three patients and carers below highlighted the differences.

Family A

Mrs Smith (age 58) was admitted to the unit on a Saturday with a possible blood clot in the lung. She was seen in the unit with a relative and discharged home with Clexane injections (blood thinner) and an outpatient CT scan booked for Monday. The relative was happy to administer injections, and the unit's contact details were given to them if any problems were experienced. The CT scan was performed on Monday at 10.30 am. No report was available at 1 pm, so she was permitted by the Consultant on duty to go home to await the results. The results were available at 5.30 pm and reviewed by Dr Hall, the consultant. There was no evidence of clots in her lungs, but a large lung tumour was noted.

The medical team arranged an urgent appointment in the chest clinic, and the nurse was directed to inform Mrs Smith of the result of the scan telephonically and that a follow-up appointment in the chest clinic was arranged. However, she was not to mention the tumour over the telephone. Nurse Tate (a junior nurse with less than a year of experience after qualifying) felt uncomfortable following the consultant’s directions (who has been a consultant in acute medicine for more than five years) and verbalised her concerns.

Nurse Frey (who has been qualified for more than five years) was the senior nurse on duty and directed nurse Tate to follow her order. So, despite her objections, she telephoned the patient and informed her of the result as instructed. However, when Mrs Smith asked her directly if there was anything she should be worried about, nurse Tate replied yes. Before she could explain further, Mrs Smith hung up. A few hours later, a very irate relative (son) came to the unit, but no doctors were available at that time to speak to him, and nurse Tate had already finished her shift and went home. The next day nurse Tate came to see me in tears as nurse Frey informed her that Mrs Smith's relatives were making a complaint against her. She was upset as both Dr Hall and nurse Frey instructed her to make the call despite her objections and felt she was not given a choice.

Family B

Mr Kay (age 75) presented to A&E with a productive cough and shortness of breath. He and his daughter were in the A&E corridor waiting to be seen, and due to the long wait, the decision was taken to move him to AEC despite him not fitting any pathway. He was made comfortable, seen, had treatment commenced and was transferred to a medical ward for admission. His relatives informed me he has been to A&E several times in the last few months and had already been waiting for a few hours before coming to AEC. In the AEC, the senior doctor, Dr Grant (who has been a medical registrar for more than three years), explained in detail to Mr Kay and his relatives what he thought was wrong. He explained to the family that an abnormality was seen on the CXR, which required further investigations. Mr Kay was later diagnosed with terminal cancer. During the next few months, he presented a few times to the unit after being referred by his GP, and we tried to treat him and get him home on the same day as per his wishes. The family gave positive feedback on their experience with the team at the hospital and emailed the ward manager. They gave written permission for their experience to be included.

Family C

This family shared their story with the patient experience team and the Trust Board of executives. Mr and Mrs Thompson attended AEC on several occasions, so I knew them both well. Mrs Thompson recently had a stroke and suffered from dementia, which was not formally diagnosed. Mr Thompson was her primary carer and was referred by AMU to monitor his kidney function following a recent in-patient stay. He was usually a smartly dressed, jovial man who loved to tell jokes. On one of their visits, I was called by a nurse who reported that Mr Thompson was very abrupt and refused to have his blood taken. She said, *“He is in a bad mood today*”. As it was so uncharacteristic of him, I went to see if I could convince him to have his blood taken.

On approach, I noted he was unshaven, dishevelled and both he and his wife were agitated. After giving them some tea and toast, their daughter, who worked at the hospital, was contacted with his permission. Whilst talking to them, it transpired that he had not been sleeping or eating properly for a few days as Mrs Thompson was very agitated, especially at night, and he felt ashamed to ask for help. I spent some time talking about their options and the dementia support group he previously refused to attend. Their daughter was distressed, seeing them both in this state and informed me that her dad refused to accept that her mother has dementia and will not get better. After allowing me to take his blood, we let them sleep in the recliner chairs whilst waiting for the blood results. The family emailed feedback about their experiences to the ward manager and consented to its inclusion in this study.

In dealing with Mrs Smith's relative, nurse Frey focused on the procedures and policies rather than on what the relative needed at that moment, which was empathy.

> *"In the worse moment of my life, I just wanted someone to sit down and explain the results to me, to show me some kindness even if they could not answer my questions. But all I got from her is reassurance that her colleague is in deep trouble over this. And she made no effort to find a doctor to speak to me. I felt she had an agenda and I was just collateral damage. That was my biggest issue. I left feeling more anxious than when I arrived, and none of us slept that night." (Son of Mrs Smith, Narrative A).*

In contrast, Mr Grant and the Thompson family had positive experiences because the nurses abandoned the usual procedures and adapted their practice to meet both families' needs.

> *"As a family we would like to thank the staff on AEC for the care, compassion and kindness that was shown to my dad and all of us. You spoke to us, not at us; your professionalism made us feel safe during the worst time of our lives, we knew you had our best interest at heart despite all the chaos at times. And lastly you gave us all hope for humanity and for the health service as we lost any faith in both prior to the day you took us off a corridor. Keep scouting for patients, you do it beautifully." (Relatives of Mr Grant, Narrative B).*

> *"In the current state of affairs, where staff are under constant pressures to meet targets, you could have just noted his refusal to have his blood taken and send them*

> *back home. But you didn't. You realised something was wrong and acted with compassion and care, you fed them, gave them a place to rest and made sure I could do my job without worrying about them. The time you took to talk to him and listen to his fears helped him to see he needs help and support and I am happy to report he has attended the first carer support group." (Relative of Mr and Mrs Thompson, Narrative C).*

The findings also highlighted the differences in expectations of the managers and NHS staff. The reform agenda and financial incentives steered the setup of the AEC. Most of the staff reported their struggle for creating an ethos of care in the unit, and thus tensions escalated when expectations were unmet or clashed.

> *"A&E is heaving, so now I am told to create another assessment space to take more patients. Everyone is already cramped together and can probably hear each other's thoughts by now. Plus, who will see these extra patients as I don't see any extra staff." (Observations, Roman, Consultant).*
>
> *"We [the organisation] are willing to try new ways of working, but I feel the commitment from management to support new initiatives falters over time, and adequate resources are not allocated." (Interview, Tessa, Manager).*
>
> *"In the past, it was usually driven by the national agenda at the start, but in the end, it is often tied to financial incentives." (Interview, Heidi, Manager).*
>
> *"We GPs had nothing to do with the setup of the unit and to be honest, I do not see why we should as it is run by secondary care."(Interview, Saad, GP).*
>
> *"At the moment, the main focus unfortunately for NHS Trusts is on closing the financial gap and looking at different ways to save money." (Interview, Stephen, Manager)*

8.4.2 Values

This sub-theme dealt with the differences in values and how they can lead to dilemmas, contradictions and tensions, both personally and professionally. One of the participants (Nurse Tate, a junior staff nurse) reflected on why she informed a patient of a possible malignancy over the telephone despite different instructions. "*It just felt morally wrong to* *let them turn up at the appointment unprepared."* She described her inner turmoil and how she felt an omission was just the same as a lie. Describing why she became a nurse, she concluded by saying:

> *"If that was my mother I would be horrified to turn up at a routine appointment to be given that devastating news. What if the lady went to her appointment alone?" (Narrative, Nurse Tate).*

Her personal and professional values were contradictory to what she was instructed to do. The senior nurse (Nurse Frey) and the consultant (Dr Hall) were both dismissive and critical of the decision she made and positioned her as lacking self-discipline, *"she was told to inform the patient there was no blood clot, no less, no more,"* Nurse Frey responded when asked about the incident. However, one of the other consultants (Dr Franks, a consultant with more than twenty years of experience) pointed out the emotional impact on nurse Tate who felt she was doing the right thing for the patient and the family. In his view, there was a delicate balance between responding to the feelings of guilt and supporting the patient and their family when giving bad news. Furthermore, he pointed out that it was a skill set learnt through experience and needed time to develop.

> *"I did not wake up this clued-up about how to deal with difficult situations (laughing). I made a lot of mistakes when talking to patients, but that is how I learned. And I try to model my own views about the importance of relating* ***with*** *patients and relatives rather than* ***to*** *(he emphasised words) them to all the staff I work with." (Narrative, Dr Franks, Medical Consultant).*

8.4.3 Experiences

This sub-theme dealt with the differences in the views of experiences between patients, carers and NHS staff. Patients appeared to find comfort in small gestures like one said, *"I* *just come here for the nice cups of tea"* (Observations, Vera, Patient). Others pointed out the positive care experience and highlighted the needs usually met.

> *"Dr * made an appointment to see me again on the unit after three days to see if my leg is better. And I was given a card with the number of the ward and told to ring if I feel unwell or my leg gets worse, or I was unsure of something. I told me I do not need to go to my GP or A&E if I feel worse but just come straight back. I liked that you know." (Interview, Jackie, Patient).*

> *"My son has just recently turned 16, so I was worried about bringing him there, but the nurses made him feel at ease, and the doctor talked to him about his favourite football team." (Interview, Denise, Carer).*

At times, the NHS staff' discourse focused on what was going wrong, and the nurses appeared to take patients' frustrations personally instead of seeing them as directed at the process. *"Can someone please sort the long waiting times for CT/VQ reports? Patients and relatives are giving us the evil eye and more over it!"* (Observations, Delia, Staff nurse). However, patients and carers emphasised the importance of personalised care and communication during the care episode.

> *"He [the doctor] took his time talking with me and never made me feel rushed or a nuisance. That place was so busy, yet he took his time with me (smiling)." (Interview, Hazel, Patient).*

> *"I was really unhappy when I came into the unit. Having spent a few hours on the A&E corridor made me lash out at the staff. But the girls just listened to my outburst and then sat with me until I was calmed down. I was never judged or ignored because of that. And the lovely doctor reassured me. That's all I wanted, someone to listen to me." (Interview, Penelope, Patient).*

> *"My daughter has special needs and hate hospitals but thanks to a nurse… she didn't even cry when they took her blood. The ward manager allocated the same nurse to look after her whilst she was on the unit which is very important as she gets unsettled by too many strangers." (Interview, Michelle, Carer).*

> *"After the events of the past and all the bad press, I was very reluctant to bring my mother here. The newspaper articles frightened me. The staff explains everything to you from the minute you walk in, they did not ignore me as the carer as people*

> *sometimes do but made sure I understood as well. The doctor has the most gentle bedside manner, kneeling down to be at the same level as my mother when he spoke to her. I will definitely be writing to my MP to tell her how wonderful the staff are." (Interview, Dana, Carer).*

8.5 THEME THREE SAFETY

8.5.1 Competing priorities

The sub-theme of competing priorities was highlighted by most NHS staff as contributing to the difficulties they experienced with the service. They pointed out how the time constraints due to the unit's high activity levels led to competing priorities, ultimately impacting patients' time spent in the unit waiting and simultaneously their experiences.

The patients and carers highlighted waiting periods during the whole journey through the AEC and specifically: to be seen by the doctors, for tests and investigations, for discharge instructions, for medication and ambulance transport.

> *"I was told by A&E to bring my mother here for a scan of her leg. There was no one at reception so we just sat down in the waiting room. Then after sitting in the waiting room for 30 minutes we were told she should have gone to another department first then come here. She has missed her scan now and I have to take another day off on Thursday to bring her back." (Observations, Chloe, Carer).*

> *"Can someone please explain to me what my dad is waiting for now? I have sat with him all day and no one has told me anything!" (Observations, Sally, Carer).*

Participants also pointed out the contradiction between the urgency relayed by their GP to them and the reality of what they experienced in the AEC.

> *"My GP told me I have to get to the hospital immediately as I am very poorly, but I did not see a nurse for two hours and waited another four hours for a doctor who ordered an x-ray which I waited a long time for. Then I was told I have to be seen by another doctor and that took a further two hours. I then was told I had to wait for a bed which I eventually got at 3 am." (Observations, Harry, Patient).*

Patients and relatives also spoke about the unexpectedness of the wait and put it down to poor communication.

> *"This is unacceptable. My mother had her CT scan at 11 am. Whilst the staff on here have explained to me as soon as we arrived that it is a long time for results I feel we should have been told about this by A&E last night. That way I could have sorted out transport. It's 6 pm and still no report." (Observations, Maggie, Carer).*

8.5.2 Change fatigue

NHS staff all spoke frankly about the number of hospital changes over the last few years. They talked about how most of it was *"policy-driven and pushed on us by the by the managers without considering the impact on patients."* (Observations, Roman, Consultant).

Others raised concerns about the passing through of interim managers.

> *"They are always bringing in these temporary managers who I believe are paid a lot of money to tell us to do things we have tried already. And when we say it is not going to work as we have tried it in the past they say we are negative." (Observations, Henry, Staff nurse).*

> *"These people learn all these fancy things in their books and then try and force the NHS situation to fit those books. Its madness." (Observations, Barry, Patient).*

The rate at which the changes happened also concerned participants.

> *"The NHS has to change, I accept that. But it just seems that it's happening more often. You just trying to get used to the previous change when another one comes along. In the meantime, you still have the day-to-day jobs today. And the money it costs every time." (Interview, Saad, GP).*

A few participants voiced concerns over the frequent name changes of the wards accompanying the change efforts.

> *"What are we calling the unit this week?" (Interview, Stuart, GP).*

The effect on patients was noted when one of them expressed his frustration as follow:

"It would help if this unit is clearly signposted. Took me half an hour to find it. Nobody in this hospital seems to know what AEC is?" (Observations, Barry, Patient). However, the frequent changes meant the signage needed replacing frequently. For GPs, it compounded their confusion with the unit and led to a practice of, "*I do not know what you take and do not take, so I prefer to send my patients to A&E"* (Interview, Saad, GP). The GP went on to clarify that the reason for this is to save him much needed time, "*sometimes you hold a long time for the call to be answered, only to be told your patient is not appropriate*." (Interview, Saad, GP).

The managers all pointed out the financial need for the changes and admitted that

> *"at the moment, the main focus is on closing the financial gap and looking at different ways to save money" (Interview, Tessa, Manager).*

They also agreed that

> *"for AEC services to succeed, there must be close working between the CCG, the organisation and all staff involved, from board to floor." (Interview, Heather, Manager).*

However, there was an acknowledgement from one manager when we discussed the unit's closure that this is common with innovation projects.

> *"Unfortunately, this happens in the NHS. We start something and soon move on to the next shiny new thing. Maybe it is because there is a lack of understanding about what it would take to sustain it, like time, money, staff, (Shrugging her shoulders)." (Interview, Tessa, Manager).*

Furthermore, it was pointed out that these changes happen too frequently, yet the culture of innovation does not include a culture of acquiring feedback.

> *"One of the exec team commented that we spend too much time on acquiring patient and staff experience feedback, giving a platinum service when we really can afford silver only." (Interview, Tessa, Manager).*

8.5.3 Psychological safety

Research diary entry 15/5/15

At the monthly staff meeting, staff verbalised a perceived lack of understanding and support for the unit from senior managers and other departments. They verbalised frustrations with inappropriate use of the unit, unfilled vacancies and ongoing use of the unit to prevent A&E breaches. Staff became very upset at this meeting as they felt they were expected to give care under less than ideal conditions. Between themselves, they came up with the idea of a 'time out' sign, which would indicate to their colleagues if they feel overwhelmed. They also agreed to try a 'safety huddles' approach, where they reconvene twice a day to update what is happening on the unit, what people are up to, and who needed extra help to get their jobs done.

Extract from reflective research diary

One of the staff reflected on her anxieties and feelings of never enough.

> *"No matter how much you do or give. It is never enough. I run around all day, yet I go home feeling like I have not done enough for the patients." (Focus Group, Penny, Staff nurse).*

The narrative reflection of experiences of care of Mrs Smith and her family in the AEC demonstrated the negative impact uncaring could have on patients and relatives. However, Nurse Tate also experienced the same feelings of uncaring and left the unit shortly afterwards and cited feeling unsafe and unsupported in the unit.

8.6 THEME FOUR POWER

The acknowledgement of power and the role differentials played in the daily discourses and actions on the unit was constructed in the ambiguities, incongruities, and divergence expressed most acutely by participants.

8.6.1 Power differentials

Feelings of limited power were expressed by a senior staff member who reported she felt "*powerless"* when a manager shouted to her, "*tell your staff to stop being obstructive and take your GP patients from A&E corridors".* She reflected on how that feeling stemmed from not standing up for the staff and not being assertive enough to say to the manager her behaviour was unacceptable and unprofessional. She rationalised her reasoning for not acting because "*this is how it has always been*" and then went on to say, *"I always back away from confrontations"*.

Individual healthcare professionals' insistence to only deal with groups they have deemed competent appeared to be constructed within both a medical framework and a socio-cultural one. GPs rationalised their preference to speak to a colleague by linking it to efficiency, and nurses linked it to role legitimacy.

> *"I do not think it is right that nurses are taking referrals. I just feel that doctors will grasp quicker what I am trying to say. I think nurses are great at their job in general, but it is a time-saving concern." (Interview, Stuart, GP).*
>
> *"I do not know what the referral protocol is, but there is one nurse in particular who refuses to take a referral from me and insists I get a GP to ring back. It is absolutely ridiculous." (Interview, Leigh, ANP).*

8.6.2 Agendas

This sub-theme links with power differentials and psychological safety. An example in this study was how Nurse Frey used her influence and professional status to create an unsafe environment for Nurse Tate. Thus, this sub-theme referred to the different and sometimes concealed agendas that continue to play out in areas where new services are implemented, which can have a detrimental effect on service development and experiences. This behaviour appeared to be a known occurrence in the NHS, as one participant highlighted:

> *“From my experience, if the senior staff on the wards resist an idea or change, other staff also do not engage. It is like follow the leader game.” (Interview, Tessa, manager).*

Furthermore, senior management's agendas and their focus on performance, efficiency and finances were perceived as a lack of support for the unit.

> *“Every time we raise the issue about the inappropriate use of the unit or the fact that the beds are used overnight which means it affects how we work for that day, we are told it’s an executive decision. That way everyone on the shop floor separates themselves from the decision making and creates an invisible bogey-man.” (Focus group, Jenny, Staff nurse).*

> *“To be honest, the setup of AEC, as well as its survival, is not an issue we in the community are concerned about. If it fails, it may mean we get a go at setting up a similar service in the community.” (Interview, Heidi, Manager)*

The lack of evidence on whether the service influenced the patients and carers' experiences and its financial gains also led to pessimism amongst senior managers about the unit's viability. Paradoxically, any attempts to obtain that feedback are met with much resistance and comments from senior management, *“stop with the navel-gazing and get on with it.*” (Interview, Tessa, Manager).

8.7 SUMMARY

The findings provided a detailed description of the factors that impacted the care delivery in the unit and thus on study participants' experiences. The findings demonstrated that the practice context was shaped by dominant discourses and power differentials that was paradoxical to delivering person-centred care. Thus, leading to misalignment in values, expectations, and experiences and ultimately to a psychologically unsafe environment, where staff would be unable to flourish (Gaffney, 2011; McCormack & Titchen, 2014) and any attempts at the transformation of services will fail. In the next chapter, the findings will be discussed and linked with relevant literature and theory.

CHAPTER NINE DISCUSSION

9.1 INTRODUCTION

This study's primary research aim was to explore how the introduction of an AEC service has impacted patients, carers, and NHS staff's experiences. The four themes: ‘understanding the prevalent discourse’, ‘misalignment’, ‘safety’ and ‘power’, were extracted from the data collected through observations, semi-structured interviews and a focus group. The three patients' narratives were shared with me by the patients’ experience team and the complaints department on request by the relatives. This chapter will further discuss the data's findings and consider both supporting and contradictory evidence concerning the study's four themes. The chapter is presented in two sections. Section one offers an exploration of the four themes and locates the findings within the relevant literature. Furthermore, the section highlights patients, carers and staff's experiences, the challenges they encountered, and how they navigated those challenges. Section two presents and explains the conceptual framework used to explain the findings in section one.

The chapter situated the study findings within the literature and demonstrated how the research findings addressed the study questions through interviews, observations and a focus group. Thus, generating knowledge of how the introduction of AEC influenced participants’ experiences. The following questions were addressed

1. How did the introduction of a purpose-specific AEC unit influence patients, carers, and NHS staff's experiences?
2. What factors influenced their experiences?

SECTION ONE LOCATING THE FINDINGS WITHIN THE LITERATURE

9.2 THE INTERRELATEDNESS OF DISCOURSE AND POWER

9.2.1 Understanding the prevalent discourse

The theme emerged as I tried to understand the stories participants were trying to tell using words such as ‘busy’, ‘being good’, and body languages like shoulder shrugs and eye rolls. The research findings revealed how several tools were utilised by participants in the study (the AEC community members) to make sense of ambulatory emergency care experiences. One of those tools was the verbal and non-verbal discourses that occurred in the unit. The notion of discourse generally refers to communication, either written or spoken. Discourses were found to be used by participants as a vehicle to make sense of and express their shared experiences.

The study findings thus corresponded with previous research, which found that communication between patients and healthcare professionals were crucial for positive care experiences (Attree, 2001; Bridges et al., 2009; Entwistle et al., 2012; McCabe, 2004). However, the findings also clearly demonstrated that the communication levels and the quality of the interactions varied between the patients, carers and the different NHS staff groups according to their own needs and agendas (Maben et al., 2012a; 2012b; Tadd et al., 2011). Hence pointed to the formation of different ‘discourse communities’ *“…that have different goals or purposes and use communication to achieve these goals”* (Borg, 2003, p.398).

Discourse communities "*…are groups of people who share common ideologies, and common ways of speaking about things"* (Little, Jordans & Sayers, 2003, p. 73). This membership can be reassuring on the one hand and risky on the other, as it can potentially hamper our actions and thoughts. Nelson (2001) pointed out that these narratives can influence how we constructed our identities and advocated using 'healing narratives' or 'counter-stories' to restore autonomy to the disempowered (p.150). During the study, various 'discourse communities' were identified within the AEC context and the broader organisational context", each with their own motivations that ultimately impeded or enhanced participants' experience.

The data collected from NHS staff reflected how they often dealt with situations beyond their control, and thus their discourse was rooted in 'victimhood'. They attributed this to the constant balancing of their jobs (caring for patients), doing what is morally right and dealing with administrative and bureaucratic issues (for example, the A&E 4-hour standard and unclear referral pathways). In their interviews, they vocalised fears that their workload and bureaucratic interventions might compromise patients' care.

> *"How do I manage to get the patients directly into AEC with the demands from A&E to take the GP patients from there first? The other day I was told by an A&E nurse that their corridors are full of 'my' patients! And she wanted to know what I was going to do about it as if I am the show master" (Focus group, Jenny, Staff nurse).*
>
> *"No matter how much you do or give. It is never enough. I run around all day, yet I go home feeling like I have not done enough for the patients." (Focus group, Penny, Staff nurse).*

The NHS staff's discourse relayed the tension they experience every day as they feel a moral and professional obligation to deliver a high-quality service but are restrained by managers and policy-makers (Corley, 2002; Maben et al., 2006, 2007, 2012a, 2012b). Thus, their experiences were shaped by these tensions and the perceived relationship with employers and colleagues (the context).

The data collected from patients and carers revealed that they felt that they had little control over delivering healthcare (passive receivers), and the interpersonal relationship with staff shaped their experiences.

> *"I was scared when I came into the unit, having spent a few hours on A&E corridor made me lash out at the staff. But the girls just listened to my outburst and then sat with me until I was calmed down. I was never judged or ignored because of that. And the lovely doctor reassured me. That is all I wanted, someone to listen to me" (Interview, Penelope, Patient).*

> *"My son has just recently turned 16, so I was worried about bringing him there, but the nurses made him feel at ease, and the doctor talked to him about his favourite football team" (Interview, Denise, Carer).*

The centrality of the role that the interpersonal relationship between patients and staff played in patients and carers experiences was highlighted in other studies (Attree, 2001; Entwistle et al., 2012; Frank, Asp, & Dahlberg, 2009; Gordon, Sheppard & Anaf, 2010; O'Cathain, Coleman, & Nicholl, 2008; Picker Institute, 2008; Tsiakanas et al., 2012; Wellstood, Wilson, & Eyles, 2005).

The data collected from the senior managers revealed an awareness of the challenges that staff were facing, but rather than focusing on practical ways to solve the issues, they focussed on the importance of partnership working to ensure services succeed.

> *"For AEC services to succeed, there must be close working between the CCG, the organisation and all staff involved, from board to floor" (Interview, Heather, AEC network).*

The above data extracts highlighted that we all are members of different discourse communities that determine how we narrate our experiences. Patients and their carers' discourse reflected their acceptance of a situation they often viewed as outside their control, and they placed value on things like physical comfort and interpersonal relationships with staff. NHS staff' discourse centred on coping with their constant struggle with doing their job, providing emotional support to patients, carers and colleagues and manoeuvring a system that often conflicted with their values. Lastly, the discourse of senior managers centred on turning troubled situations into positive achievements through partnership working.

In their study, looking at oncology patients' experiences, Little, Jordan & Sayers (2002) found that the patients' discourse centred on themselves as victims of circumstances. In contrast, healthcare staff's discourse centred on them as martyrs or heroes, depending on the context, and policymakers characterised adverse experiences and challenges as opportunities to be taken. Their findings align with this study's findings as patients, carers, and NHS staff viewed themselves as people to whom things happen (passive mode) and dispersed blame for negative experiences onto external factors.

The narratives of the different 'discourse communities' in the NHS appeared to be rooted in 'a-system-in-crisis' perspective, reinforced by media, politicians and hearsay. Patients and carers used the discourse of 'busyness' to justify any waiting and to demonstrate their empathy with healthcare professionals (Gordon et al., 2010; Kihlgren et al., 2004; Nystrom et al., 2003), whilst directing the blame at the government or managers for creating *"this mess"* (Observation, Barry, Patient). On the other hand, NHS staff used the discourses of 'busyness', 'stumbling blocks' and 'oppositions' to justify their perspectives of themselves as the 'casualties' of an overloaded and unrealistic system. Furthermore, policymakers and managers professed that the 'challenges' should be viewed as opportunities to improve the healthcare system. The government and policymakers' rhetoric continues to attribute choice and agency to patients, carers, and NHS staff, yet resources to support this are scarce and targeted.

The study findings also demonstrated how these opposing and sometimes fixated discourses prevented people from sharing their concerns with other communities, preferring to complain amongst their peers. Consequently, inhibiting reflection and critique opportunities and hampering practice development and ultimately, negatively impacting experiences (Little et al. 2002). Some participants were so caught up in their feelings of oppression and powerlessness that the idea of ‘activism’ was lost on them. Thus, leading to missed opportunities to contribute to service development. The discourses were often constitutive, thereby sustaining and reproducing the status quo rather than encouraging resistance.

> *…a discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart. (Foucault, 1998, p.100-101).*

9.2.2 Understanding issues with power differentials

Linked to the theme of discourse was the theme of power which emerged during observations and interviews. The theme highlighted participants’ underlying concerns about power differentials and how that led to a sense of disempowerment, thus hampering their ability to influence care experience. Patients and carers deferred the responsibility of their care experience to healthcare professionals as they viewed them as the ‘experts’, *“I am happy to wait my turn as the nurses know which patients need care the most”* (Observations, Vera, Patient).

The value they placed on professional knowledge took precedence over their knowledge and 'truth' of their care experience. Furthermore, it influenced the level of the quality of care they expected or the feedback they gave about their experiences, which, in turn, reinforced impotence. Other researchers also pointed to how the diminished sense of significance and fear of getting staff in trouble of some patients, especially the older population, influence feedback given about care experiences (Bridges, 2008; Bridges & Nudges, 2009; Morphet et al., 2015).

The patients and carers' discourse placed healthcare professionals in a powerful /powerless dichotomy. This dichotomy was echoed in the conversations with staff from all levels.

> *"I am supposed to send one of the HCAs to help on another ward. That will leave the unit short staffed but if I say no I will get a telling off and still has to do it." (Observations, Henna, Staff Nurse).*
>
> *"I felt deflated really. It was like I was being told off for something that was outside my control. They decided to bring an expert in, and I trusted his judgements. Plus I felt as they brought him in my knowledge must not be up to par with his, so I did not feel confident enough to challenge him." (Interview, Tessa, Manager)*

As I related in chapter four, I did not subscribe to the notion of people being agency-less and 'trapped' by structures. Instead, my history taught me that even the most oppressive structures could not inhibit agency as people resist through instances of activism and active participation, even if very limited (Biko, 1987; Fanon, 2001; Gordon, 2015). However, during the study, I noted how 'powerlessness' and 'oppression' became normalised and accepted in the healthcare context. Furthermore, people use those feelings to disengage from a change in the healthcare arena, thereby reinforcing the powerful/powerlessness dichotomy. To understand the paradox, I considered Michel Foucault's (1926-1984) work that focused on power. Through a Foucauldian lens, power is not viewed as a tool of oppression and prohibition, held and wielded by certain individuals or institutions, but as

> *...diffuse rather than concentrated, embodied and enacted rather than possessed, discursive rather than purely coercive, and constitutes agents rather than being deployed by them (Gaventa, 2003, p.3).*

Therefore, power is an outcome of actions, and elements of power are transferred amongst those involved. In other words, power is everywhere and continually present in all our actions and so cannot be described in the negative/positive binary.

> *...we must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (Foucoult, 1991, p.194).*

***Manager**: "What is happening? Why are you refusing to take patients from A&E?"*

***Staff member**: "I am not refusing to take any patient. I just explained to the A&E nurse that I cannot take patients for about twenty minutes as I am trying to create a space for patients to be seen. The unit is currently bursting. There is no assessment space, and the doctors are unable to review patients for discharge. Patients are also waiting a long time for the results of their investigations."*

***Manager:** "well, be creative! What is the holdup with results and what have you done to sort it?"*

***Staff member**: "The radiology department is apparently very busy today. I have spoken to them several times and… (interrupted by manager).*

***Manager**: "Get it sorted and move your GP patients off A&E corridors. The staff on A&E are struggling to manage with the influx of patients. And patients are breaching left right and centre. I'm sick to death of hearing how obstructive AEC staff is being when we are all under pressure." (walks away).*

The nurse remained stood in front of the whiteboard, struggling to maintain her composure but walked off five minutes later in tears. This left the unit without two staff members as one of her colleagues also left to offer her support and 'coach' her back. An ANP took over co-ordination of the unit, leaving one less person to do the initial medical assessment for patients.

Extract of conversation between manager and RN

Therefore, Foucault recognised the possibilities of resistance within people's daily discourses and actions and how it is used to ‘survive’ the day-to-day routines (Gaventa, 2003). The extract above of a conversation between two staff members provided an example of how power “*… is everywhere’ and ‘comes from everywhere’ so in this sense is neither an agency nor a structure”* (Foucault 1998, p.63). In the exchange, the manager used her authoritative power to ensure ‘things were done’, but the ‘scattering’ of power during the interaction prompted the nurses' resistance and ultimately caused patients' delays.

9.3 MISALIGNMENT

The theme emerged as participants tried to make sense of the differences in their respective expectations and experiences. The extract of the conversation between the manager and a staff nurse above demonstrated how differences in value and expectations led to ineffective communication and power ‘plays’. The misalignment ultimately affected the efficiency and productivity of the unit and, thus, patient care. The extract also stressed the importance of seeing everyone involved in the care context *“…as a person to be engaged with rather than a body to do things to”* (Nicholson et al., 2010a, p.12). In this study, ‘person-centred’ included patients, carers and NHS staff as acknowledging and respecting each other’s personhood is an essential aspect of care (McCormack & McCance, 2010). If patients and staff believe their presence is viewed as a problem, they withdraw from the care partnership to protect their personhood, leading to poor experiences.

Another critical challenge was workload pressures, compounded by staff shortages, which was exacerbated when staff were moved to other areas on short notice. The negative impact of work pressures on patients experiences was highlighted in the literature (Maben et al., 2012a; NHS England, 2018). In this study, staff verbalised frustrations with not delivering good patient care, leaving them feeling guilty and frustrated. Patients, in return, reported how the lack of interaction with the staff made them feel ‘invisible’.

> *“He [the doctor] was the first one to talk to me and listen you know. He took his time with me and never made me feel rushed or a nuisance. That place was so busy yet he took his time with me (smiling).” (Interview, Vera, Patient).*

In this instance, the patient relayed how the doctor's communication with her was more than just a mere exchange of words. Instead, it also signalled to her that her views were important. She felt that her humanity was acknowledged, both of which are essential aspects of person-centred care (McCabe, 2004). Person-centred care can be viewed as an approach to practice that encourages the development and maintenance of therapeutic relationships between patients, carers and healthcare staff (McCormack, Dewing & McCance, 2011; Wolf et al., 2012). This relationship is based on mutual respect and respect for people’s right to self-determination (McCormack & McCance, 2010). The centralisation of the interpersonal relationship between patients and staff have been highlighted in other studies in acute care settings (Attree, 2001; Bridges, Flatley & Myer, 2009; Entwistle et al., 2012).

The patient's interview reflected the paradox in the care delivered on the unit as she relayed how she overheard a nurse say patients were just “dumped” on her. In her interview, she relayed feeling like a *“burden and a nuisance”*, which was relieved by her interactions with the doctor and other staff members. Thus, leading to what McCormack and McCance (2010) referred to as ‘person-centred moments’. These moments occur when healthcare workers manage to live out their values and focus on their well-being. Several examples of ‘person-centred moments’ were witnessed during the observations and also mentioned in the interviews.

However, several non-person-centred moments' were also evident during this study, which led to staff expressing guilt and distress *"I go home every night feeling I did not do enough for the patients" (*Penny, Interview, Staff Nurse*)*. Nurses expressed that they sometimes felt they had to choose between getting the job done and their nursing principles, a finding echoed in the literature reviewed (Wolf et al., 2012). Contradictions in personal and professional values often led to moral stress and feelings of guilt, like when nurse Tate expressed, "*It just felt morally wrong to let them turn up at the appointment unprepared."* (Corley, 2002; Maben 2006). Several other studies have looked at the factors that impeded developing a person-centred culture and identified workplace culture and the physical environment as two key factors (Brown & McCormack, 2011; Dewar & MacKay, 2010).

In response to the changes to the urgent and emergency care spectrum, Acute Internal Medicine (AIM) and Emergency Medicine's specialities merged to create an Acute and Emergency care group at the NHS Trust, where the study took place. The importance of that merger to this study was that the AEC staff had to adapt to the culture of A&E, which prioritised technical-medical skills and efficiency. The staff in this study struggled with this 'task-orientated approach', and one staff member expressed that "*patients are not tins on the supermarket shelves*". The conflict between upholding their values and the care environment's reality caused both interpersonal and interdepartmental conflict and often led to confrontations between A&E and AEC staff.

The conflict impacted patients and carers' experiences as staff attempted to find a balance between their intentions of delivering the care they espoused to and meeting service needs (Bridges & Nugus, 2009; Bridges et al., 2010; Kihlgren et al., 2005). Some of the junior staff struggled, particularly when confronted by more senior staff and in order to 'get the job done', they limited their interactions with patients (Maben et al., 2006). Patients and relatives picked up on the internal conflict of staff *"The nurse was firing off questions at me, never looking up from her papers during this interrogation. But just before she left she made eye contact and actually gave me a little smile" (* Interview, Vera, Patient). The use of the term 'interrogation' reflected the patients' perception that she was a 'task' to be completed. Thus, on a unit where the throughput was fast and time with patients already limited, the time spent with the patient was further reduced, sacrificing person-centred caring for task-orientated care. In their study of older people's experiences in urgent care, Bridges & Nudges (2009) found that the focus on nursing's technical aspects led to people reporting a diminished sense of significance.

Some team members openly acknowledged they had to "choose" between getting the work done and talking to the patients as they did not want to "*get into trouble*". They attributed their disengagement from the healthcare worker-patient relationship to the fact that they struggled with the stress of competing demands on them. Furthermore, they pointed out that the unit's lack of support and training compounded their inability to deal with the challenges. In their studies, Corley (2002) and Maben et al. (2007) found that when staff started to feel they were delivering sub-standard care due to competing demands, they experienced moral distress, alienation, and emotional distancing from patients and eventually degrees of 'burn out'. The studies pointed out that these problems are often exacerbated by inexperience and lack of support and professional development (Maben et al., 2006, 2007).

Thus, the unit's culture became steeped in negative discourses and 'hopelessness' and was created and sustained by the AEC team, the managers and the wider acute and emergency care community (Geertz, 1973; Wolf et al., 2012). Patients and carers reported that this had a negative impact on their experiences. The interrelatedness between the cultures-both ward and organisational disengagement from the patient-staff interactions and care experiences were noted in previous studies (Maben et al., 2007; McCabe, 2004; Wolf et al., 2012). The central role culture played in sustaining change efforts has been noted in other studies (André & Sjøvold, 2017; Bate, 2000, Jacobs et al., 2015).

Research diary entry (10/6/15)

During the last month I have noted the comments of the staff down and reading through it tonight I noted they are contradictory which slightly irritated me initially.

"It's your PhD"; versus "Doing this with you today gave me more confidence"

"I don't have time to pee never mind ask patients what I can do better" versus "It encouraged me to explain things to patients"

"This is a waste of time because even if we identify changes management will stop us from implementing it" verses "I'm happy to give it a go, every little bit helps and you are only talking about small changes aren't you?"

Extract from reflective research diary

9.3.1 Reflection on research diary entry

Why are some staff so resistant to try anything different? Is it because they are working in an environment that feels punitive? Where mistakes are punished, and the spotlight is on the negative things they do rather than the positive? Does the organisation have a 'never enough' culture, or is it society itself? *"Whatever we do will not be enough, and if we get it wrong, we are punished and humiliated"*, a nurse responded in an interview whilst talking about the low level of motivation amongst staff. If shame, comparison, retaliation, blame and disciplinary measures appear to be the order of the day, how can people feel safe and brave enough to be creative? More importantly, why do people decide to engage or disengage?

When I started this research, my viewpoint was that patients, carers, and NHS staff wanted to shape the service and have a say in how their care was delivered. This viewpoint was influenced by my own experiences of growing up under an oppressive regime, in which my values of cooperation, empowerment and justice is rooted. However, over the last few years, I found people reluctant to actively participate yet happy to sit on the side-line and complain if things go wrong. It is as if they are waiting to say, *"I told you so".* I found it frustrating as I believed they were wasting opportunities to change things, opportunities others never had. It felt like people were 'sleepwalking', despondent, with no energy or passion, basically just trying to survive. I started asking, "*why are they not interested*"? "*Why is everything so negative at the moment*"? So, I asked a colleague the question. And she responded

> *"Nobody listens to the minions. Everyday someone makes decisions about what is best for Jo Blog without really knowing what it is Jo really needs. Yes, they asked opinions but in the end, their decision is based on other things, and your opinions weren't really needed. So why even bother to ask us if you going to do it anyway? And anyway, we have heard it all before!" (Interview, Amina, ANP).*

Her response echoed the daily conversations I had with people in the hospital's wards and hallways and vibrated with the reasons people disengage. They reflected people's sense of being reluctant participants in the 'games' of management of the NHS, and thus they acted out their feeling of resentment and unhappiness in their daily working lives. In teams, this negativity can soon have a ripple-in-a-pond effect and thus obstruct any innovation ideas.

Thus, the study context reflected a place where all participants had to engage continuously in 'emotional labour' (Hochschild, 1983; Smith et al., 2009) to enable them to rationalise their experiences and defend their actions (Maben et al., 2012; Smith et al. 2009). The findings also demonstrated how people's behaviours, attitudes and the extent of emotional labour were regulated by the organisational culture (Hochschild, 1983). The dichotomy of the organisational culture and the mini-culture on the unit led to uncertainty about the boundaries of ‘acceptable’ behaviour at work entailed and, coupled with the toll of continuous ‘emotional labouring’, raised issues about psychological safety for all participants.

9.4 SAFETY

The central theme of safety emerged as participants commented on how AEC's pace and unpredictability led to competing priorities and ‘change fatigue’, perpetuating feelings of feeling unsafe.

9.4.1 Psychological safety

During this study, staff often verbalised how their opinions are never asked for, and thus they felt change efforts were imposed on them. A well-respected team member expressed how senior managers' treatment made her feel ‘insignificant’, which led to her withdrawing from any change efforts.

> *“I have been doing this for more than twenty years. And in that time, I have seen managers trying the same things previous managers have tried and which failed. But when I try to voice my opinion I am told to stop being negative. I can actually see them rolling their eyes even before I open my mouth. So, now I just keep my views to myself” (Observations, Amina, ANP).*

During an informal discussion with one of the managers during the observation phase, the staff member was pointed out as “*one of the obstructive ones*”.

The lack of encouragement of employee voice was evident, and in return, staff withdraw from the conversation about innovation and transformation. Furthermore, staff expressed how the discourse of staff being ‘obstructive’ or ‘difficult’ affected their relationships with peers and staff from other units and affected their feelings of worth.

> *“It is the probably the most used word in this department and bounced about several times a day. If I ask A&E to hold off bringing a patient, I’m obstructive. If I refused to take an inappropriate referral I am obstructive. If I refuse to send one of the nurses to another unit as it would leave the ward short, I am being difficult. I think they confuse me expressing my concerns about how these things would impact on the safety of the patients on the unit as being difficult and nothing I do can change that, except maybe just shut up and do as I am told”. (Observations, Delia, Staff nurse)*

Employee voice is defined as “*promotive behavior that emphasizes expression of constructive challenge intended to improve rather than merely criticize” (*Van Dyne & LePine, 1998, p. 109). This definition’s key is seeing suggestions or feedback as constructive rather than criticism or an obstruction, which unfortunately appeared to be lacking in the unit's dialogues and across the hospital. Furthermore, the staff needed to feel safe enough to raise their concerns (Nembhard & Edmondson, 2006; Smith et al., 2009). In this study, it was clear that staff felt unsupported and to protect themselves, they withdrew from any change efforts.

The finding was echoed by other studies that highlighted that curtailing voice behaviour ultimately impacts an organisation’s ability to embrace and sustain transformation and change efforts (Nembhard & Edmondson, 2006; Walumbwa & Schaubroeck, 2009). Paradoxically, if staff do not engage, suggestions for change and the resultant modification of practices are only driven from the board level. Thus, creating a vicious circle that reinforced the practice of ‘silencing’ of staff at ward level as a means of curbing ‘dissent’.

Walumbwa and Schaubroeck (2009) pointed out the roles of ethical leadership and psychological safety in enabling employees to voice their opinions. Ethical leaders “*are* *seen to act according to their fundamental values and beliefs, rather than to respond to external pressures or narrow and transitory interests."* (Walumbwa & Schaubroeck, 2009, p.1276). In displaying honest and open behaviour, they promote interpersonal trust and respect amongst staff. Hence, encouraging the team members to express their concerns or make suggestions and listen to others who do the same. Furthermore, in modelling behaviours that demonstrate respect and being clear about acceptable behaviour on the unit, they set a precedent for staff working on the unit.

However, as this study found, sometimes ethical leadership at the ward level is not enough if the organisational culture is steeped in authoritative management where all decisions are enforced from top-down management. The managers' drive to 'protect' staff can ultimately lead to her or himself feeling unsafe. Psychological safety refers to an environment where

> *…employees feel secure in pointing out problems, new ideas, or suggestions that are intended for the benefit of the work unit as a whole. (Walumbwa & Schaubroeck, 2009, p.1283).*

According to Edmondson (1999), this required a ward culture based on mutual respect, enabling the expression of disagreements and hearing those disagreements without fear of reproach. Psychological safety encourages staff participation at all levels of the organisation and is necessary for the continuance and success of quality improvement projects (Baer & Frese, 2002; Nembhard & Edmondson, 2006; Smith et al., 2009; Woodrow & Guess, 2008). If people perceived the environment to be psychologically unsafe, they would not engage in change efforts.

The extract of the conversation between the manager and the staff nurse also demonstrated how the differences in expectations could lead to conflict and 'horizontal violence' if not handled appropriately. As discussed in chapter four, ‘horizontal violence’ occurs when people direct their frustrations and anger at their peers rather than the source of their hostilities, which is often people in power. In nursing, it is also called ‘lateral violence’ and can be done by individuals or groups and usually occurs over time (Jackson, Firtko & Edenborough, 2007; Woodrow & Guess, 2008). The effects on the nurse are depression, anxiety attacks, and often it can lead to burnout. Also, workplace violence can adversely affect patient care (International Council of nurses, 2006; Taylor, 2016; Woodrow & Guess, 2008).

The nurse later related how the incident made her feel inadequate and disrespected in front of the rest of her team. As stated previously, any call for person-centred care should include nursing staff which included upholding their dignity and respect. The action of ‘walking away’ signalled an intention to withdraw or disengage. Khan (1990, p. 694) defined engagement as those moments “*when people employ and express themselves physically, cognitively, and emotionally”* and disengagement as the moments when “*people withdraw and defend themselves physically, cognitively, or emotionally”*.

During the study, it became evident that people either consciously or unconsciously decided whether they wanted to participate or not and that any participation was influenced by what was happening in the care context and not a reflection of their commitment (Khan, 1990). In an unpredictable NHS, healthcare staff were asking themselves daily, “*how meaningful is it for me to bring myself into this performance”; “how safe is it to do so”* and lastly “, *how available am I to do so?”* (Khan 1990, p.703). In this study context, meaningfulness, safety and availability were influenced by their work conditions and the interactions with colleagues and patients.

9.4.2 Psychological safety and patients

Studies in the UK and USA have looked at the complex relationship between staff and patient safety in environments where there were concerns regarding bullying and the impact on job satisfaction, stress and burnout, and the quality of care (Woodrow & Guest 2008). One of the study's key aspects was how patients adapted their role to what they perceived was expected of them to ensure a psychologically safe environment and their ability to express concerns without fear of repercussions. The discourse surrounding the NHS meant they expected to wait, to be met by ‘busyness’ and for the contact with NHS staff to be brief. *“They have not got all day to chat with me dear, they are too busy with all the poorly patients*” (Hazel, Interview, Patient). So, when they get a staff member who spent time with them, it stands out for them. Patients in this study expressed gratitude for the time taken to speak with them. Rather than seeing it as a fundamental right, they viewed it as a concession. *“The nurse was so good you know. She made me a cup of tea despite being rushed off her feet*” (Hazel, Interview, Patient).

The four themes highlighted the different challenges people encountered when entering the AEC unit and the tools they used to counteract those challenges. In this study, challenges referred to the perceived problems and constraints identified by the participants. The perceived challenges in this unit that impacted the experiences of patients, carers and NHS staff on AEC are presented in table 9.1.

Challenges perceived by participants
Workload pressures
Staff shortages
Long waiting times
Ineffective communication
Unrealistic expectations
Working in an uncertain environment
Lack of clarity about the unit
Variations in care when on the unit
Organisational pressures to meet targets
Lack of engagement of key stakeholders from onset
Competing demands
Competing priorities
Lack of senior managers support
Toxic work relationships
Prioritising of A&E patients to disadvantage of GP patients
Conflict between different groups of staff
Negative view of staff by other departments
Mismatch between policy requirements and the reality on the unit
Fear of being reprimanded
Balancing values with tasks
Emotions-frustrations, anger, fear
‘disconnect’ between departments/primary and secondary care
Problems with space

Table 9. 1 Perceived challenges that impacted the experiences of patients, carers and NHS staff

SECTION TWO THE CONCEPTUAL FRAMEWORK OF SENSEMAKING

9.5 THE SENSEMAKING FRAMEWORK OF EXPERIENCES

Sensemaking is when you try to make sense of and explain a complicated, ambiguous situation (Weick, 1995; Weick, Sutcliffe, & Obstfeld, 2005). Sensemaking theory draws on insights from philosophy, psychology, sociology and organisational studies and is a term used by researchers from different disciplines. However, the three most notable researchers in this field are Karl Weick (1993, 1995), Brenda Dervin (1983) and Russell, Stefik, Piroli and Card (1993). To assist me with developing the conceptual framework for this study, I turned to the work of Weick (1988; 1995) and Maitlis and Sonenshein (2010).

The publication of Karl Weick's seminal article, '*Enacted Sensemaking in Crisis Situations*' (1988), caused a shift in thinking about how a crisis unfolds in organisations and how to control any emergent crisis quicker. His article highlighted that organisations in crises should focus on the roles communication, cognition and actions played rather than focusing on faults in procedures and practices (Maitlis & Sonenshein, 2010). In so doing, the complex causes of the crisis would be brought to the forefront. Sensemaking lies at the core of Weick's (1988) seminal piece. For this study, the definition of sensemaking is based on the work of Weick (1988; 1995) and Weick, Sutcliff, & Obstfeld (2005), who viewed it as a social construction process "*…that occurs when discrepant cues interrupt individuals' ongoing activity, and involves the retrospective development of plausible meanings that rationalize what people are doing*" (Maitlis & Sonenshein, 2010, p.551).

Thus, the core theme that underlined sensemaking in this study was meaning-making. At the core of meaning-making is the bracketing off of clues from the environment and the interpretation of those clues based on "salient frames" (Maitlis & Sonenshein, 2010, p.552). Thus, sensemaking is about choosing some aspects from a perceived reality and making them more noticeable through words or texts. In this context, the use of sensemaking was appropriate as the data revealed situations characterised by uncertainty, complexity, and perplexity.

According to Weick (1988), the four foundational concepts for sensemaking is enactment, commitment, capacity, and expectations. Underpinning the concept of enactment is the idea that environments are created and maintained through people's actions and their attempts to make sense of those actions (Maitlis & Sonenshein, 2010). For example, the study participants often situated their experiences within the context of a 'busy' unit or 'busy' staff. Most of the patients used the concept to rationalise waiting time and empathise with the pressures staff faced and dispersed blame onto external forces such as 'government cuts'. On the other hand, staff used the concept to voice concerns about workload, staff shortages and lack of support from senior staff and managers.

Using the sensemaking lens, I reflected on how the unit's daily practices were shaped by institutional and organisational rules and participants' constructed roles and identities (Maitlis & Sonenshein, 2010). The repetitive nature of the activities, the punitive way management dealt with any attempts to diverge from the organisations' goals and the language they used to 'rein staff back in' (like labelling them as obstructive when they raised genuine concerns) created an environment where unsafe practices became viewed as 'normal' and 'unthreatening' by some and perpetuated the feelings of psychological unsafety by others.

The theme of enacted sensemaking demonstrated how participants enacted crises by participating in 'institutional work' (Maitlis & Sonenshein, 2010). Thereby, they sustained the rules and norms that provided the foundation for a unit steeped in fire-fighting activities daily. Furthermore, the recursive process enacted and re-enacted participants' collective understanding that the unit's daily routines needed to be shaped by organisational processes and procedures. Thus, recreating the structures, identities, and expectations that simultaneously enabled and constrained the practices that participants deemed essential for ambulatory emergency care delivery.

Commitment serves as one of the core concepts of the sensemaking frame of this study. Weick (1988) links the concept of commitment to people's keenness to publicly label an issue as the reason for a crisis, leading them to develop a 'blind spot' as they do not consider other reasons for the crisis. Thus, the issue remains unaddressed. Both Weick (1995) and Maitlis & Sonenshein (2010) highlighted how people's commitment to actions and their focal justifications of those actions could lead to 'blind spots'. The steadfast commitment to their actions, combined with the tendency to seek corroborative and avoid refuting evidence, can prevent individuals from seeing the incongruent clues (Maitlis & Sonenshein, 2010).

An example of this commitment was the labelling of AEC staff by the managers and A&E staff as obstructive when they pointed out staffing and capacity issues. These issues were never addressed as the focus was on changing the staff's attitude rather than finding ways to address the concerns raised by AEC staff. They limited their repertoire of meanings (AEC staff are obstructive) and actions (shouting and disciplining them). In this instance, commitment inhibited the ability managers meaning-making ability and her perceptions (sensemaking).

The review of the literature highlighted how public commitments to the health service often influenced policy directives and patients' evaluation of the service (Gorskey, 2008; Klein, 2018; O' Cathain et al., 2008; Williams, Coyle & Healey, 1998), which could contribute to the formation of 'blind spots'. On the other hand, Landau and Chisholm (1995) supports the use of pessimism and suggest that organisations should harness it to stimulate their "failure-avoidance management strategy" (Maitlis & Sonenshein, 2010, p.555) and thus prevent situations to turn into a crisis. These notions corresponded with the research findings of successful organisations where employees were instilled with a ‘preoccupation with failure’ and constantly encouraged to use ‘vigilant wariness’ (Maitlis & Sonenshein, 2010, p.556; Weick et al., 2005).

Capacity refers to people’s ability to recognise when a situation is troublesome as “*people see those events they feel they have the capacity to do something about*” (Weick, 1988, p. 311). During the study, it was evident that the staff was ‘constantly ‘fire-fighting’ as issues arose daily that interfered with the unit's functioning and their abilities to care for the patients. Furthermore, most of the staff were very junior and inexperienced. Wieck’s (1988) opinion that in crises, “*…there is often a reduction in the level of competence directed at the problem as well as an overall reduction in the use of action to develop meaning”* (p. 312) echoed staff’s realities.

A concept associated with capacity and important in sensemaking is identity construction which was central for this study. Identity construction referred to whether participants viewed themselves as active participants or passive recipients and how interpretations and actions were shaped by people’s views of their roles (Currie & Brown, 2003; Weick et al., 2005). AEC staff struggled with understanding their identities in the team and the wider urgent and emergency care division. They verbalised how their identities became synonymous with whether they were seen as ‘team players’ or ‘troublemakers’, and thus they struggled to verbalise their roles in the team. This struggle was not related to the level of experiences or their roles. Consequently, they became reluctant to voice their opinions or participate in any transformation attempts.

Most of the patients and carers offered positive feedback about their experiences. However, some of this feedback was contrary to what I witnessed during their care episodes. The patients identified themselves as ‘*needing help’* and thus responded according to this identity they appropriated. To ensure they get the help needed, they appeared to accept ‘sub-standard’ experiences as normative, pointing out reasons for this, such as nurses' busyness or more pressing needs of other patients. This finding of ‘justifications of negative experiences’ was reflected in several studies (Bridges, 2008; Kihlgren, Nilsson, Skovdahl, Palmblad, & Wimo, 2004; Morphet et al., 2015; Nystrom, Dahlberg, & Carlsson, 2003; Sørlie, Torjuul, Ross, & Larsen-Kilgren, 2006).

The justification included blaming managers and the government (Kihlgren et al., 2004) and comparing care with previous experiences or media reports. Additionally, the organisation received bad publicity shortly before this study commenced. Hence, patients and carers entered the ward with low expectations and trepidation; as Dana, one of the carers, put it, “*after the events of the past, I was very reluctant to bring my mother here as the newspaper articles frightened me*”. Thus, patients and carers' identities were highly influenced by a preconceived notion of the organisation, which affected their care expectations. Findings from other studies revealed how some participants took on the role of being ‘good’ by not asking for help or ‘moaning’ to ensure they get the care needed (Coyle & Williams, 2001; Nystrom, Dahlberg, & Carlson, 2003).

Like the patients’, NHS staff’ behaviour was also influenced by the negative press, and they used the notion of ‘busyness’ to justify acts or omissions to protect their integrity. Though, whereas patients and carers situated their discourse in positive feedback, staff were vocal about the negative experiences and the challenges they faced. Their main concerns centred around conflicting demands of the job on them, which led to frustration, anger and outbursts. Some of the NHS staff focused on task-driven care instead of patient-focused care to reduce anxiety and concerns. However, this increased their feelings of guilt and frustration, and when faced with negative feedback from other colleagues or patients, they became distressed.

Nevertheless, it was clear that there was a difference between how different team members dealt with the challenges in similar circumstances. Some staff members reflected openly about their feelings of ‘passion-and-commitment-lethargy’, which they linked to the lack of support. However, they were quick to point out that the reason they came into nursing was to make a difference but felt “*worn down*” by “*the system*”. These were the ones who frequently became overwhelmed by the workload and became emotionally upset at times. Their reduced resilience and determination appeared to lead to a ‘fixed mindset’, and every situation viewed as a challenge (Dweck, 2017).

Through the sensemaking lens, I reflected on my previous assertions that staff and patients were passive actors and that the staff's discourse was overtly negative, thus sustaining the hostile environment to their detriment. I concluded that a balance between ‘vigilant wariness’ and optimism was needed to prevent the creation of blinkers and encourage disruption of the status quo.

The concept of expectations is related to meaning-making and refers to people’s assumptions about the unit's importance and the expectations that followed from this. Several staff members pointed out the lack of support from managers and how they felt unvalued. The conversation extract in section 9.2.2 demonstrated how the manager viewed the A&E staff as "*struggling*" whilst the AEC staff were seen as "*obstructive*". The lack of support and under-appreciation led to and sustained a cycle of negativity and stress. The examples from the data highlighted the circular nature of crises; the unfolding of crises was triggered by people's perceptions and meanings of events, and those perceptions and meanings informed other people's actions.

The sense-making framework enabled the explanation of the experiences of research participants in 'a system-in-crisis'. In this study, sense-making was used as a tool to turn the ongoing complexities and the 'hidden' realities of the participants' experiences into a "*…situation that is comprehended explicitly in words…*" (Weick et al., 2005, p. 409). Hence, sense-making involved delving into your data, searching for answers and asking, *'What story is this data telling me*?'" (Stake, 1995; Weick et al., 2005).

When looking at the data and reflecting on what I witnessed in practice, the story the data was telling me contained a gap that initially I could not grasp. Thus, an explanation needed *"…to be forcibly carved out of [the] undifferentiated flux of raw experience and conceptually fixed and labelled…"* (Chia, 2000, p.513). The framework enabled me to put the 'hidden' circumstances and experiences into words. Hence, reviewing all participants' data revealed 'hidden' concerns with powerlessness, vulnerability and psychological safety. These concerns remained 'hidden' during the study as participants used justification to protect their integrity (identity) to navigate the care context.

In order to bring them to the front and understand their meaning, the sense-making framework was used. The sensemaking framework is a contextually sensitive frame for analysing the factors that influenced people's experiences in AEC and enabled me to identify and interpret the gaps, silences, or internal contradictions evident in the data. Other researchers can use the framework to offer further insight when the research problem focuses on *how* individuals make sense of situations. Sensemaking is suitable to use in NHS studies where the purpose is to understand individual perspectives, networks of relationships and influences, and uncovering context-specific meanings.

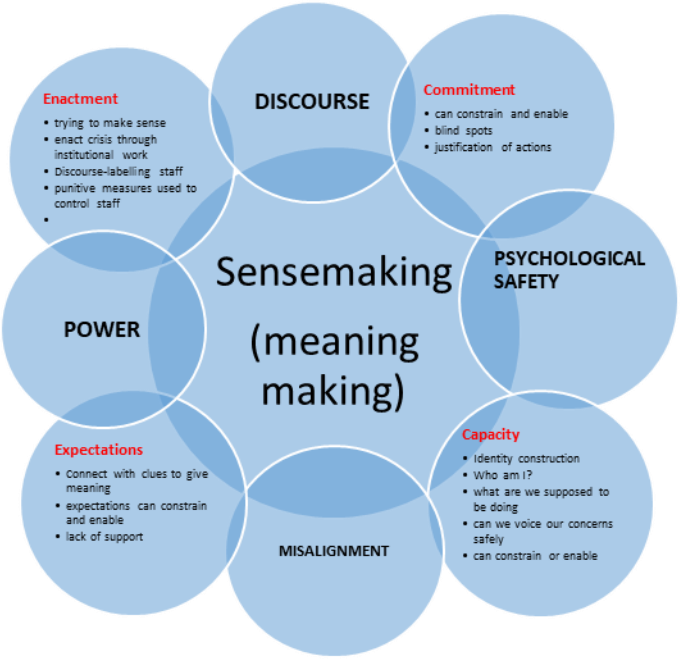


Figure 9. 1 The sense-making framework (adapted from Maitlis & Sonenshein, 2010 and Weick, 1995).

9. 6 REFLECTING ON THE RESEARCH PROCESS

9.6.1 Recruitment of participants

The recruitment of patients and carers was done as a partnership working between myself and the AEC staff. I spent much time before commencing the study engaging healthcare professionals, service user groups and members of the local community in meetings, open days and coffee mornings to discuss the study and determine the best ways to encourage participation. Additionally, information leaflets and posters were displayed in the unit, GP surgeries and the A&E department, informing people of the planned study. On the other hand, the recruitment of healthcare professionals was much more complicated. Despite reaching out to GPs through various means, I only managed to recruit two GPs and two ANPs to the study. Participation in research by GPs is notably low, and barriers to participation given for this was lack of time and irrelevance of research to clinical practice (Rosemann & Szecsenyi, 2004; Thomsen et al., 2006). Similarly, whilst the AEC staff were supportive of the study, the medical staff did not sign up for any of the three focus groups, and eventually, two of the focus groups were cancelled on short notice by managers due to "pressures on the service".

9.6.2 Researcher's Perspective

Stake (1995) rightfully pointed out that when drawing our conclusion, "…*we draw from understandings deep within us, understandings whose derivation may be some hidden mix of personal experience, scholarship, assertions of other researchers*" (1995, p. 12). Therefore, he encourages the researcher to reflect on the roles they play during the research process. I have been a nurse for nearly thirty years (working both as a healthcare assistant and a registered nurse) in a variety of settings and countries and have worked in the acute medical environment (AMU/GPAU/AEC) setting as an ANP since 2007 and thus knew most of the staff. I have also been a patient and a carer. Thus, I had first-hand knowledge of these units' practices and how it felt to be a nurse/patient/carer (Creswell 2013). The 'intersecting relationship' between myself and the research participants meant I had subjective knowledge of how marginality, identity, subjectivity, and power can influence experiences (Charmaz, 2017, p. 36).

My personal and professional experiences enabled the ‘indwelling’ needed as a practitioner-researcher. However, through ongoing reflection and reflexivity, I needed to ensure I remained aware of how my biases and preconceptions may influence my interpretation of participants’ experiences and meaning-making (Dwyer & Buckle, 2009; Maykut & Morehouse, 1994). Reflexivity meant critically looking at my impact on the research setting, the knowledge created, and the role of power, which required an open dialogue with the participants (Winter, 1989).

The reflexive process started early in the professional doctorate programme and continued throughout the study. I reflected on my values, beliefs, and assumptions, which is essential to ensure transparency and deal with ethical concerns and rigour issues (Herr & Anderson, 2005; Rose, 1997). Additionally, I was open with participants about the differing roles I occupied and captured my thoughts and feelings in the fieldnotes and the fieldwork diaries. The diaries had a dual role: acting as an audit trail and cross-checking information during data analysis and report writing.

By using fieldwork diaries to narrate my reflections and being open about my values, perceptions and beliefs, I hoped to address a concern about case study research regarding the ‘unusual problems of ethics’ due to the potential influences of my own experiences and biases on the findings (Guba & Lincoln, 1981). To ensure the data selected reflected participants concerns and not my own, I kept detailed records of the “decision rules” I followed when selecting data extracts (reasons selected and the basis for selection).

Supporting ‘methodological self-consciousness’, the decision was taken at the onset of the study to write in the first person as it encouraged acknowledgement of the role played by myself in the research process and supported the dual aim of personal and professional development (Adler-Collins, 2008; Herr & Anderson, 2005). This view is championed by a proponent of practitioner action research Richard Winter (1989, 2015), who encouraged practitioners to view practitioner-research as an extension of their professional roles, thereby rooting their research in principles such as justice, inclusivity, care and empowerment.

The insider role status meant I had eased my access to participants (Dwyer et al., 2009), however as Branick and Coghlan (2007) pointed out, the dual role also led to “loyalty tugs” and “behavioural claims” (p70). For example, Nurse Tate's incident affected her morale, and as a senior staff member, I felt it appropriate to offer her support and guidance. However, it signalled to Nurse Frey that I was *“out to get her”*. Unfortunately, it caused a ripple effect through the study as she retaliated by encouraging staff not to participate in the study. Thus, the narrative changed from a service improvement study to ‘your PhD study’ and caused some staff to withdraw their support for the study. Whilst the incident was disconcerting, Stake (1995) reminded me of the importance of interpreting the actions and behaviours whilst simultaneously trying to understand and “*…preserve the multiple realities, the different and even contradictory views of what is happening*” (p.12).

9.6.3 Methodological fit of case study methodology

Case study research has been described as a holistic, empirical and interpretive research strategy to study the complex phenomenon in their natural setting and centres on understanding the dynamics present within settings (Eisenhardt & Graebner, 2007; Stake, 1995). Due to the heterogeneity of case study designs, it was imperative that I clarified the selected design from the onset and ensured it fitted with the study's methodological foundation, theoretical focus, research questions, style of data collection, and analysis (Edmondson & McManus, 2007).

The case study research design by Stake (1995) was selected as a frame for this study as it aligned with my philosophical assumptions that people's experiences are accessible through language and meaning-making (sensemaking), which determine whether they become active or passive participants (Guba & Lincoln 2005). According to Stake (2005), the case study's direction is shaped by the researcher's interest (the case itself or a wider phenomenon). In an intrinsic case study, the case itself is of interest. In researching a new phenomenon such as the impact of AEC on participants' experiences, the in-depth exploration through a single intrinsic case study offered the opportunity to uncover subtleties and contradictions and construct a holistic comprehension of it (Flyvberg, 2006; Stake, 1995).

This single intrinsic case was chosen because of my inherent interest in understanding the participants' experiences in an AEC unit (Stake, 1995). The primary purpose was not theory-building but understanding the case itself and contributing to the knowledge base of patients, carers, and staff's experiences in AEC. Stake's (1995) approach corresponded with this study that asked questions about the ''how'' and ''what'' of participants experiences in AEC. Participants were purposefully selected, and data were collected from patients, carers and NHS staff through semi-structured interviews, observations and a focus group. The triangulation of data served as a clarification of meaning and gave me access to various views. Data were analysed using thematic analysis (Braun & Clarke, 2006) and three techniques for analysis and interpretation (direct interpretation, categorical aggregation and naturalistic generalisation) advocated by Stake (1995).

The selection of case study methodology was congruent with the study's philosophical frame, and the research design was appropriate to answer the study questions. I demonstrated to the reader that I have been "*…in the field, making observations, exercising subjective judgements, analysing and synthesising, all the while realising [my] own consciousness"* (p. 41). Through the detailed description of the study context (social, political and cultural), ongoing reflexivity about my own place in the study and the comprehensive description of data collection, analysis and the findings, ethical research and truth-value was established. The recursive cycle of collecting data, analysing, coding and constantly comparing data abstracts grounded my findings in the participants' experiences and indicated that this data accurately represented the phenomenon studied.

9.6.4 Case study on the theory continuum

Whilst theory building was not the primary purpose of this study, I agree with Weick (1995) that theory building should be seen as being on a continuum (building theory; developing theory and testing theory), and the researcher should be open about where on the continuum the study is located. Thus, theorising is part of any research process as the researcher uses assumptions, opinions and findings to explain or predict research participants' behaviour (Weick, 1995). According to Ridder (2017), *"... theories are a systematic combination of components and their relationships within boundaries"*. The novice researcher's challenge is to match their selected research strategy with the appropriate phase of the theory continuum and adequately defend their decisions (Edmondson & McManus, 2007; Ridder, 2017).

I overcame this challenge by following Ridder's (2017) outline that locates the different case study designs on different theory continuum phases. Demonstrating the suitability of Stake’s intrinsic case study design for this study and matching it with the appropriate phase of the theory continuum contributed to the rigour of the study. This intrinsic case study was located at the beginning of the continuum (building theory) as it examined a phenomenon that was new and inadequately understood, has not been researched before, and there was no theory that explained the phenomenon (Ridder, 2017, p.17).

Hence, the case was described in detail and connections were revealed and conclusions drawn through a comprehensive examination of the data sets (Snow, 2004; Edmondson & McManus, 2007). The focus on observations and the use of intuition, sensemaking and interpretation to understand a phenomenon (Stake, 1995; Swedberg, 2012) linked theory building with the time spent in the field and the use of observation.

This study's contribution to theory building was developing a sensemaking framework that supported the theoretical abstractions I made from the data. Through a sensemaking lens, meaning-making of experiences was uncovered as a complex interplay between enactment (trying to make sense of issues), commitment (justification of actions), capacity (identity construction), expectations, social interaction, the organisational context and the setting itself. Furthermore, throughout the thesis, I was open about why the case was selected. There have been no published studies of AEC up to the time the study was completed, so no theory to explain the experiences. I provided a detailed description of the study context and situated the case within the wider social, cultural and political contexts.

Data collection, analysis, and interpretation were inductive and recursive and enabled me to build understandings of the data, and new concepts were constructed, which enhanced our understanding of how the introduction of the unit influenced experiences. As a result, it was demonstrated that the research strategy was synchronous with the investigation of a new phenomenon and thus a starting point for further research and the development of new theories about the experiences of patients, carers and staff in AEC.

9.6.5 Case study and generalisability

Pollitt & Beck (2010) define generalisation as "…*an act of reasoning that involves drawing broad inferences from particular observations*" (p.1451). Whilst the debate about the importance of generalisation in case study research is ongoing, both Yin (2009) and Stake (1995) acknowledge the importance of generalisation. So, even though I believe that the relatability of this case study (the degree it could be related to the readers' practice setting) was important and generalisability was not my primary aim, Ayres et al. (2003) reminded me that just "…*as with statistical analysis, the end product of qualitative analysis is a generalization, regard-less of the language used to describe it''* (p. 881)

Stake (1995) supported the view that the case is selected for its purpose, but some generalisations can be made based on the repetition of findings in the data. He proposed two ways to generalise when doing case studies; naturalistic generalisation and propositional generalisation. The term naturalistic generalisation was introduced by Stake and Trumbull in 1982. Stake (1995) describe naturalistic generalisation as "…*conclusions* *arrived at through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves*" (p.85).

This intrinsic case study's primary aim was to understand how AEC's introduction impacted patients, carers, and NHS staff' experiences. Thus, the focus was on demonstrating the case's particularity and offering the reader the opportunity to vicariously experience the study (Stake, 1995, p. 7). This goal was attained by providing the findings in an acceptable way (thick description) to enable the reader to judge whether the findings could inform their case or cases. To assist the reader in making naturalistic generalisations, I provided a detailed description of the study context, situated the case within the wider social, cultural and political contexts and provided a thick description of the data through data extracts and narratives.

Once interpretations of the data were made, I drew conclusions based on the study data (assertions), which Stake (1995) called propositional generalisations (p.9). Stake proposed readers will use both naturalistic generalisations (taking narrative descriptions to provide vicarious experience) and propositional generalisations (taking assertions made by the researcher) and use them in conjunction with existing knowledge to determine if the findings relate to their practice settings.

9.6.6 Limitations of the Research

9.6.6.1 Sampling related limitations

The study context was limited to one AEC at an NHS Trust in the Northwest of England; therefore, findings may not be transferable to other health care settings. However, the purpose of this study was to provide enough detail and depth of the description of the data findings within this case study to enable others to draw on suitable elements to inform practice and service provision in their areas. Furthermore, the aim was to contribute to the dearth of knowledge of patients, carers and NHS staff' AEC experiences. The initial sample did not include senior managers, and it was only during observations and focus group that it became apparent that managers played a prominent role in setting up and longevity of these services, yet they were not part of the study population.

9.6.6.2 Methods related limitations.

The use of focus groups as a method seemed appropriate but, in this study, I struggled to recruit to the GP focus group, as discussed above, and two focus groups were cancelled due to the service's demands. Telephone interviews were initially deemed appropriate but had to be changed to face to face due to practicality issues when I lost my office base. Upon reflection, telephone interviews would not have been appropriate for this case study interested in gathering rich and contextualised data about participants' experiences, and I found that when participants sat opposite me, they appeared to interact easily and openly.

9.6.6.3 Limitations of the Methodology

Stake (1995) pointed out that a qualitative researcher a) acknowledges their role in the research process (subjective); b) seeks to understand the phenomenon, and c) viewed knowledge as being constructed rather than discovered (p. 36). Therefore, this study's findings cannot be generalised to every AEC unit but can be used to explore this phenomenon in practice further. For example, the sensemaking framework can be adopted in practice to identify, explore and generate both sensemaking and sensegiving opportunities at an individual and organisational level. It breaks down the complexities and transience of the different meaning-making elements in organisations in crisis or supports innovation and change efforts.

9.7 SUMMARY

Most of the patients and carers agreed that the unit's care was reasonable and reported positive experiences. The ones who had a negative experience made sense of it by referring to the unit's activity levels or the more pressing needs of other patients (Britten & Shaw, 1994; Kihlgren et al., 2004; Morphet et al., 2015). In her study of older people's experiences in an AMU, Darby (2014) also found that participants dispersed blame for any negative experiences away from the staff onto the effect of cutbacks by the government.

To understand the experiences of patients, carers and staff who negotiated an AEC context steeped in 'a system-in-crisis' discourse and their responses to the challenges along the way, a recursive circle sensemaking framework was developed. Thus, the underlying and often unreported incidents that affected the care delivered to the unit's patients were uncovered and given meaning through a conceptual sensemaking framework.

The study findings confirmed the findings of most of the published studies. Additionally, the study findings also highlighted the pace-quality continuum where healthcare providers are forced to focus on technical skills to ensure more patients are seen, often at the expense of experiences. However, the study added new understandings about what role discourses and power imbalances played in creating care environments that felt unsafe and misaligned.

In this study, both a psychological unsafe safe environment and an employee disempowerment culture negatively affected care experiences and led to disengagement.

Thus, these findings indicated that to create an environment where person-centred care, rather than ‘person-centred moments’ was practised, key players' engagement and involvement from the onset were vital.

CHAPTER TEN CONCLUSION

10.1 INTRODUCTION

The final chapter in this study summarises the findings and the implications for practice and policy. In this single qualitative intrinsic case study, the following research questions were answered:

1. How did the introduction of a purpose-specific AEC unit influence patients, carers, and NHS staff's experiences?
2. What factors influenced their experiences?

Additionally, the following aims and objectives were met.

Research Aims

- To explore how the service has impacted the experiences of both those receiving and providing care.
- To contribute to the developing an AEC service, based on the study population's needs and therefore contribute to practice
- To contribute to the public knowledge base of how AEC units impact patients, carers, and NHS staff's experiences.

Research Objectives

- To critically explore the experiences of patients, carers and NHS staff.
- To determine which areas of the patient's journey through the AEC needed improvement.

- To implement required changes to the AEC service by working with staff, GPs and managers.
- To critically reflect on my 'lived' experiences as a senior nurse trying to coordinate research in an uncertain NHS setting.

10.2 FINDINGS

Data were collected from patients, carers and NHS staff through observations, a focus group and semi-structured interviews and analysis followed Braun & Clarke's model of thematic analysis and Stake's tradition of analysis. The research questions were answered, and the aims and objectives met in this study grounded in an interpretive framework. When the unit was closed unexpectedly in the middle of the data collection process, the study's participatory element had to be abandoned. A case study was the most appropriate methodology to use as it chronicled the contextual issues such as organisational circumstances, policy interventions and behaviours surrounding particular events.

Data analysis was recursive and interpretive. Firstly, the larger contexts (background to the study, the policy contexts that supported the centring of experiences and setup of AEC units and the literature) were described in the first three chapters. The personal context and how it linked to the selected philosophical frame was described in chapter four. The selected methodology, the bounded case, ethical considerations, and rigour of the study was discussed in chapter five. In chapter six, the data collection process was described and defended. Stake's (1998) framework for data analysis was used and included a thorough description of the unit and the participants, categorical aggregation and direct interpretation to deconstruct and synthesise the data in chapter seven. Finally, the themes and typology constructed were rich in narrative data and storytelling by participants. The findings described individual experiences as well as shared meanings and understandings about those experiences.

Through thematic analysis, the contextualised extracts from the participants relayed their experiences of the care on AEC. Elements of sensemaking theory played a crucial role in explaining the study's findings as patients, carers and NHS staff attempted to make sense of their experiences and tried to define relationships. The findings revealed how participants tried to make sense of the misalignment in care experiences using dominant discourses to rationalise it. Furthermore, they attempted to make sense of manoeuvring 'a system-in-crisis' whilst still maintaining their security, integrity and identity. However, the findings also highlighted how participants never openly discussed or raised concerns about psychological safety and power differentials. This 'hidden' nature of their concerns appeared to foster a culture steeped in person-centred-moments of good care rather than an overall person-centred culture needed for human flourishing and transformation (McCormack & Titchen, 2014).

The findings also correlated with published studies that linked staff experiences of their work environment with patient and carers' experiences (Maben et al., 2012a). To date, no published study has explored the experiences of patients, their carers and NHS staff in a unit such as the AEC. Thus, this study will help commissioners, managers, and staff better understand how social, political and cultural factors influence patients and carers care experiences and ultimately impact the sustainability of services. It is also a reminder to those who consider setting up a new AEC unit that the 'one-size-fits-all' approach will not work. Lastly, the findings highlighted that the setting up of new services required more than the mere relay of information but should be based on co-operation and mutual agreement of benefits.

In the following sections, the implications and recommendations for practice and healthcare policy are discussed.

10.3 RECOMMENDATIONS FOR PRACTICE

The success and sustainability of AEC services depend on enhanced communication between all stakeholders. Examples of issues to address or actions to take when setting up a new service include obtaining commitment and support for the unit from management and leaders at all levels and across all professions. Additionally, ward leadership should be capable of dealing with the pressures of setting up a new service in an uncertain political climate.

Excellent communication with and between all stakeholders is critical to ensure the longevity and success of new services. To ensure the unit's success, awareness and understanding of the service should be purposefully driven to enable patients, carers, and NHS staff to understand the service's function clearly. On referral to AEC, the patients GP practice should ensure the patient or relative is handed a copy of their medical history, including allergies and medication and the referral letter to take with them. All NHS staff should be provided with communication skills training to complement their technical skills.

The unit must be clearly signposted to ensure patients can find the unit without trouble. The AEC's reception desk must always be staffed to ensure patients and carers are acknowledged on arrival and informed where to be seated. A dedicated telephone line for

GP referrals should be available. Posters about the unit can also be displayed at GP surgeries.

GPs should be invited to visit the unit to meet staff and assess the unit's suitability from their own patients' perspectives. The visit can allay their concerns regarding the suitability of facilities and safety and provide an opportunity to see first-hand how the unit functions. The GPs can be invited to shadow the consultant/registrar for a shift and vice versa and could include senior nurses and practice nurses/ANPs to overcome the primary-secondary care divide as shadowing would give them insight into each other's work environment. There must be closer working with district nurses and ANPs in the community teams who can support elderly patients at home after discharge. In a similar vein, the community ANPs can benefit from close liaison with AEC to refer patients they think meet the criteria. Staff in the AEC need to identify patients early who will benefit from follow up and refer to the appropriate ANP in the community teams. The medical team or ANPs need to ensure they complete all discharge letters before the patient leaves the unit to ensure the GP is informed of any changes to care or follow up required.

Setting up a new AEC unit requires the planning and involvement of all stakeholders from the onset. The development of an AEC business plan in conjunction with CCG, secondary care and primary care before setting up the service is imperative. The business plan should include a Standard Operating Procedure (SOP) and Key Performance Indicators (KPIs). Another helpful strategy that would address concerns about communication and 'management buy-in' would be to form an AEC strategy group at the NHS Trust who meet monthly and has agreed to the group's Terms of Reference.

Training of nursing staff in ambulatory care was identified as a critical concern by senior staff who identified knowledge gaps. The ambulatory care nursing module at Bradford University aims to enhance the practitioner's knowledge and understanding of common acute conditions seen in ambulatory areas, but unfortunately, it only covers the management of children and young people. The University of Sheffield offers an online Observational and Ambulatory Medicine course that aims to support students in the setting up and facilitation of ambulatory care units. Another concern was the use of documentation unsuitable for the patient group, which can be addressed by developing AEC specific assessment booklets for new patients. The healthcare assistants can be trained to enable them to take blood, do ECGs and start the initial assessments, to shorten waiting times for patients.

10.4 IMPLICATIONS FOR HEALTHCARE POLICY AND PRACTICE

A concern raised by patients, carers and NHS staff alike was the fragmented follow-up care after discharge from the hospital. Similarly, concerns regarding the home circumstances of elderly patients were thought to lead to 'inappropriate' admissions from A&E. One of the ways to address this issue is through integrated working across the primary-secondary care interface. There is already an integrated care service established in the local area, including a team of experienced ANPs and community matrons. They work closely with the GPs in the area and the acute medicine team on the AMU to identify patients they can support at home. As yet, the AEC team does not utilise this service; however, it can provide the follow-up care some patients require, preventing them from returning to the unit.

Networking is also crucial for the establishment and sustaining of an AEC service. Therefore, NHS organisations who are thinking of establishing an AEC service would also benefit from joining the AEC Network. However, they must be committed to the time and effort required to ensure they benefit from the membership and utilise all the services offered. The network offers a twelve-month membership for a fee, during which time they offer organisations hands-on support with the setting up of AEC services, staff development and engagement of stakeholders. Furthermore, healthcare professionals can join the British Association for Ambulatory Emergency Care (BAAEC), whose main aim is to promote AEC's development as a speciality in the UK. The BAAEC works with the NHS AEC Network and the Royal College of Emergency Medicine (RCEM) to support AEC services' development and sustaining. The RCEM has recently released the AEC Toolkit (2019) that offers guidance for enabling the transfer of A&E patients to AEC units.

Three further documents are of importance when setting up a new AEC service, including the AEC Operational Guide (AEC Network, May 2017, p. 2), which acts as "*an aide for operational managers to improve the management and efficiency of AEC units".* Additionally, the RCP Toolkit 10 contains the RCP's clinical guidelines and contains information about patient selection for AEC, training, AEC resources, and clinical governance (RCP, 2014). Lastly, the updated Directory of AEC (AEC Network, 2018) sets out AEC's underlying principles and details fifty-three clinical scenarios appropriate to be managed in an AEC service. This resource also provides information about clinical coding for each scenario which is beneficial when organisations want to analyse AEC activity and potential.

10.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The recommendations for the focus of future research include

1. how organizational dynamics in health care organizations influence the adoption of new initiatives.
2. A study to explore whether the focus of delivering AEC should be more on changing practices and mindsets than creating the physical space.
3. A multi-centre case study to explore the experiences of patients, carers and NHS staff.
4. An in-depth exploration of the links between staff experiences of work and patient experiences in an AEC unit.
5. A quantitative study investigating the cost-effectiveness of the AEC service.
6. An exploration of the reasons why NHS staff are reluctant to initiate or participate in research.

10.6 CONCLUSION OF THE STUDY

Richards, Coulter and Wicks (2015, p. 3), in a BMJ editorial, stated that:

> *It's time to get real about delivering person centred care. It's not a panacea for all of medicine ills, but we should not underestimate its contribution to tackling them. Working collaboratively and sharing decisions about care, services and research* is *challenging. It requires a sea change in mind-set among health professionals and patients alike. But its rewards are rich and reaped mutually.*

Improving the patients', carers and NHS staff' experiences have been high on the reform agenda of successive governments, but efforts are predominantly localised, erratic and short term. Whilst most of the participants reported a good experience, the evidence pointed to ‘person-centred moments’ rather than a person-centred culture. This study highlighted how the ‘service-in-crisis’ discourse played out daily in the AEC unit and ultimately enabled an environment where people felt insecure and thus disengaged from improving the service. The aspiration is that this study reminds policymakers, commissioners, NHS leaders and NHS staff that changing healthcare practices “*can’t be business as usual, it has to be business Unusual”* (Anonymous). I also hope that the study facilitates a conversation on what is needed to ensure patients, carers and NHS staff feel safe enough to engage and become *Activists* for person-centred care.

Furthermore, the study reminds aspiring researchers that entering any research context contains professional and personal risks and challenges whether you enter as an insider or an outsider. However, seeing those challenges as part of your development enables embracing creativity and personal growth.

> *Turning and turning in the widening gyre the falcon cannot hear the falconer. Things fall apart; the centre cannot hold; mere anarchy is loosened upon the world,*

(W.B. Yeats cited in Achebe, 2010, p.2).

APPENDICES

Appendix 1 University of Salford Ethics Committee Approval Letter

Research, Innovation and Academic
Engagement Ethical Approval Panel
College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r .shuttleworth@salford.ac.uk
www.salford.ac.uk/

4 November 2014

Dear Desiree,

RE: ETHICS APPLICATION HSCR14/71 – A participatory action research study to assess and strengthen the impact of the introduction of an ambulatory emergency care unit on the experience of service users, carers and staff

Based on the information you provided, I am pleased to inform you that application HSCR14/71 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth

College Support Officer (R&I)

Appendix 2 NRES Committee North West Ethical Approval Letter

National Research Ethics Service

NRES Committee North West - Greater Manchester East

3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ

06 March 2015

Dear Ms Demingo,

Study title: A participatory action research project to assess and strengthen the impact of an ambulatory emergency care unit on the experience of service users and staff.

REC reference: 15/NW/0114

IRAS project ID: 142978

Thank you for your letter of 2 March 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Rachel Heron, nrescommittee.northwest-gmeast@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated

Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants	2	31 July 2014
Covering letter on headed paper [Cover letter]		14 January 2015
Covering letter on headed paper [Cover letter]		26 February 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Salford university insurance]		19 January 2015

Interview schedules or topic guides for participants [Interview guide] 1 05 March 2014

Interview schedules or topic guides for participants [observations topic guide] 2 05 March 2014

Interview schedules or topic guides for participants [topic guide for interviews] 2 05 March 2014

IRAS Checklist XML [Checklist_05022015] 05 February 2015

IRAS Checklist XML [Checklist_02032015] 02 March 2015

Letter from sponsor [letter from sponsor] 22 January 2015

Letters of invitation to participant [participant invitation letter] 2 12 May 2014

Letters of invitation to participant [staff invitation letter] 2 12 May 2014

Letters of invitation to participant [GP invitation] 2 12 May 2014

Other [patient mapping tool] 1 08 August 2014

Other [GANTT chart] 1 08 August 2014

Other [ethical approval letter from university of salford] 1 08 August 2014

Participant consent form [participant consent form] 4 26 February 2015

Participant information sheet (PIS) [information sheet for participants] 2 12 May 2014

Participant information sheet (PIS) [GP information sheet] 2 12 May 2014

Participant information sheet (PIS) [staff information] 3 26 February 2015

Participant information sheet (PIS) [information sheet for participants] 3 26 February 2015

Participant information sheet (PIS) [GP information sheet] 3 26 February 2015

REC Application Form [REC_Form_05022015] 05 February 2015

Research protocol or project proposal [research proposal] 08 August 2013

Summary CV for student [CV of Desiree Demingo] 1 05 January 2015

Summary CV for supervisor (student research) [CV of supervisor] 21 January 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/NW/0114 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

R Heron **On behalf of Mr Francis Chan**

Chair

Email: nrescommittee.northwest-gmeast@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Tony Warne, University of Salford*
Ms DESIREE DEMINGO [redacted]
Ms Jan Smith [redacted]

Appendix 3 University of Salford Ethics Committee Substantial Amendment Approval Letter

Research, Innovation and Academic
Engagement Ethical Approval Panel
Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT
T +44(0)161 295 2280
www.salford.ac.uk/

30 March 2016

Dear Desiree,

RE: ETHICS APPLICATION HSCR 14-71 – A participatory action research study to assess and strengthen the impact of the introduction of an ambulatory emergency care unit on the experience of service users, carers and staff.

Based on the information you provided, I am pleased to inform you that your request to amend application HSCR14-71 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

Appendix 4 NRES Committee North West Ethics Committee Substantial Amendment Approval Letter

Health Research Authority
National Research Ethics Service
North West - Greater Manchester East Research Ethics Committee
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ

23 February 2016

Ms Desiree Demingo
Stockport NHS Foundation Trust
Hazel Grove
Stockport
Sk2 7JE

Dear Ms Desiree Demingo

Study title: A participatory action research project to assess and strengthen the impact of an ambulatory emergency care unit on the experience of service users and staff.

REC reference: 15/NW/0114

Amendment number: 1

Amendment date: 29 January 2016

IRAS project ID: 142978

1. Focus groups for [AEC] staff changed to individual interviews.

2. Focus groups for GP's changed to short telephone interviews.

3. Interviews with patients and carers-telephone interviews changed to face to face interviews.

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The following points were discussed with the researcher in correspondence:

The Committee asked if there was a lone working policy in place for interviews taking place in participants' home, and how this would be adhered to. You responded by email: *'If the individual interviews are at participants own homes, I will leave my contact details and expected duration of interview with the ward clerk on ACU. I will also ensure my mobile is* *switched on and that I contact the ward clerk after interview is completed to comply with the*

University Lone Researcher Policy'.
If participants are to travel for the study interviews, the Sub-Committee advised that travel expenses and parking costs should be re-imbursed. *You confirmed that this would be the case, and provided updated information sheets.*

Approved documents

The documents reviewed and approved at the meeting were:

Document   Version   Date

GP/consultant information sheets or letters [GP Invitation Letter] 3 29 January 2016

GP/consultant information sheets or letters [GP Participant Info 2 29 January 2016
Sheet]
Interview schedules or topic guides for participants [Staff Interview 2 29 January 2016
Schedule]
Interview schedules or topic guides for participants [Patient 2 29 January 2016
interview schedule]
Letters of invitation to participant [Staff Invitation Letter] 3 29 January 2016

Letters of invitation to participant 3 29 January 2016

Notice of Substantial Amendment (non-CTIMP)   29 January 2016

Participant consent form 3 29 January 2016

Participant information sheet (PIS) [Staff information sheet] 4 22 February 2016

Participant information sheet (PIS) [Patient information sheet] 4 22 February 2016

Research protocol or project proposal 2 29 January 2016

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for

Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

15/NW/0114: Please quote this number on all correspondence

Yours sincerely

R Heron Signed on behalf of
Professor Janet Marsden
Chair

E-mail: nrescommittee.northwest-gmeast@nhs.net
A Research Ethics Committee established by the Health Research Authority

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Jan Smith, [redacted]

Appendix 5 Search strategy

	Patient	Intervention 1	Intervention 2	Outcome
Concept	patient* PATIENTS/OR EMERGENCY PATIENTS OR	“ambulatory emergency care” AMBULATORY CARE/EMERGENCY CARE OR	“medical admissions unit*” OR	experience* OR
Alternative terms	service user* EMERGENCY SERVICE OR Client* PROFESSIONAL-CLIENT RELATIONS/ OR CONSUMER ATTITUDES/ OR PATIENT CENTERED CARE OR Participant* RESEARCH SUBJECTS/ OR PARTICIPANT OBSERVATION/ OR CONSUMER PARTICIPATION/ OR NONPARTICIPANT OBSERVATION/ OR REFUSAL TO PARTICIPATE/ OR POWER AS KNOWING PARTICIPATION IN CHANGE TOOL/ OR Customer* CONSUMER SATISFACTION OR consumer* CONSUMERS/	ambulatory adj3 emergency OR “admission avoidance scheme*” OR “admission avoidance” OR admission* adj3 avoid* OR “ambulatory care” SUBACUTE CARE OR “medical day care” OR "medical daycare". OR "surgical day care". *AMBULATORY SURGERY OR "surgical daycare". OR "ambulatory day care" OR outpatient*. OR "subacute care" OR "day surger*"	"medical assessment* unit*". OR mau* OR "emergency department*" EMERGENCY SERVICE/ OR EMERGENCY MEDICINE OR accident adj3 emergency OR "emergency room*" OR casualty	Views* OR perspective*. OR perce* OR belie* OR feel* OR know* OR understand* OR satisf* OR attitude* OR opinion*

AND **AND** **AND**

	Population 2	Intervention 1	Intervention 2	Outcome
Concept	"informal carer*" OR	“ambulatory emergency care” AMBULATORY CARE/EMERGENCY CARE OR	“medical admissions unit*” OR	experience* OR
Alternative terms	carer* OR companion* OR relative* OR "family member*" EXTENDED FAMILY/ OR FAMILY RELATIONS/ OR "close friend" OR family OR families	ambulatory adj3 emergency OR “admission avoidance scheme” OR “admission avoidance” OR admission* adj3 avoid* OR “ambulatory care” SUBACUTE CARE OR “medical day care” OR "medical daycare". OR "surgical day care". *AMBULATORY SURGERY OR "surgical daycare". OR "ambulatory day care" OR outpatient*. OR "subacute care" OR “day surger*"	"medical assessment* unit*". OR mau* OR "emergency department*" EMERGENCY SERVICE/ OR EMERGENCY MEDICINE OR accident adj3 emergency OR "emergency room*" OR casualty	Views* OR perspective*. OR perce* OR belie* OR feel* OR know* OR understand* OR satisf* OR attitude* OR opinion*
	AND	AND	AND	

	Population 3	Intervention 1	Intervention 2	Outcome
Concept	"health care professional*" MULTIDISCIPLINARY CARE TEAM/ OR PROFESSIONAL-FAMILY RELATIONS/	“ambulatory emergency care” AMBULATORY CARE/EMERGENCY CARE	“medical admissions unit*”	experience*
Alternative terms	OR "caregivers" CAREGIVERS/ OR CAREGIVER SUPPORT/ OR "health professional*" OR "primary care provider*" OR "health care worker*" HEALTH PERSONNEL/ OR MULTIDISCIPLINARY CARE TEAM/	OR ambulatory adj3 emergency “admission avoidan” OR OR “admission avoidance” OR admission* adj3 avoid* OR “ambulatory care” SUBACUTE CARE OR “medical day care” OR "medical daycare". OR "surgical day care". *AMBULATORY SURGERY OR "surgical daycare". OR "ambulatory day care" outpatient*. OR "subacute care" OR “day surger*"	OR "medical assessment unit*". OR mau* OR "emergency department*" EMERGENCY SERVICE/ OR EMERGENCY MEDICINE OR accident adj3 emergency OR "emergency room*" OR casualty OR	OR Views* OR perspective*. OR perce* OR belie* OR feel* OR know* OR understand* OR satisf OR attitude* OR opinion*

AND **AND** **AND**

Appendix 6 Synthesis of patient experience literature

Authors, date and title	Setting	Research approach	Data analysis	Findings
Munro, Nicholl, O’Cathain & Knowles (2000) Impact of NHS Direct on demand for immediate care: observational study	UK	Observational study Review of call logs	The Durbin-Watson statistic	In its first year NHS Direct did not reduce the pressure on NHS immediate care services, although it may have restrained increasing demand on one important part—general practitioners’ out of hours services.
Trout, Magnusson & Hedges, 2000). Patient Satisfaction Investigations and the Emergency Department: What Does the Literature Say?		Literature review	Electronic databases searched for articles that highlighted link between satisfaction and the ED service	Mostly surveys. Key themes: perceived waiting times; satisfaction associate with provision of information and patient-provider interpersonal factors. Noted lack of agreed definition for satisfaction and suggested “when the patient’s own expectations for treatment and care are met (or exceeded).” p.695
Considene et al. (2010). Older people’s experiences of accessing emergency care	Australia (Thee ED’s)	Observations and follow up semi-structured face-to-face interviews	Descriptive statistics and thematic analysis	Four major themes: Variations in ED use by older people; reluctance to access ED care; mixed experiences of waiting; perceived factors influencing access to emergency care
Olthuis et al., (2014). Matters of concern: A Qualitative study of emergency care from the perspectives of patients	Netherlands (ED)	Qualitative ethnographic study-observations and interviewing	Grounded theory approach	Pointed out the ‘labor’ of patients to deal with being in the hospital. five concerns were identified: anxiety, expectations, care provisions, endurance and recognition.
Bridges, Flatley & Myer (2009). Older people's and relatives’ experiences in acute care settings: Systematic review and synthesis of qualitative studies		Databases were searched	Comparative thematic approach to synthesis	Themes: positive experiences associated “creating communities: connect with me”, “maintaining identity: see who I am” and “sharing decision-making: include me”.
Gordon, Sheppard & Anaf (2010). The patient experiences in the Emergency Department: A systematic synthesis of qualitative research		Databases were searched	Thematic analysis	Categories: emotional impact of emergency; staff-patient interactions; waiting; presence of family and setting.

Entwistle, V., Firnigl, D., Ryan, M., Francis, J., & Kinghorn, P. (2012). Which experiences of health care delivery matter to service users and why? A critical interpretive synthesis and conceptual map.		Databases were searched	Critical interpretive synthesis of research literature	considers *communication* to support understanding of health issues and treatment choices, but also *attitudes* and *positioning within* relationships, and the implications of these for patients' capabilities, including *individual identities, self-evaluations and capabilities*.
Foley, Droog, Boyce, Healey & Browne. (2017). Patients experiences of different regional models of urgent and emergency care	Ireland	Cross-sectional survey of 8 urgent and emergency care systems		Three domains were assessed: entry into the system; progress through the system and patient convenience of the system. No differences were found in type of system used and experiences.
Knowles E, O'Cathain A, Nicholl J (2012). Patients' experiences and views of an emergency and urgent care system.	UK	Telephone interviews using the Urgent care system questionnaires	SPSS version 12	Seekers of Urgent care found that they entered a system of care with several providers rather than a single provider. Overall good levels of satisfaction but reduced if had care pathway included 3 or more providers.
Bos N, Sizmur S, Graham C et al. (2013). The accident and emergency department questionnaire: a measure for patients' experiences in the accident and emergency department.	UK	Self-completion postal questionnaire		Themes: Arrival at Emergency Department; Waiting; Doctors and Nurses; care and treatment; Tests; Pain
Picker Institute Europe (2008). Development of the Questionnaire for use in the NHS Emergency Department Survey.	UK	Focus group		Main themes: *Waiting*: including length of time, information given about waiting and waiting times at different stages; *staff interpersonal aspects*: being treated with dignity and respect, confidence and trust in staff, being listened to; tests and treatments-pain relief, not being given conflicting advice; *environment*: comfort of waiting areas, privacy and cleanliness

Frank C, Asp M, Dahlberg K. (2009). Patient participation in emergency care—a phenomenographic study based on patients' lived experience.	Sweden	Interviews		Themes: space; acknowledgement and becoming involved.
O'Cathain A, Coleman P, Nicholl J. (2008). Characteristics of the emergency and urgent care system important to patients: a qualitative study.	UK	Focus groups and interviews		Themes *Accessing the system*: Ease of access, choice or confusion; making choices; *Communication and coordination*: effect of waiting, co-ordination across services, information continuity and sharing of records, communication between patient and healthcare professional; *progress through the system:* need for proactive behaviour, healthcare seeking behaviour
Bridges J., & Nugus, P. (2009). Dignity and significance in urgent care: older people's experiences	UK	Semi-structured qualitative interviews	QSR XSight 2.0 was used to organise a thematic content analysis of data	The three key features of leading to a diminished sense of significance were: the primacy of technical, medical care; an imbalance of power; and the subordination of patients' non-medical needs.
Nystrom, M., Nyden, K., & Petersson, M. (2003). Being a non-urgent patient in an emergency care unit—a strive to maintain personal integrity.	Sweden (ED)	interviews	Inductive interpretive approach	Themes: fragmented care; difficulty to be heard and relating to the nurses stressful job, thus feel like they are becoming part of the problem. Maintaining personal integrity by relinquishing participation in order
Nystrom M, Dahlberg K & Carlsson G (2003) Non-caring encounters at an emergency care unit – a life-world hermeneutic analysis of an efficiency-driven organization.	Sweden (ED)	Interviews of nurses and patients	Interpretive analysis	Themes: fragmentation of nursing care; busy staff; patients tried to be a 'good' patient to ease stress of nurses; variability in quality of care depending on nurse on duty;

Attree, M. (2001) Patients' and relatives' experiences and perspectives of `Good' and `Not so Good' quality care	UK (general medical unit)	Grounded Theory qualitative approach Semi-structured interviews	Thematic analysis	Themes: interpersonal and interactional aspects of care were key. Good Quality Care: individualized, patient focused and related to need; provided humanistically, through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern. Care described as `Not so Good' was routine, unrelated to need and delivered in an impersonal manner, by distant staff who did not know or involve patients.
Maben et al. (2012). Exploring relationship between patients' experiences of care and the influence of staff motivation, affect and well-being.	UK	Mixed method =2 patient focus groups and manager interviews. Staff and patients survey, patients and carers interviews and non-participant observations.		Relationship between staff well-being and patient experiences. Variations in patient experiences was linked to staff work experiences. high-demand/low-control work environment, poor staffing, ward leadership and co-worker relationships were highlighted as difficulties staff face when caring for acutely ill older people. Patients expressed elements of 'dehumanised' care.
Eckwall, A., Gerdtz, M., & Manias, E. (2007). The influence of patient acuity on satisfaction with emergency care: perspectives of family, friends and carers.	Australia (ED)	Survey	SPSS	Older people more satisfied than younger people. Relatives of people who were deemed more urgent was more satisfied than the less urgent ones.
Eckwall, A., Gerdtz, M., & Manias, E. (2009). Anxiety as a factor influencing satisfaction with emergency department care: perspectives of accompanying persons.	Australia (ED)	Survey	SPSS	Satisfaction and anxiety levels were inversely related. Satisfaction also related to perceived waiting time and adequate information.

Luxford, K., Gelb Saffran, D., & Delbanco, T. (2011). Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience.	USA	Qualitative study-semi-structured interviews with patient representatives and senior staff in 8 organisations	MAXQDA, a software package used to develop thematic framework	Findings suggested refocusing organisational culture from ‘provider-focus’ to ‘patient-focus’ was imperative for a patient-centered culture; key facilitators were: dedicated leadership; a clearly communicated strategic vision; patient and families engagement; sustained focus on staff satisfaction; patient experience measuring; resourcing; building capacity, clear lines of accountability and incentives and a culture strongly supportive of change and learning.
Tsiakanas et al., (2012). Using patients’ experiences to identify priorities for quality improvement in breast cancer care: patient narratives, surveys or both.	UK	Mixed methods. Narrative interview and postal survey.	Thematic qualitative analysis of narratives and open questions on surveys	Themes: appointment system; staff spending adequate time with patients; information about treatment and side effects. Narrative interviews highlighted the ‘relational’ aspect of care and postal surveys the ‘functional side. Recommended that survey is used in conjunction with qualitative method
Keating, N., Green, D., Koa, A., Gazmararian, J., Wu, v., & Cleary, P. (2002). How are patients’ specific ambulatory care experiences related to trust, satisfaction, and considering changing physician.	USA	Telephone survey	Multivariable analysis	Lower trust between physician and patient cause of problems in ambulatory care.
Wellstood, K., Wilson, K., & Eyles, J. (2005). “Unless you went in with your head under your arm”: Patients’ perceptions of emergency room visits.	Canada (ER)	Qualitative study. Interviews	NVIVO	Themes: waiting times; perceptions of quality of care and staff-patient interactions

Boudreaux, E., d'Autremont, S., Wood, K., & Jones, G. (2004). Predictors of Emergency Department Patient Satisfaction: Stability over 17 Months.	USA (ED)	Telephone interviews	Statistical analysis	Satisfaction themes were: age, perceived wait before bed placement, perceived wait before physician evaluation, physician care, discharge instructions, and waiting time satisfaction
Larsen-Kilgren, A., Nilsson, M & Sørlie, V. (2005). Caring for older patients at an emergency department – emergency nurses' reasoning.	Sweden (ED)	Qualitative interviews of staff	Thematic content analysis	Themes: good care required them to be knowledgeable; understanding and accountable. Barriers to good care: prioritising of technical skills, routines. Nurses felt ED not appropriate for elderly patients. Researchers highlighted state of tension and possibility of burnout.
Larsen-Kilgren AL, Nilsson M, Skovdahl K, Palmblad B & Wimo A (2004) Older patients awaiting emergency department treatment.	Sweden (ED)	Qualitative interviews patients	Grounded theory	Themes: long waits; feeling abandoned by staff; pointed out busyness of staff; criticism directed at managers and felt basic needs not met
Sørlie, V., Torjuul, K., Ross, A., & Larson-Kilgren, M. (2006). Satisfied patients are also vulnerable patients – narratives from an acute care ward.	Sweden (Acute care ward)	Qualitative study Patient interviews	Phenomenological hermeneutics	Overall patients were satisfied. But they view hospital stay as a compromise. Felt vulnerable. Busyness of staff noted and took some responsibility to ease it by not calling for help.
Britten & Shaw (1994). Patients' experiences of emergency admission: how relevant is the British government's Patients Charter?	UK (A&E)	Qualitative interviews		Themes: uncomfortable trolleys; busy department; long waits; feeling of abandonment by staff; rationalised waiting by referring to patients who they perceived to be more in need. basic needs met.
Morphet, J., Decker, K., Crawford, K., Innes, K., Williams, A., & Griffiths, D. (2015). Aged care residents in the emergency department: the experiences of relatives.	Australia (ED)	Qualitative study Semi structured interviews with relatives	Inductive content analysis	Themes: recognition of the role of the relative; clear communication by staff; perception of older people by staff; busyness of staff;

Olofsson, P., Carlstrom, E., & Back-Pettersson, S. (2012). During and beyond the triage encounter: Chronically ill elderly patients' experiences throughout their emergency department attendances	Sweden (ED)	Qualitative study Patient interviews	Descriptive phenomenological	Contradiction between initial assessment at triage and the rest of the time in ED. During initial triage patients felt confident and expectations are set, however later experienced long waits and felt abandoned.
Majholm, B., Esbensen, B., Thomsen, T., Engbæk, J., & Møller, A. (2012). Partners' experiences of the post discharge period after day surgery – a qualitative study	Denmark (Day surgery)	Qualitative semi-structured interviews.	Systematic text condensation	Themes: transfer of responsibility means they have to take time off work.
Moss, C., Nelson, K., Connor, M., Wensley, C., McKinlay, E., & Boulton, A. (2014). Patient experience in the emergency department: inconsistencies in the ethic and duty of care	New Zealand (ED)	Qualitative study interviews	Tronto's ethic of care (framework) and thematic analysis.	Participants highlighted need to be treated with dignity and respect, for their self-knowledge to be respected and their vulnerability to be dealt with sensitively.
Mottram, A. (2011). Patients' experiences of day surgery: a Parsonian analysis	UK (Day Surgery)	Grounded theory study Semi structured interviews of patients and carers	Grounded theory	Themes: importance of nurses giving patient adequate information about the surgery and recovery.
Erkal, S. (2007). Patients' experiences at home after day case cystoscopy	Turkey (Day Surgery)	Questionnaires	Statistical analysis	Reiterated importance of adequate pre-discharge information
Majasaari, H., Sarajärvi, A., Koskinen, H., Autere, S., & Paavilainen, F. (2005). Patients' Perceptions of Emotional Support and Information Provided to Family Members.	Finland (Day Surgery).	Questionnaires	SPSS	Findings highlighted ongoing concern with lack of post discharge information

Carter, K., Kilburn, S., & Featherstone, P. (2007). Cellulitis and treatment: a qualitative study of experiences.	UK (Acute medical care)	Qualitative study. Semi structured interviews	Framework analysis	Themes: generally satisfied with day care; poor information; repeating of questions; doctors talking 'over' them; issues with hospital environment-noise, hygiene, overcrowding; poor continuity of care.
Williams, L., Fryer, J., Andrew, R., Powell, C., Pink, J., & Elwyn, G. (2008). Setting up a Paediatric Rapid Access Outpatient Unit: Views of General Practice Teams.	UK (Paediatric services)	Qualitative study interviews	Thematic content analysis	Themes: benefits-easy telephone access; provides access to specialist opinion, diagnostic tests; referral issues-vague referral criteria; confusion between unit and inpatient unit regarding referral criteria, restricted opening hours, Lack of information-limited understanding of the unit; concerns regarding sustainability,
Blair, M., Gore, J., Isaza, F., Pajak, S., Malhotra, A., Islam, S., Vigneswaran, T., & Lachman, P. (2008). Multi-method evaluation of a paediatric ambulatory care unit (PACU): impact on families and staff	UK (Paediatric services)	Mixed method. Parent survey, patient mapping journey, staff interviews, referrer survey, routine activity analysis and comparison with A&E service	Quantitative data-SPSS Qualitative data-content analysis	All parents were satisfied with the service. Some further work needed doing on referral pathways.
Bolster, D., & Manias, E. (2009). Person-centred interactions between nurses and patients during medication activities in an acute hospital setting: qualitative observation and interview study.	UK	Interviews and observation	Framework analysis	Themes: Provision of individualised care; Patient participation; identification of Contextual barriers to personalised care-time constraints and multi-disciplinary communication
Validating a Model of Patient Satisfaction With Emergency Care, Sun, Adams & Burstin, 2001	UK	survey		Themes: waiting, lack of information about waiting, investigation, diagnosis and follow up

Bridges (2008). Listening Makes Sense: Understanding the Experiences of Older People and Relatives Using Urgent Care Services in England		Literature review		six key themes: reluctance that some older people have in seeking help; a diminished sense of significance while in receipt of services; the fear and anxiety that can be provoked in the alien environment of emergency care; the importance of personalized and continuous care; the key influencing role that accompanying family members can have.
The acute care experience of older persons with cognitive impairment and their families: A qualitative study. Petry, H., Steinbrüchel-Boesch, C., Altherr, J., Naef, R. (2018)	Switzerland	Qualitative study Interviews of patients and relatives	Content analysis	Found care experiences varied between good and bad. core dimensions of care: staff attitude-caring, responsiveness and attentiveness; involvement of family; organisational-support to provide person-centred care.
Williams, Brian & Coyle, Joanne & Healy, David, 1998. "The meaning of patient satisfaction: An explanation of high reported levels	UK	Mixed methods Interviews and questionnaires		Patients can alter their expectations based on their understanding of the constraints faced by practitioners.
Schoenfelder, Tonio & Klewer, Jörg & Kugler, Joachim. (2010). Factors Associated with Patient Satisfaction in Surgery: The Role of Patients' Perceptions of Received Care, Visit Characteristics, and Demographic Variable	Germany (Surgery)	Quantitative Questionnaires	Statistical analysis	Satisfaction with care was variable. Communication between healthcare providers and patients

Kieft, R., de Brouwer, B., Francke, A., & Delnoij, D. (2014). How nurses and their work environment affect patient experiences of the quality of care: a qualitative study	Dutch (Mental Health; hospital; home care and nursing home care)	Qualitative Four focus groups with staff	Thematic analysis	Facilitators of patient experiences of the quality of nursing care: clinically competent nurses, collaborative working relationships, autonomous nursing practice, adequate staffing, control over nursing practice, managerial support and patient-centred culture. Barriers: cost-effectiveness policy and transparency goals for external accountability. Nurses feel pressured to increase productivity and report a high administrative workload.
Ogilvie, D. (2005). Hospital-based alternatives to acute paediatric admission: A systematic review. *Archives of Disease in Childhood*, *90*, 138-142.		Literature Review		pediatric day assessment services are a safe, efficient, and acceptable alternative to inpatient admission, however observed that most of the evidence was of limited quantity and quality
Nurse–patient communication: an exploration of patients' experiences Catherine McCabe 2004	Ireland	Qualitative interviews hermeneutic phenomenological approach	'hermeneutic circle'	Themes: 'lack of communication', 'attending', empathy' and 'friendly nurses'. Focus on Task-orientated approach of nursing limits patient centred care
Patient dignity in an acute hospital setting: Leslie Baillie, 2009	UK	Qualitative Interviews of patients and staff and observations	Thematic analysis	Dignity affected by the environment, staff behaviour and patient factors-like attitudes, behaviours.
Patient outcomes after treatment in acute care psychiatric hospitals and wards. Gerolamo 2004		Systematic review		Readmission, rehospitalisation, recidivism; symptom and function improvement; client satisfaction; suicide and self-injury
Shattell M, Melanie Andes M, Thomas S. (2008) How patients and nurses experience the acute care psychiatric environment.	USA	phenomenological study Phenomenological interviews	The researchers analyzed each transcript for meaning units (Thomas and Pollio 2002)	for patients there was boredom, and for nurses, pressure and chaos. Although they shared some themes, nurses and patients experienced them differently.

Dawson, J (2014) STAFF EXPERIENCE AND PATIENT OUTCOMES: WHAT DO WE KNOW?		Literature review		clear links between improved staff experience and better care for patients. staff engagement, should therefore be seen as integral to overall objectives for the NHS
SMITH P., PEARSON P.H. & ROSS F. (2009) Emotions at work: what is the link to patient and staff safety? Implications for nurse managers in the NHS		Review of two case studies.		The recognition of emotions and the importance of emotional labour at an individual and organizational level managed by emotionally intelligent leaders played an important role in promoting worker and patient safety and reducing workplace risk.
Goodrich & Cornwall (2008). seeing the person in the patient The Point of Care review paper		Literature review		Unreliable quality Seeing the person in the patient Who is in charge? Seeing the patient as a parcel
Whitehead J, Wheeler H (2008). 'Patients' experiences of privacy and dignity.		Literature review Qualitative semi-structured interviews with patients, carers and NHS staff		Although healthcare professionals and patients attach importance to patients' privacy, there is insufficient understanding of the problem
Luxford & Sutton (2014) How does patient experience fit int How does patient experience fit into the overall healthcare picture?		Review paper		As population health management, accountable care, and healthcare reform mature, the efficacy of those efforts depend more and more on how well providers can integrate the design of patient experience and empowerment into the expanding care continuum
Dixon-Woods et al., (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study	UK	Mixed-methods study involving collection and triangulation of data from multiple sources, including interviews, surveys, ethnographic case studies, board minutes and publicly available datasets.	used a more interpretive, narrative approach.	It is essential to commit to an ethic of learning and honesty, to work continually to improve organisational systems, and to nurture the core values of compassion, patient dignity and patient safety through high-quality leadership. Organisations need to put the patient at the centre of all they do, get smart intelligence, focus on improving organisational systems, and nurture caring cultures by ensuring that staff feel valued, respected, engaged and supported.

Coughlan, M., Corry, M., 2007. The experiences of patients and relatives/significant others of overcrowding in accident and emergency in Ireland: a qualitative descriptive study.	Ireland	Qualitative descriptive approach Semi-structured interviews of patients and relatives	Content analysis	Participants were generally positive in their attitudes towards the care they received, but some descriptions appeared to suggest that the quality of care was not always ideal.
Richardson, S., Casey, M., Hider, P., 2007. Following the patient journey: older persons' experiences of emergency departments and discharge.	UK	Mixed methods Flow audits and interviews with patients	Thematic analysis	trust, acceptance, relinquishment and deference
Muntlin, A˚., Gunningberg, L., Carlsson, M., 2005. Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement.	Sweden	survey	Statistical analysis	Patients estimated quality of care at the emergency department as fairly good, but there were areas in need of improvement. A high percent of inadequate quality was related to the environment in the emergency department. About 20% of patients reported that they did not receive effective pain relief. More than 20% estimated that nurses did not show an interest in their life situation and patients did not receive useful information on self-care and about which physician was responsible for their medical care.

Appendix 7 Study Poster

ARE WE THERE YET?

Impact of an Ambulatory Emergency Care (AEC) unit on the experience of service users, carers and staff

WORKING WITH SERVICE USERS, CARERS AND TAFF TO CREATE BETTER EXPERIENCES OF CARE

INFORMATION ABOUT RESEARCH TAKING PLACE HERE ON THE AEC UNIT:

At [redacted] Trust we are committed to research which continually measures patient experience.
In line with this vision and as part of my doctoral studies at the University of Salford, I am undertaking a research project looking at how the introduction of a purpose-specific AEC unit impacts on the experience of service users, carers and staff. As part of the study I will be undertaking observation from time to time on the unit, looking at what happens from the moment you arrive on the unit.

Aim: To determine how the new service has affected the experiences of the people using the services and also contribute to the development of the service based on the needs of the community it serves.

Appendix 8 Patient Invitation Letter

Impact of an Ambulatory Emergency Care (AEC) Unit on the experience of service users and staff

Patient invitation letter

Desiree Demingo
ANP
AEC Unit
[redacted]

Dear AEC patient/carers,

[redacted] is committed to research which continually measures patient experience and leads to service improvements, to ensure patients receive the highest standard of care. I am writing to inform you about the study being planned on the AEC unit at [redacted] Hospital. The aim is to look at what happens during the time you spend on AEC and to improve any areas highlighted as lacking, in order to ensure you receive the best possible care, thus have a good experience.

Please look at the enclosed information sheet and consider whether you would like to take part in an individual interview. If you are willing to be interviewed, please return the reply slip to a member of staff on the unit before you are discharged. I will contact you after a week to introduce myself and answer any further questions you may have. Consent will be obtained by me on the day of the interviews. Please talk to me or a member of staff if you have any questions about the study.

Kind regards
Desiree (Advanced Nurse Practitioner -ANP)

……..

Reply slip

I am happy to be contacted to take part in this study.

Name (please print)………………………………………………………..
Contact telephone number………………………………….

Appendix 9 Patient/carer Participant Information Sheet

Impact of an Ambulatory Emergency AEC unit on the experience of service users and staff

Participant information sheet for patients, carers, family/friends

Study title: A participatory action research study to assess and strengthen the impact of the introduction of an AEC unit on the experience of service users and staff.

Invitation paragraph

You are being invited to take part in the above named study looking at the experience of service users and staff on AEC, as part of my doctoral study at the University of Salford.

Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with myself or a member of staff on AEC if you wish. Please contact me on the details below if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

1. Purpose of the study

The purpose of this study is to gain an understanding of how the introduction of an AEC unit impacts on the experience of care of service users, carers and staff working on the unit, as well as bring about changes in practice through partnership working with stakeholders. When introduced it was expected that the service would improve the experience of both those receiving and providing care. The study will attempt to uncover if the service has achieved this goal and how it can be helped to further meet the expectations of service users, carers and staff.

2. Why have I been invited?

You are invited as someone who has either received care on AEC or is a relative or informal carer of someone who has received care.

3. Do I have to take part?

No. It is up to you to decide whether or not you would like to take part. You can change your mind at any time and a decision to withdraw or a decision not to take part will not be held against you in any way.

4. What will happen to me if I take part?

If you complete and return the reply slip at the bottom of the invitation letter, I will contact you to discuss taking part in an interview. I will check your understanding of this information sheet and answer any queries you may have. I will interview you on your own or you may have someone sit in with you (e.g. a friend) if you prefer. The interview will take place at a time and venue to suit you, such as your own home or at [redacted] Hospital and will last approximately 30-45 minutes. With your agreement I would like to audio-record the interview.

5. What are the possible benefits of taking part?

I hope the findings will be useful to help identify what works well and not so well on AEC in order to enhance the service for both those receiving and providing services.

6. What are the possible disadvantages of taking part?

You may find talking about your experience upsetting at times. As a nurse I would support you and stop the interview if you needed me to. I would only restart the interview if you want to.

7. What if something goes wrong?

This is unlikely however, if you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you may complain to my supervisor Dr. Tracey Williamson at the University of Salford. The normal NHS complaints mechanisms are also available to you. Details can be obtained from a member of staff on the ward.

8. Will my taking part in this study be kept confidential?

Yes. All information which is collected about you during the course of the study will be kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised. With your agreement, I may like to use some anonymised quotes from what you tell us for presentations of study findings e.g. in study report, at conferences, in teaching and in promoting AEC e.g. on the AEC internet website.

9. What will happen to the results of the study?

I will share the findings in a variety of ways including local events and presentation to local groups/forums that may be interested. Summary of findings will be published in hospital and AEC newsletters. The results will be also published on hospital intranet site and made available to all participants. Articles will be published in academic journals and presented at conferences.

10. Who has reviewed the study?

This study has been reviewed by the University of Salford College of Health and Social Research Ethics Panel, as well as NHS Research Ethics Committee through the Integrated Research Application System (IRAS).

11. What do I do now?

You do not have to decide immediately, but if you are if you are interested please complete the reply slip at the bottom of the invitation letter and hand it to a member of staff on AEC. Please take this information sheet away and read it at home again and discuss with others if you wish.

Further information and contact details
Desiree Demingo
Advanced nurse practitioner
AEC
[redacted]

Dr Tracey Williamson
Research Fellow Public Engagement / user
Involvement in Research
[redacted]

[redacted]

[redacted]
Anish Kurien MBA, PRINCE2
Research and Innovation Manager | College of Health and Social Care
[redacted]
Thank you for taking the time to read this information sheet and for considering taking part.

Appendix 10 Staff Invitation Letter

Impact of an ambulatory emergency care (AEC) unit on the experience of service users and staff

Staff invitation letter

Desiree Demingo
Advanced nurse practitioner
AEC
[redacted]

Dear all,

[redacted] is committed to research which continually measures patient experience and leads to service improvements, to ensure patients receive the highest standard of care. I am writing to inform you about the study being planned on AEC at [redacted]. The aim is to study and improve the patient's journey through the unit, in order to enhance the experiences of patients, their carers, and staff working on the unit. I am planning a series of 3 focus group sessions for AEC staff and would ideally like you to attend all three. Please look at the enclosed information sheet and consider whether you would like to take part. If you are willing to participate in focus group please return the reply slip to me or the ward clerk on the unit.

The first event will take place on [insert date] at [redacted]……, [redacted]
At each event I will be serving refreshments, so please let me know if you have any specific dietary requirements or any other needs that I will need to meet to allow you to attend. I look forward to hearing your ideas about how we can improve and enhance the experiences for our patients and ourselves.
Kind regards

Desiree Demingo (ANP)

....……………………………………………………………………………………………......................

Reply slip

I am happy to be contacted to take part in this study.
Name (please print) ………………………………………………………..
Contact telephone number………………………………….

Appendix 11 Staff Participant Information Sheet

Impact of an Ambulatory Emergency Care (AEC) unit on the experience of service users and staff

Participant information sheet for AEC staff

Study title: A participatory action research study to assess the impact of the introduction of an AEC unit on the experience of service users and staff.

Invitation paragraph

You are being invited to take part in the above named study looking at the experience of service users, carers, GPs and staff on AEC, as part of my doctoral study at the University of Salford.

Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and contact me on the details below if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

12. Purpose of the study

The purpose of this study is to generate knowledge about how the introduction of AEC impacts on the experience of care of service users, carers and staff working on the unit, as well as bring about changes in practice through partnership working with stakeholders. When introduced it was expected that the service would improve the experience of both those receiving and providing care. The study will attempt to uncover if the service has achieved this goal and how it can be helped to further meet expectations of service users, carers and staff.

13. Why have I been invited?

You are invited as someone who provides care for the patients presenting to AEC for assessment.

14. Do I have to take part?

No. It is up to you to decide whether or not you would like to take part. You can change your mind at any time and a decision to withdraw or a decision not to take part will not be held against you in any way.

15. What will happen to me if I take part?

If you complete and return the reply slip at the bottom of the invitation letter, I will contact you to discuss taking part in the focus groups. I will check your understanding of this information sheet and answer any queries you may have. I am planning one set of three focus groups for staff and whilst I ideally would like you to attend all three I am aware this may not be possible due to commitments, so please attend what you can. If needs be I can do individual interviews but focus groups are the preferred method. The focus groups will take place at a room at the education centre of the hospital and will last approximately 45 minutes. With your agreement I would like to audio-record the focus groups. If you decide to withdraw from the study after attending any of the focus groups your data will still be used as there is no way it can be separated.

16. **What are the possible benefits of taking part?**

I hope the findings will be useful to help identify the delays in patients' journey through the unit and what improvements need making. I also hope that the findings will help others setting up similar services elsewhere.

17. **What are the possible disadvantages of taking part?**

There are no known disadvantages to you taking part. Participation will however require a contribution of your time on 1 to 3 occasions.

18. **What if something goes wrong?**

This is unlikely however, if you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you may complain to my supervisor Dr. Tracey Williamson at the University of Salford. The normal NHS complaints mechanisms are also available to you. Details can be obtained from a member of staff on the ward.

19. **Will my taking part in this study be kept confidential?**

Yes. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised. With your agreement, I may like to use some anonymised quotes from what you tell me for presentations of study findings e.g. in study report, at conferences, in teaching and in promoting the unit e.g. on AEC internet website. As the focus group is a group discussion, other participants will hear your views first hand, but we will discuss confidentiality at the start of the discussion.

20. **What will happen to the results of the study?**

I will share the findings in a variety of ways including local events and presentation to local groups/forums that may be interested. Summary of findings will be published in hospital and AEC newsletters. The results will be also published on hospital intranet site and made available to all participants. Articles will be published in academic journals and presented at conferences.

21. **Who has reviewed the study?**

This study has been reviewed by the University of Salford College of Health and Social Research Ethics Panel, as well as NHS Research Ethics Committee through the Integrated Research Application System (IRAS).

22. **What do I do now?**

You do not have to decide immediately, but if you are interested in this study please contact me either via telephone or email, on the details below. Please read the information leaflet at home again and discuss it with others if you wish.

Further information and contact details

Desiree Demingo
Advanced nurse practitioner; AEC,
[redacted]
Dr. Tracey Williamson
Research Fellow Public Engagement/user Involvement in Research
[redacted]
Anish Kurien MBA, PRINCE2
Research and Innovation Manager | College of Health and Social Care
[redacted]

Thank you for taking the time to read this information sheet and for considering taking part**.**

Appendix 12 GPs Invitation Letter

Impact of an Ambulatory Emergency Care (AEC) unit on the experiences of service users

GPs invitation letter

Desiree Demingo
Advanced nurse practitioner
[redacted]
[redacted]

Dear all,

[redacted] is committed to research which continually measures patient experience and leads to service improvements, to ensure patients receive the highest standard of care. I am writing to inform you about the study being planned on the AEC unit at Stepping Hill Hospital. The aim is to explore and situate the service and its impact on the experiences of service users, in a wider context, from its inception. I am planning to obtain the views of GP's who used the service through telephone interviews. Please look at the enclosed information sheet and consider whether you would like to take part. If you are willing to participate, please contact me on the details below.

Please could you reply to desiree.demingo@[redacted] if you have any questions about the study and/or want to participate?

Kind regards

Desiree Demingo (ANP)

Appendix 13 GPs Participant Information Sheet

Impact of an Ambulatory Emergency Care (AEC) unit on the experience of service users, carers and staff

Participant information sheet for GPs

Study title: A participatory action research study to assess the impact of the introduction of an AEC on the experience of service users, carers and staff.

Invitation paragraph

You are being invited to take part in the above named study looking at the experience of service users, carers, GPs and staff on the AEC unit, as part of my doctoral study at the University of Salford. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and contact me on the details below if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

1. Purpose of the study

The purpose of this study is to generate knowledge about how the introduction of AEC impacts on the experience of care of service users, carers and staff working on the unit, as well as bring about changes in practice through partnership working with stakeholders. When introduced it was expected that the service would improve the experience of both those receiving and providing care. The study will attempt to uncover if the service has achieved this goal and how it can be helped to further meet expectations of service users, carers and staff.

2. Why have I been invited?

You are invited as someone who refers patients to unit for assessment.

3. Do I have to take part?

No. It is up to you to decide whether or not you would like to take part. You can change your mind at any time and a decision to withdraw or a decision not to take part will not be held against you in any way.

4. What will happen to me if I take part?

If you complete and return the reply slip at the bottom of the invitation letter, I will contact you to discuss taking part in the interviews. I will check your understanding of this information sheet and answer any queries you may have. I am planning to hold individual telephone interviews with GPs/ANPs. The interview will take place on a date which suits you and will last approximately 20-30 minutes. With your agreement I would like to audio-record the interviews which will later be typed up.

5. What are the possible benefits of taking part?

I hope the findings will be useful to help identify the delays in patients' journey through the unit and what improvements need making. I also hope that the findings will help others setting up similar services elsewhere.

6. What are the possible disadvantages of taking part?

There are no known disadvantages to you taking part. Participation will however require a contribution of your time on one occasion.

7. What if something goes wrong?

This is unlikely however, if you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you may complain to my supervisor Dr. Tracey Williamson at the University of Salford, whose contact details is below. I have also included the contact details of the university contact, Anish Kurien, if you need to complain beyond the supervisor. The normal NHS complaints mechanisms are also available to you.

8. Will my taking part in this study be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised. With your agreement, I may like to use some anonymised quotes from what you tell me for presentations of study findings e.g. in study report, at conferences, in teaching and in promoting AEC e.g. on AEC internet website. As the focus group is a group discussion, other participants will hear your views first hand but we will discuss confidentiality at the start of the discussion.

9. What will happen to the results of the study?

I will share the findings in a variety of ways including local events and presentation to local groups/forums that may be interested. Summary of findings will be published in hospital and AEC newsletters. The results will be also published on hospital intranet site and made available to all participants. Articles will be published in academic journals and presented at conferences.

10. Who has reviewed the study?

This study has been reviewed by the University of Salford College of Health and Social Research Ethics Panel, as well as NHS Research Ethics Committee through the Integrated Research Application System (IRAS).

11. What do I do now?

You do not have to decide immediately, but if you are interested in this study please contact me either via telephone or email, on the details below. Please read the information leaflet at home again and discuss it with others if you wish.

Further information and contact details

Desiree Demingo
Advanced nurse practitioner
AEC,
[redacted]
Dr. Tracey Williamson
Research Fellow Public Engagement/user Involvement in Research
[redacted]
Anish Kurien MBA, PRINCE2
Research and Innovation Manager | College of Health and Social Care
[redacted]

Thank you for taking the time to read this information sheet and for considering taking part.

Appendix 14 Participant Consent Form

Participant Identification Number:

CONSENT FORM

PROJECT TITLE: Impact of an Ambulatory Emergency Care (AEC) Unit on the experience of service users, carers and staff

Name of researcher: Desiree Demingo

Please initial box

1. I confirm that I have read and understand the information sheet dated XXXX for the above study and that the nature and purpose of the research project have been explained to me. ☐
2. I have had the opportunity to consider the information, ask questions and had these answered satisfactorily and have been informed about who to contact if any issues arise during the project. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
4. I agree to be interviewed and the interview to be audio recorded and notes to be made ☐
5. I understand that my personal details will not appear in any reports, articles or presentations. ☐
6. I understand and agree that my words may be quoted anonymously in presentations of the study findings e.g. in publications, reports, web pages, teaching materials, conferences. ☐
7. I agree for the information to be stored securely in keeping with the Data Protection Act ☐
8. I agree to take part in the above study.

______________________	_______________	_______________
Name of Participant	Date	Signature
______________________	_______________	_______________
Researcher	Date	Signature

One copy will be given to the participant and the original to be kept in the file of the research team.

Appendix 15 Patient Mapping Tool

AEC Patient mapping tool from admission to discharge

Age: _________ Gender: _________ Date: _________

Reason for attendance
(key symptoms and/or diagnosis): ___________________________

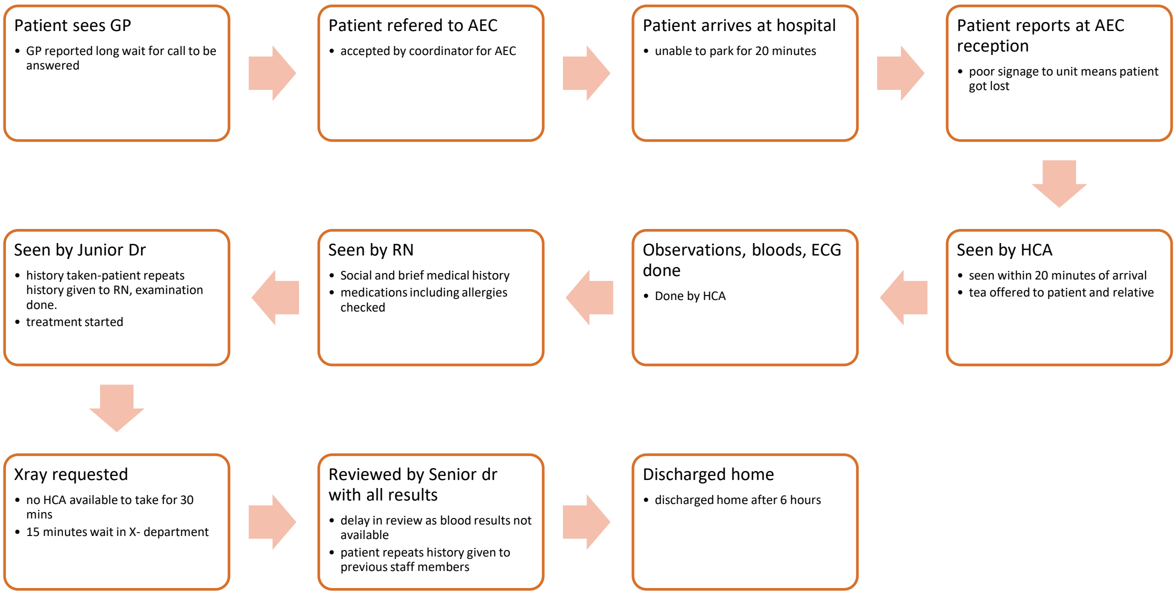
Pathway if applicable___________________________

Stage	Description of Action	By Who?	Time started	Time completed	Comments (any problems or comments by staff/patients/ carers)

APPENDIX 16 TOPIC GUIDE FOR OBSERVATIONS

Topic	**Guide for observations**	**Comments**
Communication and information	Observe communication between staff and patient and carers /between staff groups.	
Waiting times	Are patients left waiting? Reasons? What are the consequences? Any repetition of activities? Why? Is there a clinical reason for this?	
Environment and facilities	design of physical environment and how it is navigated and utilised by patients and staff	
Staffing	Look at how people work, noting where in patients journey there are challenges • key issue to be included is whether staff shortages impact on care experiences	
Patient/family &friends involvement	Are patients and carers being involved in decisions about treatment and discharge?	
Summary and reflection		

Appendix 17 Visual map of patients' journey



Appendix 18 Patient/Carer interview guide

Patient/Carer interview schedule

The story of your journey

Introduction

1 Your journey so far

(Referral – tests and investigations – diagnosis – treatment – discharge – follow-up)

1.1 **The first time you noticed something was not right**

- What was your first reaction?

1.2 **The appointment/call with your GP**

- What happened and what stands out in your mind about that?

1.3 **Your first trip to the ambulatory care unit**

- How long was it between seeing your GP and going to the hospital? What was it like during the gap? (e.g., worrying time? Anxious?)
- First impressions of the hospital and the unit (the reception area, waiting area, the general place, other people there, staff)?

1.4 **First meeting with other staff, including tests**

- Did you wait long to be seen?
- What happened and what stands out about it?

1.5 **The first meeting with medical team/Advanced nurse practitioners**

- Did you wait long to be seen?
- What happened and what stands out about it?
- Did you wait long for investigations like bloods, CXR's?

1.6 **Back to family and friends**

- What role did your family and friends play during this episode?

1.7 **Treatment begins**

- Did you wait long to have treatments you needed?

1.8 **Follow-up**

- How much information did your GP have about what had happened to you when you went back? Was he/she well-informed?

2 <u>Issues</u>

2.1 **Overall satisfaction**

- Broadly speaking, how satisfied have you been so far with the care and treatment you have received?
- What are the best bits and worst bits of the service?

2.2 **The information you received**

- Did you find it difficult or awkward to communicate with the staff on ACU?
- What would you have liked more information about?
- Have there been times when you have been given conflicting or contradictory information?
- Were you clear about diagnosis, treatment and follow up?

2.3 **How much influence you had**

- Have you had any choice in hospital, consultant, and treatment options?
- Are there any things in which you would like to have had more 'say'?

2.4 **Your relationships with the staff you met**

- Tell me about your relationships with staff.
- Do you feel as though staff have accompanied you on this journey, or do you feel you have done it very much on your own?

2.5 **What other types of support did you have?**

<u>3 Best and worst areas</u>

3.1 Where would you say are the crucial points in the journey – moments of truth?

3.2 Are there crucial touch points? The parts we should focus on in the design process?

3.3 What were the best and worst parts of your whole experience?

3.4 Based on your experience do you have any suggestions of how we can improve the service

THANK YOU

Appendix 19 Interview Guide for senior managers

Guide for interviews with senior team:

Background:

1. Can you give me an overview of AEC; when and how was it first initiated? Who was responsible for leading its implementation?

   (Prompt: was the decision based on the needs of the organisations or driven by policy)

2. What were the main aims and objectives of AEC? To which broader health policy was it linked? Within the organisation who was responsible for championing the service? Was there arrangement in place for clinical lead? How much engagement of service users and staff took place?
3. How was it funded? (Prompt: was there a business case? Was it government funded or by the CCG?)
4. What was the CCGs' expectations about return of investment?
5. What is the main successes of the program? And failures?
6. What factors enable or hinder the implementation and sustainability of the service
7. What are the main lessons learned?
8. Is there anything you would do differently if you have to do it over?

Closing:

Is there anything else you would like to share with me?

Thank you for taking the time to talk to me

Appendix 20 Interview guide for GPs/ANPs

Script and interview schedule for GP/ANP interviews

Thank you for agreeing to take part in this project. The aim is to study and improve the experiences of both those providing and receiving services in order to enhance the way in which care is delivered within the ambulatory care unit. Today, I wish to understand your experience of referring patients to the unit in order to develop services. With your consent, I would like to tape record the interview but the data gained from the interview will be made anonymous and you will also have the opportunity to review your interview transcript if you wish.

1 Introduction

- Can you give me an overview of your understanding of AEC in general?
- How much input did you have in the service design?
- What impact does the AEC service has on your workload?

2 experiences

- What are the positive aspects of this service?
- What do you think are the main problems with this service from the point of view of GPs/ANPs?

• (*If GP/ANP talk about politics within the service*) How does this issue impact on the patient experience?

[Interviewer to summarise list of positive aspects and problems]

Appendix 21 AEC Strategy Group: Terms of Reference

Terms of Reference

1	Committee	**ACU [AEC] Strategy Group**
2	Purpose	The overall aim of the Ambulatory [Emergency] Care Strategy group is the provision of rapid access clinical care as an alternative to Emergency Department or inpatient care. Patients have access to clinical staff and rapid diagnostic facilities that assist diagnosis, observation and treatment, they are provided with a one stop package of care.
3	Powers of the Committee	The committee has the power to :- • Co-opt additional members where appropriate • Develop the Ambulatory Care service • Approve Ambulatory Care Pathways • Implement NICE Guidance • Implement actions to ensure a safe and robust service • Alert other business groups of problems associated with service delivery
4	Role of the Committee	• Review and redesign current system for GP referrals to medicine • Developed an agreed approach to streaming patients from ED triage • Ensure compliance with devised pathways • Shape and influence further pathway development • Identify resources required • Liaise with clinical teams to ensure all are aware of clinical pathways and service delivery • Monitor review and audit current practice • Review available data and relevant information and give advice on implications to Trust and CCG • Ensure adherence to national guidance
5	Chair	Chair – Dr Consultant Acute Physician and Ambulatory Care lead Deputy Chair Advanced Nurse Practitioner

6	Membership	- Dr - Consultant Acute Physician and Ambulatory Care lead - - Emergency Department Consultant and Clinical Lead Ambulatory Care - – Business Manager - – Matron Emergency Department / Acute Medicine - – Nurse Consultant - – Advanced Nurse Practitioner - – Advanced Nurse Practitioner - – Advanced Nurse Practitioner - – Ward Manager Ambulatory Care Unit - – Lead Specialist Pharmacist Acute Medicine
7	Individuals roles and responsibilities	- All attendees should be punctual - Apologies for absence should be sent to the Chair prior to the meeting - Members may nominate a deputy to attend on their behalf if they are unable to attend in person - All group members are expected to contribute to discussions and bring to the group the views of their areas - Group members are expected to be prepared for the meeting i.e. reading papers, taking appropriate actions from the last meeting - Non group members will be invited for individual agenda items as required - Members are expected to feed back to their area the outcomes of the meeting and any key issues
8	Quorum	A meeting cannot go ahead if it is in-quorate - 50% attendance including Chair or Deputy Chair
9	Attendance Requirement	Members are required to attend a minimum 50% of meetings
10	Frequency and Timing	- Monthly - Last Wednesday each month - Duration 1 hour
11	Reporting Arrangements In and Out	- Minutes to be posted on Ambulatory Care microsite - Report to CCG

Appendix 22 AEC Leaflet

What is the Ambulatory Emergency Care Unit (AEC)?

This is a new service which offers same day emergency care to patients in hospital. Patient's on arrival are assessed, diagnosed and treated by our nursing and medical team.

A guide to the unit

Prior to your arrival, your GP/Senior Doctor in the Emergency Department will have discussed your referral with the senior nurse who has deemed it appropriate for you to be treated by the Ambulatory Care Team.

On arrival to AEC, you will be greeted by a member of staff who will direct you to our 25 seated waiting area.

A member of the nursing team will then invite you into our initial assessment area. During this assessment, the nurse will record vital observations and appropriate investigations relating to your current condition.

Please be aware that these investigations may take some time to arrange and for the results to be available. We ask for your patience and understanding regarding this and should you require further information, please do not hesitate to speak to the nurse in charge.

Following your initial assessment, you will subsequently be examined by a Junior Doctor or Advanced Nurse Practitioner who will discuss with you the next stage of your treatment and develop a plan of care with you.

The plan of care will require you to be reviewed by a Senior Doctor (Registrar/Consultant). The unit is covered by a registrar from 9am until 10pm and Consultant cover 12pm until 7pm. As every patient requires a senior review, there may be a delay in your assessment. Again, should you require further information, please do not hesitate to speak to the nurse in charge.

Contact us

Patient and relative contact number:

0161 419 5907/5908

If you would like this leaflet in a different format, for example, in large print, or on audiotape, or for people with learning disabilities, please contact:
Patient and Customer Services, [redacted].

A free interpreting Service is available if you need help with this information. Please telephone the Lips Service on 0161 922 5149 or E-mail: tam-pct.lips@nhs.net	English
هناك خدمة مجانية للمترجمين متوفرة اذا أردت مساعدة بخصوص هذه المعلومات. الرجاء الاتصال بخدمة ليبس أو LIPS على الرقم 0161 922 5149 أو عن طريق الايميل tam-pct.LIPS@nhs.net	Arabic
এই তথ্য বুঝতে সাহায্যের প্রয়োজন হলে বিনামূল্যে দোভাষী বা ইন্টারপ্রিটার সার্ভিস রয়েছে, আপনাকে সাহায্য করার জন্য। দয়া করে লিপ্স সার্ভিসকে টেলিফোন করুন 0161 922 5149 এই নম্বরে অথবা ই-মেইল করুন: tam-pct.LIPS@nhs.net এই ঠিকানায়।	Bengali
如果你需要幫助來瞭解這份資料的內容，我們可以提供免費的翻譯服務。請致電 0161 922 5149 聯絡語言翻譯及病人支持服務(LIPS)，電子郵件：tam-pct.LIPS@nhs.net	Chinese
اگر برای فهمیدن این اطلاعات به کمک احتیاج دارید می توانید از خدمات ترجمه بصورت مجانی استفاده کنید. لطفا با LIPS از طریق شماره تلفن 0161 922 5149 یا ایمیل tam-pct.LIPS@nhs.net تماس بگیرید.	Farsi
Bezpłatna Serwis tłumaczenia jest dostępny, jeśli potrzebujesz pomocy z tą informacją. Proszę zadzwonić do Obsługi usta na 0161 922 5149 lub E-mail: tam-pct.LIPS @ nhs.net	Polish
اگر آپ کو یہ معلومات سمجھنے میں مدد کی ضرورت ہو تو مترجم کی مفت سروس موجود ہے۔ براہ کرم ایل آئی پی ایس LIPS کو 0161 922 5149 پر فون کریں۔ ای میل: tam-pct.LIPS@nhs.net	Urdu

Our smoke free policy
Smoking is not allowed anywhere on our sites. Please read our leaflet 'Policy on Smoke Free NHS Premises' to find out more.

Leaflet number	Intranet Office will supply

Appendix 23 Initial codes

Communication	Metaphor-interrogate	No one to clerk	A&E busy	waiting	angry relative	No staff
Lack of communication between different departments	Staff feel like they not involve in decisions about the unit	No agreed protocol for day attenders	Staff feeling bullied into making decisions	Waiting for results of CT scans	Given hot drink and toast	Poor signage to the unit
Ineffective communications between team members	GPs state they were not involved	Lack of clarity of pathways	Organisational challenges	Waiting to go to x-rays	Staff smiling despite being run off their feet	High parking charges
Lack of involvement of relatives	GP state its not a primary care service	Variation in service	Blame culture	Waiting at the reception desk	Nice, clean ward	Repetitive tasks
Ineffective communication between primary and secondary care	Urgency to roll out new services limits engagement	Issues with the referral process	Tensions between A&E/AEC staff	Waiting for the referral to be taken	Attentive staff	Unrealistic expectations
Repetitive questioning	tokenism	Access to the unit	Lack of support	Waiting for blood results	Felt like doctor was listening	No tv
Everyone too busy to talk	I was never aware of the unit	Unit used overnight for A&E patients	Feeling stuck in the middle	Waiting to be seen by nurses	Just came in for review	Unmanned reception
Labelling patients	Too busy for feedback	Unit tied to financial incentives	Competing demands	Waiting to be seen by junior doctor or ANP	Satisfied with care	Safety concerns
‘being dumped’	Staff do not have time for involvement	Why can’t I just come when I need a drain	Competing agendas	Waiting to be seen by consultant	Staff explained everything	Staffing issues
Appropriate communication makes difference	External managers brought in to drive innovations	My GP has to see me first before I can come here	Targets driven	Waiting for transport	Good follow up care	Medical staff all go to teaching at the same time
Eye contact	involvement	Told one thing by my GP and another by the nurses	Focus on cost savings	Waiting for take home medication	Contact details given if any problems after discharge	Difficulty with parking

Body language was off	My daughter was not involved in discussions	Disappointed that I’m not having a scan today	Staff shouting at each other	GP waiting for discharge letter	happy	Disconnect between departments
Talks to loud	Several GP complaint today as they been told to send patient to A&E	Nurse in AEC refused to take referral form ANP	Staff needed ‘time out’	Waiting for notes to arrive (day attenders)	content	Missing notes
No information given	Demand exceed capacity	Nurse refusing to take patient with high NEWS	Conflicting demands	Long wait in A & E	Information provided	No space to see patients
Not knowing what to expect	Tearful nurses today	A&E staff told me I am just coming here for a scan	Conflicting agendas	Long wait for AMU bed	Staff explained what’s happening	Problems with privacy and dignity
inconsistency	Waiting room full	No doctor to do Lumbar puncture	Mismatch between polices/agendas and reality	Missed my appointment waiting for porter	Seen very quick by nurses when arrived	Lack of awareness of unit
Some staff have poor bedside manners	Can hear everything in waiting room	My notes went missing	‘pointless to change things as nobody listens’	Several staff resigned soon after unit opened	Very gently manners	Assessment document too extensive
Staff spoke in raised voices	No privacy	GP has had no letter form hospital	‘don’t have time’	People rushing around	Good with my daughter who has learning difficulties	Always offer refreshment
Consultant spoke to me at my level not to top of my head like some do.	Sat in waiting room without a clue	I like that I don’t have to stay in hospital	Collective relationships and power	District nurse never turned up	Talked in appropriate language	Displayed empathy
He asked if I understood	They listen without judging	Met nice people in waiting room	Constraints influencing factor	Grumpy nurse	Had a good laugh with the doctor	Lack of empathy
The nurse has a blank stare today	Long wait for tablets	I feel frustrated/angry	Traditional way of working seen as a constraint	frustrated	I felt safe	Mismatch between expectations and reality

I can’t hear and they speak softly	I feel frustrated/angry	anxious	Us vs them dynamic	No space for relative in waiting room	I’ve been here a few times	A&E very busy
The doctor spoke to me in a kind voice and he held my hand	Waited 6 hours for ward bed	prioritising	Friction and conflict	Fault finding	Thanks for feeding me	Staff on AEC very busy

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