



Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy Services in England and Wales: a focus group study

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Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy

Services in England and Wales: a focus group study

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3 Running Header: **A focus group study evaluating change in endoscopy services**
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8 **Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy**
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10 **Services in England and Wales: a focus group study**
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15 **ABSTRACT**
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17 **Objective:** Explore professional views of changes to gastroenterological service organisation and
18 delivery and barriers and facilitators impacting on change. The work was undertaken as part of
19 an evaluation in endoscopy service provision catalysed by the Modernising Endoscopy Services
20 programme of the Modernisation Agency.
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27 **Design:** Focus groups followed by group-working activities.
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30 **Setting:** Secondary care gastroenterology units in England and Wales.
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32 **Participants:** In England 13 GI professionals agreed to participate and five participated. In
33 Wales 18 GI professionals agreed to participate and 15 participated. Participants were medical,
34 surgical and nursing specialists in gastroenterology. Purposive sampling led to inclusion of senior
35 people who held leadership and management roles and who were, therefore, directly involved in
36 service modernisation, and exclusion of those involved in the Modernisation Endoscopy
37 Programme.
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46 **Results:** Four, one and a half hour focus groups took place in 2007. Summative and thematic
47 analyses captured essential aspects of text in summative and thematic formats and achieved
48 consensus on key themes. Four themes were revealed: 'loss of personal autonomy and erosion of
49 professionalism', 'lack of senior management understanding', 'barriers and facilitators to
50 change', and 'differences between English and Welsh units'. Themes indicated that low staff
51 morale, lack of funding and lack of senior management support are barriers to effective change.
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Conclusion: Despite ambitions to implement change, ineffective management support continues to hamper modernisation of service organisation and delivery. Whilst the NHSMA's Modernising Endoscopy Services Programme acted as a catalyst for change by affecting the way staff work, communicate and think, it was not effective in heralding change itself. However, it was clear that gastroenterologists are keen to consider the potential for change and future service modernisation. The methodological framework of innovative qualitative inquiry offers the opportunity for comprehensive and rigorous enhancement of quantitative studies, including randomised trials, when a mixed methods approach is needed.

ARTICLE SUMMARY

Article Focus

- Examine the opinions of gastroenterologists and specialist nurses regarding the effects of change on service organisation and delivery;
- Establish views regarding the impact of change on professional practice and self identity;
- Describe barriers and facilitators to change in gastroenterological endoscopy services and across units in England and Wales to explore differences.

Key Messages

- GI consultants, surgeons and nurse specialists describe barriers to change and service modernisation resulting largely from lack-lustre senior management support, inadequate funding, and low staff morale;
- The Modernising Endoscopy Services (MES) Programme raised the profile of change, but was not effective in catalysing change itself. Nevertheless, participants see real

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3 potential in overcoming barriers to change in order to promote future service
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5 modernisation;
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8 • The methodological framework of innovative qualitative inquiry used in this study
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10 offers the opportunity for comprehensive and rigorous enhancement of quantitative
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12 studies, including randomised trials, when a mixed methods approach is needed.
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15 **Strengths and limitations of this study**

- 16
17 • The number of people participating in the focus groups was small;
18
19 • However, the qualitative study was looking for depth rather than breadth of data
20
21 disclosure;
22
23 • Participants covered a wide range of medical surgical and nursing professions
24
25 working in Gastroenterology and there is no reason to believe their views are not
26
27 representative of the wider Gastroenterological professional population.
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34 **DATA SHARING**

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36 There is no additional data available
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41 **INTRODUCTION**

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43 Gastrointestinal disease is recognised as the third most common cause of death in the UK and the
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45 leading cause of cancer, and the burden of gastrointestinal disease on services in the NHS is at a
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47 record high,[1] The rise in gastroenterology service workloads is causing increasing difficulty in
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49 offering patients timely and appropriate appointments in hospitals, and in maintaining
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51 appropriate, timely patient assessment, and effective, long-term support.
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To counter these difficulties, and to meet the challenges posed by radical reform of the NHS in both England and Wales,[2,3] changes are needed in the organisation and delivery of services.

This study explored professional perceptions of the difficulties associated with this.

The work was set in the context of a larger mixed methods study to assess the impact of the Modernisation Agencies' Modernising Endoscopy Services (MES) Programme.

OBJECTIVES

This qualitative study aimed to:

- Consider the opinion of gastroenterologists and specialist nurses regarding the effects of change on service organisation and delivery;
- Establish views regarding the impact of change on professional practice and self identity;
- Describe barriers and facilitators to change in gastroenterological endoscopy services;
- Clarify perceptions of change to services across units in England and Wales; and,
- Explore whether there are different views in England and Wales.

METHOD

Participants

Qualitative data were captured through four focus groups involving medical, surgical and nursing specialists in gastroenterology focus groups based in England and Wales. Participants were identified from the British Society of Gastroenterology's list of all registered gastroenterologists

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2
3 in the UK. Potential participants were sent details of the study and asked to take part in a
4
5 qualitative focus group. The sample was purposive,[4] targeting senior people who held
6
7 leadership and management roles and who were, therefore, directly involved in service
8
9 modernisation, but who were not involved in the MES Programme.[5]
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14 15 *Focus groups*

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17 The focus groups aimed to clarify professional understanding of changes that had already taken
18
19 place and their impact on modernising service organisation and delivery, in order to assess the
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21 acceptability of innovative models of referral, diagnosis and follow-up. All focus groups
22
23 examined barriers and facilitators to change and the impact of change on professional practice
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25 and self-identity.
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32 The four focus groups were designed to help elicit views and opinions using consensus-building
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34 activities.[6,7] An observer was present, to observe proceedings, manage any equipment and
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36 examine issues of group dynamics. A facilitator familiar with the study and its aims facilitated
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38 the event, asking pertinent questions and, where necessary, giving prompts for answers.[8,9]
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44 Each focus group lasted 90 minutes, and followed a pre-designed interview schedule to uphold
45
46 rigour and maintain methodological consistency. The schedule was based on the study aims and
47
48 an in-depth literature search, which had identified a wide range of issues relating to: staffing,
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50 funding, impact of change, facilitators and barriers to change, effects of modernisation on
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52 services, extent and rate of change and changes undertaken across units. A financial contribution
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54 was offered to all focus group participants in recognition of their time.
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3 Four focus groups were conducted in 2007: one in England and three in Wales. In the English
4 focus group (FG1), 13 gastroenterologists agreed to take part and five actually participated. In the
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Welsh focus groups, 18 gastroenterologists agreed to take part and 15 actually participated (FG2 = 3, FG3 = 6, FG4 = 6) (Total n=20). Participants represented five different endoscopy units in England and nine different units in Wales. Across the total sample of 15 participants in the Welsh focus groups, one unit was represented by four participants, three units were represented by two participants each, and the five remaining units were represented by one person each.

FG1 comprised four GI consultants and one GI nurse researcher. FG2 comprised one GI consultant and two GI nurse specialists, FG3 comprised three GI consultants and three GI surgeons and FG4 comprised three GI consultants and three GI surgeons.

ANALYSIS

Data were analysed using both thematic and summative analysis frameworks.[4,10] The analytic frameworks were chosen as the most appropriate for capturing rich narratives from in-depth analysis, and to allow mixed groups of health professionals, academics and researchers to work together cohesively, irrespective of their differences in terms of qualitative methodological expertise.[10-12]

Data analysis was undertaken by a multidisciplinary group representing gastroenterology, clinical trials, psychology, health services research and statistics. They took part in two group-working sessions to discuss the initial results of thematic analysis presented as summative paragraphs.

Ethics

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3 Ethical approval was granted by the Wales Multicentre Research Ethics Committee. Written
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5 consent was obtained from study participants to take part in tape-recorded focus groups.
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10 11 **RESULTS**

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14 Similar issues were identified across English and Welsh focus groups with little variation and
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16 four key themes emerged: ‘loss of personal autonomy and erosion of professionalism’; ‘lack of
17
18 senior management understanding’; ‘barriers and facilitators to change’; and ‘differences
19
20 between English and Welsh units’. The basis for these themes is described below alongside
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22 verbatim quotations (grammatical irregularities remain unaltered).
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29 *1 Loss of personal autonomy and erosion of professionalism*

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34 Lack of recognition by senior management for the work of the units, lack of steer from the
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36 Government or match between political, managerial and unit agendas, low profiles for
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38 endoscopy, and factional discord between different professional groups has led to
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40 disillusionment, particularly amongst senior GI physicians and surgeons. Individual autonomy
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42 has also been eroded, whereby notions of professionalism are linked to an individual’s ability to
43
44 make informed decisions that can impact on modernisation: “*clinical autonomy has gone*”
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46 (FG3.3). This has led to a dispirited workforce feeling undervalued: “*we are now... seen as*
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48 *employees rather than professionals*”. (FG3.5):
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3 *If you want my Damascus moment, it was when somebody came back from a meeting*
4 *sitting alongside a hospital administrator who said that consultants, as far as managers*
5 *are concerned, are really on the level of a store manager. (FG3.2)*
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12 Low morale has left professionals feeling disengaged and less likely to be flexible in adapting to
13 change or taking on board new approaches to working: *“there is an attitude of suspicion”*
14 (FG1.1). Under-staffed units and staff deskilling is of particular concern, both for nurses and
15 consultants. Thus, whilst expansion is helpful, units appear to be running without their full
16 complement of staff with no major drives to recruit additional staff. In addition, greater staff
17 specialisation, for example differences between GI physicians and surgeons, suggests the loss of
18 the professional ‘all-rounder’, with people working in different specialisations working
19 according to their own individual agendas and little clarity regarding who should be taking on
20 which tasks:
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36 *I would like to see a Welsh health strategy that decides what’s being done and where, so it*
37 *actually happens, with enough people to do it sufficiently specialised and not everybody*
38 *trying to do everything everywhere. (FG4.2)*
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46 Nurses are particularly demoralised, spending less time caring for patients and more time doing
47 paperwork: *“Nurse morale is really low and if they don’t do something they’ll all be leaving”*
48 (FG1.4).
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55 Low morale and low team spirit can be countered, to a certain extent, by strong medical and
56 nurse leadership, with a few motivated individuals making a difference and pulling everyone
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3 together. However, this sense of integration and belonging in the face of adversity was also
4 described as the ‘sinking ship’ mentality, having the negative effect of bringing everybody down:
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8 “People stick together because there is only one life raft” (FG4.2).
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10 11 12 13 2 Lack of senior management understanding 14

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17 Lack of senior management understanding of the work of the units and the needs of its members,
18 and lack of appropriate management systems to underpin the work of units was an overarching
19 theme across both English and Welsh focus groups. Units could not make long-lasting changes
20 to service organisation and delivery, whilst decisions around unit change and changes to the
21 process of care delivery were taken by ill-informed management with no scientific or clinical
22 expertise. This was exacerbated by a lack of funding, particularly in Wales, and extensive
23 resource deficit that left a deflated workforce with little sense of professional status. Participants
24 perceived management as favouring Government-driven targets within a top-down, managerial
25 environment. In Wales in particular, there was a conflict of interests between groups of
26 professionals, such as surgical and medical specialists, and discordance around the use of space
27 and resources: “I think historically, if you look at the way endoscopy services sit in most Trusts,
28 they don’t sit very easily in one service group” (FG4.4).
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47 Conflicting interests between staff and management were noted and senior management was seen
48 as out of touch, reactionary and not to be trusted: “management have their own agenda in terms
49 of fulfilling their local delivery plans” (FG4.4). Moreover, new target-driven political and
50 managerial directives engendered bureaucracy and legislation, creating extensive paperwork and
51 adding to the work of staff, especially nurses.
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There were difficulties convincing senior managers of the importance of endoscopy, and many layers of red tape. If management were supportive then change was effected, but this was often only the case in crisis management: *“This is a reactionary, entirety management when crises arise”* (FG4.1). Management was highly distrusted, and management systems were noted as being: *“an enormous and complex labyrinth”* (FG4.2). Middle managers were perceived as pressurised by senior managers to reach targets, and clinicians wanted to bring about change without targets attached. Lack of communication between clinicians and managers furthered this sense of frustration and futility. To overcome these hurdles, decisions were often made irrespective of the medical evidence, patient need or the immediacy of the problem:

In practical treatment the changes we want to bring have to be evidence-based. I cannot suddenly go and do something to a patient, which I think is right, irrespective of what the data shows. But changes are applied to us through the political and management system and there is no evidence. (FG3.1)

3 Barriers and facilitators to meaningful change

Groups discussed the reduction in waiting times as the main facilitator for change, alongside ‘pooled lists’ and ‘flexible staff working arrangements’: *“our waiting list has dropped a lot”* (FG3.4). However, this was not discussed in terms of better patient care or enhanced quality of care. Indeed, patient outcomes such as greater patient satisfaction with services, patient-centred care or changes for the good of the patient were predominantly absent from focus group discussion, at odds with the weight of discussion that concentrated on service re-evaluation

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3 toward performance-related goals and targets. Reduced waiting times were considered in
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5 accordance with the need to meet Government targets for improved service provision, and as
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7 something easily measured. This created: “*a depressed atmosphere*” and “*distressing times*”
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9 (FG3.1) and led to healthcare services that were unable to cater to even the most basic of patient
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11 needs. It was also mentioned that the implementation of the new consultant contract led to a
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13 decrease in working hours and consequently the quality of patient care that could be offered had
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15 fallen.
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22 English focus group participants were keen to express their support for the modernisation of
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24 endoscopy units, the improvement of services through change and the innovation of service
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26 delivery.
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32 Beside reduction in waiting times, other facilitators for change included: fast tracking of patients,
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34 more nurse endoscopists, new guidelines for referral and management of endoscopies, ‘prep’
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36 nurses and more specialist staff. Longer waiting lists were also, paradoxically, seen as a
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38 facilitator for change, encouraging the generation of new resources and acting as an impetus for
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40 the fulfilment of waiting list targets.
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46 Barriers to change related to lack of senior management support and understanding, lack of funds
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48 and the slow speed with which change was occurring: “*It’s not change that is the problem it’s the*
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50 *rate of change*” (FG1.3). Exacerbated by managerial decision-making bereft of unit input, focus
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52 group participants talked at length about: lack of funding, lack of leadership, poor skill mix, and
53
54 the difficulties different specialties had sharing endoscopy facilities. The absence of a National
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56 Service Framework for gastroenterology, poor quality information at the point of referral from
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3 general practitioners regarding prioritisation of patients, and lack of interest at an executive level
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5 did little to enhance a sense of self-worth. Endoscopy units were not recognised for their cutting
6
7 edge work, and consequently were not at the top of the Trusts' lists of priority areas for funding.
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9 This was linked to managerial inertia: "*endoscopy as an area was never effectively managed*"
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11 (FG2.1). In Wales, lack of support from external sources such as the Welsh Assembly
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13 Government, was an additional problem.
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20 4 *Differences between English and Welsh units*

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22 Focus group participants in Wales emphasised the high level of camaraderie across units, close
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24 unit links and strongly supportive nursing teams: "*We do work well together*" (FG2.1). However,
25
26 Welsh units were seen as lagging behind their English counterparts regarding: resource
27
28 availability, Government and Trust support, good management, colorectal screening and
29
30 technical development. The changes made in English units, as a result of the work of the
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32 NHSMA, were described in predominantly positive terms, but similar changes in Wales were at a
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34 much slower pace:
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41 *We are lagging behind – the waiting times in England are much better than in Wales.*

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43 *Colorectal cancer screening we are lagging probably two years behind, and some of the*
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45 *technological developments, again we are lagging behind.* (FG3.6)
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51 However this has had its advantages, as Welsh units could learn from their English counterparts,
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53 and could take care not to repeat their mistakes. No major differences were mentioned regarding
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55 clinical outcomes, indeed, Welsh units were seen as on a par with their English counterparts,
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57 learning from their experiences: "*We have been fortunate; various GI meeting speakers from*
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3 *these kinds of organisations came to Wales and presented case work” (FG3.3). Nevertheless,*
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5 there was still a strong sense that Welsh units lacked recognition amongst the wider healthcare
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7 community for the excellent work they were doing and the changes they had already made
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9 toward an improved service. Lack of recognition led to a great deal of scepticism that funding
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11 and other resources would be made available from external sources.
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14 15 16 17 **DISCUSSION** 18

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21 This study has identified important issues that need to be addressed at a local level when
22
23 modernising endoscopy services.
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28 In recognition of the fact that effective change to complex systems such as hospital services
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30 requires team effort and close group working,[13] we believe the use of focus groups was a good
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32 method for addressing this study’s aims, and we chose summative analysis to identify key
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34 themes.
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39 Summative analysis aims to disclose essential elements of a text – the indispensable aspects
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41 without which the whole would lack meaning.[10] The technique moves from an essential to a
42
43 broad canvas, unlike other qualitative analysis approaches, which start with a broad presentation
44
45 and hone data down to their defining elements.[14,15] Thematic analysis aims to clarify complex
46
47 textual data according to themes and concomitant categories, to remove any textual ambiguity
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49 through coding structures at the same time as retaining a text’s unique nuance.[14,15]
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54 Combining these methods can ensure that core concepts are revealed in thematic format
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56 alongside brief summations of focus group content. In combination, these methods can add to the
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3 veracity of a study's findings.[16] Analysed materials are fine-tuned through discussion and
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5 refinement that takes place through a number of group-working sessions following data capture,
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7 during which analysts work collaboratively and equitably.
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10 11 12 **Disadvantages of the study**

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15 The number participating was small but this is often the case in qualitative studies that aim for
16
17 depth rather than breadth of data disclosure. Furthermore, we aimed to ensure participants
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19 covered the range of medical, surgical and nursing professions involved in gastroenterological
20
21 endoscopy, and that the hospitals they were working in were both teaching and district general,
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23 and located in different regions (for example, in the north and south of the country and in the
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25 Midlands). We have no reason to believe their views were not representative of the wider
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27 gastroenterological professional population.
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32 The approach we used enriched understanding across the group and suggested a wide range of
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34 methodological possibilities for using these techniques in other gastroenterological research.
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38 The findings indicate changes towards modernisation have taken place despite limited investment
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40 in innovation in units. However, with extensive barriers still being reported, this has led to a
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42 particularly disillusioned and dispirited workforce, especially noticeable in Welsh units, where
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44 people appear frustrated with the lack of Trust or hospital management systems in place to
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46 effectively support their work and the ambitions of their units. Add to this a sense of lack of
47
48 visibility within Trusts, and the belief that decisions being made are not evidence based and do
49
50 not take account of clinical expertise, and we find units that are unable to make appropriate, long-
51
52 lasting changes to service delivery and organisation, aggravated by notions of resource deficit.
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3 This study has indicated that to achieve the positive, sustainable effects of modernisation, senior
4 management should actively support innovations, particularly by considering staff morale and
5 appropriate funding. This is in keeping with guidelines developed to support a range of
6 gastroenterological procedures and diseases, for example, Inflammatory Bowel Disease, which
7 emphasise the value of strong team working and good administrative, clinical and managerial
8 support to ensure units achieve optimal patient management.[17] The study emphasises the
9 importance of staff being fully conversant with, and supportive of, managerial decision-making.
10 Indeed, for change to service organisation and delivery to be both successful and sustainable in
11 the longer-term, the literature emphasises the value of fully accommodating clinicians, towards:
12 “a mixed clinico-managerial perspective”.[18] This, it is argued, will ensure a positive approach
13 to: “reengineering within clinical settings”.[19] However, although professional morale is low,
14 and staff appear frustrated by the lack of senior management support, the ambition to improve
15 services amongst senior clinical staff is still strong.

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36 This study was undertaken as part of a wide exploration of the effectiveness of the Modernising
37 Endoscopy Services (MES) Programme of the NHSMA. Whilst the MES Programme was shown
38 to have acted as a catalyst for change by affecting the way staff work, communicate and think, it
39 was not shown to have been effective in heralding change itself. Nevertheless, participants
40 identify the potential for real change and modernisation to units to the benefit of all. Changes
41 alluded to in these focus groups, such as improvements to service allocation and waiting times, in
42 keeping with greater observance of patient need, support quality improvement and assessment for
43 endoscopy services. Along with the Global Rating Scale (GRS) [20] (an assessment tool for
44 endoscopy units to assess how well they provide a patient-centred service), and Bowel Cancer
45 Screening Programme [21] such changes, fully supported by clinical unit staff and managers,
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3 could have a substantial impact on future targets and funding allocation, raising both the political
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5 visibility of the units and the image of units on the ground.
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10 **ACKNOWLEDGEMENTS**

11
12 We would like to thank all those involved in this quasi-experimental study and those who agreed
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14 to take part in focus groups and in qualitative analysis sessions.
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20 **COMPETING INTERESTS**

21
22 None
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36 authors and do not necessarily reflect those of the Department of Health.
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CONTRIBUTORSHIP STATEMENT

Frances Rapport was the lead author and helped run all the Focus Groups and analyse data

Anne Seagrove supported Focus Group running and observed some of the Focus Groups. She also supported writing and reviewing the article.

Hayley Hutchings was involved in designing the qualitative elements of ENIGMA and took a major role in reviewing drafts of this paper.

Ian Russell was the lead Trialist on ENIGMA and took part in the group work to analyse the qualitative data as well as supporting all written drafts and iterations of this paper.

Ivy Cheung helped design the qualitative element of the ENIGMA study, took part in analysing the qualitative data and input into all drafts of this paper.

John Williams designed ENIGMA, was the study's PI, supported the qualitative element of study development, took part in analysing the qualitative data and input into all drafts of this paper.

David Cohen was the lead health economist on ENIGMA. He helped develop the Focus Group sessions, input into group-working underpinning data analysis and input into all drafts of this paper.

References

- 1 Williams JG, Roberts SE, Ali MF, et al. Gastroenterology services in the UK: the burden of disease, and the organisation and delivery of services for gastrointestinal and liver disorders: a review of the evidence. *Gut* 2007;**56**:1-113.
- 2 Equity and Excellence: Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 date accessed: November 3rd 2011.

- 1
2
3 **3** Together for Health: A five-year vision for the NHS in Wales
4
5 <http://wales.gov.uk/docs/dhss/publications/111101togetheren.pdf> date accessed:
6
7 November 1st 2011.
8
9
- 10 **4** Seale C, Gobo G, Gubrium JF, et al. eds. *Qualitative Research Practice*. London: Sage
11
12 2004:435-57.
13
- 14 **5** Williams JG, Cheung WY, Cohen D, et al. Evaluating innovations in the delivery and
15
16 organisation of gastroenterology services initiated directly or indirectly by the
17
18 Modernising Endoscopy Services programme of the NHS Modernisation Agency:
19
20 (ENIGMA) 2008. <http://www.sdo.nihr.ac.uk/files/project/46-final-report.pdf> date
21
22 accessed: January 23rd 2012.
23
24
- 25 **6** Bloor M, Frankland J, Thomas M, et al. *Focus Groups in Social Research*. London: Sage
26
27 2001:37-58.
28
29
- 30 **7** Hutchings H, Rapport F, Wright S, et al. Obtaining consensus regarding patient-centred
31
32 professionalism in community pharmacy: nominal group work activity with professionals
33
34 and members of the public. *Int J Pharm Prac* 2010;**18**:149-58.
35
36
- 37 **8** Kitzinger J. The methodology of focus groups: the importance of interactions between
38
39 research participants. *Soc Heal Ill* 1994;**16**:103-21.
40
41
- 42 **9** Pope C, Mays N, eds. *Qualitative Research in Healthcare*. Oxford: Blackwell Publishing
43
44 Ltd 2006:21-31.
45
46
- 47 **10** Rapport F. Summative Analysis: A new qualitative research method. *Int J Qual Method*
48
49 2010;**9**:270-90.
50
51
- 52 **11** Hammond CL, Thomas RH, Rees MI, et al. Implications for families of advances in
53
54 understanding the genetic basis of epilepsy. *Seizure – Diamond Issue* (Epub:20 Nov
55
56 2010), **19**:675-79.
57
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59
60
- 12 Iredale R, Rapport F, Sivell S, et al. Exploring the requirements for a decision aid on familial breast cancer in the UK context: a qualitative study with patients referred to a cancer genetics service. *J Eval Clin Prac* 2008;**14**:110-15.
- 13 Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *J Am Med Assoc* 2004;**291**:1246-51.
- 14 Denzin N, Lincoln Y. Handbook of Qualitative Methods. Thousand Oaks, CA: Sage Publications 2000:869-87.
- 15 Robson C. Real World Research. Oxford: Blackwell 2002:465-95.
- 16 Rapport F, Doel MA, Hutchings HA, et al. Through the looking glass: public and professional perspectives on patient-centred professionalism in modern-day community pharmacy. *FQS* 2010;**11**: Art. 7 <http://nbn-resolving.de/urn:nbn:de:0114-fqs100177> date accessed: October 20th 2011.
- 17 Carter MJ, Lobo AJ, Travis SPL et al. Guidelines for the management of inflammatory bowel disease in adults. *Gut* 2004;**53**:1-16.
- 18 Berwick DM, Nolan TW. Physicians as leaders in improving health care: a new series in Annals of Internal medicine. *Annal Intern Med* 1998;**128**:289-92.
- 19 McNulty T, Ferlie E. Reengineering Health Care: The Complexities of Organizational Transformation. Oxford: Oxford University Press 2004:45-77.
- 20 GRS Link <http://www.globalratingscale.com>.
www.grs.wales.nhs.uk/Documents/GRS/Wales_Actions_2007.doc date accessed: December 4th 2011.
- 21 NHS Bowel Cancer Screening Programme <http://www.cancerscreening.nhs.uk/bowel/> date accessed: January 30th 2012.

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3 RATS guidelines have been adhered to:
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7 R Relevance – research question explicitly stated
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9 Research question linked to existing knowledge, current literature aims and objectives
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11 A Appropriate – Focus Groups considered the most appropriate method of data collection, for non-
12 sensitive topic, and convenient for a sample of busy gastroenterologists
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14 T Transparent – Sampling strategy was transparent. Purposive sampling allowed for a wide-range of
15 views from a mixture of gastroenterology specialists working in the field of endoscopy
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17 S Sound – Analysis linked to methods of data collection. Groupwork with a range of health
18 professionals, qualitative methodologists, academics and researchers using summative and thematic
19 analysis techniques, facilitated by the lead methodologist (a qualitative research expert) ensured
20 that the most appropriate approach was employed for considering rich in-depth material by the
21 team.
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Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy Services in England and Wales: a focus group study

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Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy**Services in England and Wales: a focus group study**

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24 delivery; professional practice.

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Running Header: **A focus group study evaluating change in endoscopy services**

Barriers and Facilitators to Change in the Organisation and Delivery of Endoscopy Services in England and Wales: a focus group study

ABSTRACT

Objective: Explore professional views of changes to gastroenterology service organisation and delivery and barriers and facilitators impacting on change. The work was undertaken as part of an evaluation in endoscopy service provision catalysed by the Modernising Endoscopy Services Programme of the Modernisation Agency.

Design: Focus groups followed by **analysis and** group-working activities **identifying key themes**.

Setting: English and Welsh secondary care gastroenterology units.

Participants: 20 professionals working in gastroenterology in England and Wales. Medical, surgical and nursing specialists **including endoscopy nurses**. **Opportunistic** sampling to include senior people in leadership and management roles who were directly involved in service modernisation, excluding those involved in the Modernisation Endoscopy Services Programme.

Results: 4, one and a half hour focus groups took place **in 2007**. Summative and thematic analyses captured essential aspects of text and achieved consensus on key themes. 4 themes were revealed: 'loss of personal autonomy and erosion of professionalism', 'lack of senior management understanding', 'barriers and facilitators to change', and 'differences between English and Welsh units'. Themes indicated that low staff morale, lack of funding and senior management support were barriers to effective change. **Limitations to the study include the disproportionately low number of focus group attendees from English units and the time delay in reporting these findings**.

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9 **Conclusion:** Despite ambitions to implement change, ineffective management support continued
10 to hamper modernisation of service organisation and delivery. Whilst the National Health
11 Service Modernisation Agency (NHSMA) Modernising Endoscopy Services Programme acted as
12 a catalyst for change, affecting the way staff work, communicate and think, it was not effective in
13 heralding change itself. However, gastroenterologists were keen to consider the potential for
14 change and future service modernisation. The methodological framework of innovative
15 qualitative inquiry offers comprehensive and rigorous enhancement of quantitative studies,
16 including randomised trials, when a mixed methods approach is needed.
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25 **ARTICLE SUMMARY**

26 **Article Focus**

- 27 • Examine the opinions of gastroenterologists and endoscopy nurses regarding the
28 effects of change on service organisation and delivery;
- 29 • Establish views regarding the impact of change on professional practice and self
30 identity;
- 31 • Describe barriers and facilitators to change in gastroenterological endoscopy services
32 and across units in England and Wales to explore differences.
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43 **Key Messages**

- 44 • GI consultants, surgeons and endoscopy nurses described barriers to change and
45 service modernisation resulting largely from lack-lustre senior management support,
46 inadequate funding, and low staff morale;
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- The Modernising Endoscopy Services (MES) Programme raised the profile of change, but was not effective in catalysing change itself. Nevertheless, participants saw real potential in overcoming barriers to change in order to promote future service modernisation;
- The methodological framework of innovative qualitative inquiry used in this study offers the opportunity for comprehensive and rigorous enhancement of quantitative studies, including randomised trials, when a mixed methods approach is needed.

Strengths and limitations of this study

- The study took place in 2007 but the findings offer a unique historical perspective on professional views at that time;
- This was a time when further efforts to promote modernisation of endoscopy services in England, through quality monitoring and accreditation of units was starting;
- The number of people participating in focus groups was small, however, the qualitative study was looking for depth rather than breadth of data disclosure;
- Participants covered a wide range of medical, surgical and nursing professions working in Gastroenterology and there is no reason to believe their views are not reliable and applicable to the wider Gastroenterology professional population.

DATA SHARING

There is no additional data available

INTRODUCTION

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11 This paper describes a focus group study that was undertaken five years ago as part of a wider
12 project designed to assess the impact of the Modernisation Agency's Modernising Endoscopy
13 Services (MES) Programme. The focus group study was included as an important element of the
14 mixed method study as it was recognised that it could offer a detailed understanding of how
15 changes to GI service organisation and delivery were affecting professionals' work life and
16 practices, their relationships with others within their units and with patients.
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24 Gastrointestinal disease continues to be recognised as the third most common cause of death in
25 the UK and the leading cause of cancer, and the burden of gastrointestinal disease on services in
26 the NHS is at a record high,[1] The rise in gastroenterology service workloads is causing
27 increasing difficulty in offering patients timely and appropriate appointments in hospitals, and in
28 maintaining appropriate, timely patient assessment, and effective, long-term support.
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35 To counter these difficulties, and to meet the challenges posed by radical reform of the NHS in
36 both England and Wales,[2,3] changes are needed in the organisation and delivery of services.

37 This study explored professional perceptions of the difficulties associated with this.
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43 OBJECTIVES

44 This qualitative study aimed to:
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- 49 ○ Consider the opinion of gastroenterologists and endoscopy nurses regarding the effects of
50 change on service organisation and delivery;
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- Establish views regarding the impact of change on professional practice and self identity;
- Describe barriers and facilitators to change in gastroenterological endoscopy services;
- Clarify perceptions of change to services across units in England and Wales; and,
- Explore whether there are different views in England and Wales.

METHOD

Participants

Qualitative data were captured through four focus groups involving medical, surgical and nurse specialists in gastroenterology focus groups based in England and Wales. Participants were identified from the British Society of Gastroenterology's list of all registered gastroenterologists in the UK. Potential participants were sent details of the study and asked to take part in a qualitative focus group. The sampling strategy was largely a convenience sample[4] in view of the difficulties in bringing busy GI clinicians and nurses together for UK-wide focus groups. The focus groups were designed around two major Gastroenterology events: a) the annual British Society of Gastroenterology (BSG) Conference in Birmingham, and b) the Welsh Association of Gastroenterology and Endoscopy (WAGE) annual meeting in Wales. Holding focus groups at these two events presented greater opportunity for wider audience participation, and allowed the team to target many senior GI people, who held leadership and management roles and were, therefore, directly involved in service modernisation, but were not involved in the MES Programme.[5]

Focus groups

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9 The focus groups aimed to clarify professional understanding of changes that had already taken
10 place and their impact on modernising service organisation and delivery, in order to assess the
11 acceptability of innovative models of referral, diagnosis and follow-up. All focus groups
12 examined barriers and facilitators to change and the impact of change on professional practice
13 and self-identity.
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20 The four focus groups were designed to help elicit views and opinions using consensus-building
21 activities.[6,7] An observer was present, to observe proceedings, manage any equipment and
22 examine issues of group dynamics. A facilitator familiar with the study and its aims facilitated
23 the event, asking pertinent questions and, where necessary, giving prompts for answers.[8,9]
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29 Each focus group lasted 90 minutes, and followed a pre-designed interview schedule to uphold
30 rigour and maintain methodological consistency. The schedule was based on the study aims and
31 an in-depth literature search, which had identified a wide range of issues relating to: staffing,
32 funding, impact of change, facilitators and barriers to change, effects of modernisation on
33 services, extent and rate of change and changes undertaken across units. A financial contribution
34 was offered to all focus group participants in recognition of their time.
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42 Four focus groups were conducted: one in England and three in Wales. In the English focus
43 group (FG1), 13 gastroenterologists agreed to take part and five actually participated. In the
44 Welsh focus groups, 18 gastroenterologists agreed to take part and 15 actually participated (FG2
45 = 3, FG3 = 6, FG4 = 6) (Total n=20). Participants represented five different endoscopy units in
46 England and nine different units in Wales. Across the total sample of 15 participants in the Welsh
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9 focus groups, one unit was represented by four participants, three units were represented by two
10 participants each, and the five remaining units were represented by one person each.
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14 FG1 comprised three GI consultants, one GI surgeon and one endoscopy nurse. FG2 comprised
15 one GI consultant and two endoscopy nurses, FG3 comprised three GI consultants and three GI
16 surgeons and FG4 comprised three GI consultants and three GI surgeons.
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20 21 22 **ANALYSIS** 23

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25 Data were analysed using both thematic and summative analysis frameworks.[4,10] The analytic
26 frameworks were chosen as the most appropriate for capturing rich narratives from in-depth
27 analysis, and to allow mixed groups of health professionals, academics and researchers to work
28 together cohesively, irrespective of their differences in terms of qualitative methodological
29 expertise.[10-12]
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36 Data analysis was undertaken by a multidisciplinary group representing gastroenterology, clinical
37 trials, psychology, health services research and statistics. They took part in two group-working
38 sessions to discuss the initial results of thematic analysis presented as summative paragraphs.
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42 43 **Ethics** 44

45 Ethical approval was granted by the Wales Multicentre Research Ethics Committee. Written
46 consent was obtained from study participants to take part in tape-recorded focus groups.
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RESULTS

Similar issues were identified across English and Welsh focus groups with little variation and four key themes emerged: ‘loss of personal autonomy and erosion of professionalism’; ‘lack of senior management understanding’; ‘barriers and facilitators to change’; and ‘differences between English and Welsh units’. The basis for these themes is described below alongside verbatim quotations (grammatical irregularities remain unaltered).

1 Loss of personal autonomy and erosion of professionalism

Lack of recognition by senior management for the work of the units, lack of steer from the Government or match between political, managerial and unit agendas, low profiles for endoscopy, and factional discord between different professional groups led to disillusionment, particularly amongst senior GI physicians and surgeons. Individual autonomy was also eroded, whereby notions of professionalism are linked to an individual’s ability to make informed decisions that can impact on modernisation: “*clinical autonomy has gone*” (FG3.3). This led to a dispirited workforce feeling undervalued: “*we are now... seen as employees rather than professionals*”. (FG3.5):

If you want my Damascus moment, it was when somebody came back from a meeting sitting alongside a hospital administrator who said that consultants, as far as managers are concerned, are really on the level of a store manager. (FG3.2)

Low morale left professionals feeling disengaged and less likely to be flexible in adapting to change or taking on board new approaches to working: “*there is an attitude of suspicion*”

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9 (FG1.1). Under-staffed units and staff deskilling was of particular concern, both for nurses and
10 consultants. Thus, whilst expansion was helpful, units appeared to be running without their full
11 complement of staff with no major drives to recruit additional staff. In addition, greater staff
12 specialisation, for example differences between GI physicians and surgeons, suggested the loss of
13 the professional ‘all-rounder’, with people working in different specialisations working
14 according to their own individual agendas and little clarity regarding who should be taking on
15 which tasks:
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24 *I would like to see a Welsh health strategy that decides what’s being done and where, so it*
25 *actually happens, with enough people to do it sufficiently specialised and not everybody*
26 *trying to do everything everywhere. (FG4.2)*
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31 Nurses are particularly demoralised, spending less time caring for patients and more time doing
32 paperwork: “Nurse morale is really low and if they don’t do something they’ll all be leaving”
33 (FG1.4).
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39 Low morale and low team spirit can be countered, to a certain extent, by strong medical and
40 nurse leadership, with a few motivated individuals making a difference and pulling everyone
41 together. However, this sense of integration and belonging in the face of adversity was also
42 described as the ‘sinking ship’ mentality, having the negative effect of bringing everybody down:
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46 *“People stick together because there is only one life raft” (FG4.2).*
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2 Lack of senior management understanding

Lack of senior management understanding of the work of the units and the needs of its members, and lack of appropriate management systems to underpin the work of units was an overarching theme across both English and Welsh focus groups. Units could not make long-lasting changes to service organisation and delivery, whilst decisions around unit change and changes to the process of care delivery were taken by ill-informed management with no scientific or clinical expertise. This was exacerbated by a lack of funding, particularly in Wales, and extensive resource deficit that left a deflated workforce with little sense of professional status. Participants perceived management as favouring Government-driven targets within a top-down, managerial environment. In Wales in particular, there was a conflict of interests between groups of professionals, such as surgical and medical specialists, and discordance around the use of space and resources: *“I think historically, if you look at the way endoscopy services sit in most Trusts, they don’t sit very easily in one service group”* (FG4.4).

Conflicting interests between staff and management were noted and senior management was seen as out of touch, reactionary and not to be trusted: *“management have their own agenda in terms of fulfilling their local delivery plans”* (FG4.4). Moreover, new target-driven political and managerial directives engendered bureaucracy and legislation, creating extensive paperwork and adding to the work of staff, especially nurses.

There were difficulties convincing senior managers of the importance of endoscopy, and many layers of red tape. If management were supportive then change was effected, but this was often only the case in crisis management: *“This is a reactionary, entirety management when crises*

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9 arise” (FG4.1). Management was highly distrusted, and management systems were noted as
10 being: “an enormous and complex labyrinth” (FG4.2). Middle managers were perceived as
11 pressurised by senior managers to reach targets, and clinicians wanted to bring about change
12 without targets attached. Lack of communication between clinicians and managers furthered this
13 sense of frustration and futility. To overcome these hurdles, decisions were often made
14 irrespective of the medical evidence, patient need or the immediacy of the problem:
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22 *In practical treatment the changes we want to bring have to be evidence-based. I cannot*
23 *suddenly go and do something to a patient, which I think is right, irrespective of what the*
24 *data shows. But changes are applied to us through the political and management system*
25 *and there is no evidence. (FG3.1)*
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30 31 3 Barriers and facilitators to meaningful change 32 33

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35 Groups discussed the reduction in waiting times as the main facilitator for change, alongside
36 ‘pooled lists’ and ‘flexible staff working arrangements’: “our waiting list has dropped a lot”
37 (FG3.4). However, this was not discussed in terms of better patient care or enhanced quality of
38 care. Indeed, patient outcomes such as greater patient satisfaction with services, patient-centred
39 care or changes for the good of the patient were predominantly absent from focus group
40 discussion, at odds with the weight of discussion that concentrated on service re-evaluation
41 toward performance-related goals and targets. Reduced waiting times were considered in
42 accordance with the need to meet Government targets for improved service provision, and as
43 something easily measured. This created: “a depressed atmosphere” and “distressing times”
44 (FG3.1) and led to healthcare services that were unable to cater to even the most basic of patient
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9 needs. It was also mentioned that the implementation of the new consultant contract led to a
10 decrease in working hours and consequently the quality of patient care that could be offered had
11 fallen.
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16 English focus group participants were keen to express their support for the modernisation of
17 endoscopy units, the improvement of services through change and the innovation of service
18 delivery.
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24 Beside reduction in waiting times, other facilitators for change included: fast tracking of patients,
25 more nurse endoscopists, new guidelines for referral and management of endoscopies, 'prep'
26 nurses and more specialist staff. Longer waiting lists were also, paradoxically, seen as a
27 facilitator for change, encouraging the generation of new resources and acting as an impetus for
28 the fulfilment of waiting list targets.
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35 Barriers to change related to lack of senior management support and understanding, lack of funds
36 and the slow speed with which change was occurring: *"It's not change that is the problem it's the*
37 *rate of change"* (FG1.3). Exacerbated by managerial decision-making bereft of unit input, focus
38 group participants talked at length about: lack of funding, lack of leadership, poor skill mix, and
39 the difficulties different specialties had sharing endoscopy facilities. At that time, the absence of
40 a National Service Framework for gastroenterology, poor quality information at the point of
41 referral from general practitioners regarding prioritisation of patients, and lack of interest at an
42 executive level did little to enhance a sense of self-worth. Endoscopy units were not recognised
43 for their cutting edge work, and consequently were not at the top of the Trusts' lists of priority
44 areas for funding. This was linked to managerial inertia: *"endoscopy as an area was never*
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9 *effectively managed*” (FG2.1). In Wales, lack of support from external sources such as the Welsh
10 Assembly Government, was an additional problem.

11 12 13 14 4 *Differences between English and Welsh units*

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17 Focus group participants in Wales emphasised the high level of camaraderie across units, close
18 unit links and strongly supportive nursing teams: “*We do work well together*” (FG2.1). However,
19 Welsh units were seen as lagging behind their English counterparts regarding: resource
20 availability, Government and Trust support, good management, colorectal screening and
21 technical development. The changes made in English units, as a result of the work of the
22 NHSMA, were described in predominantly positive terms, but similar changes in Wales were at a
23 much slower pace:
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31 *We are lagging behind – the waiting times in England are much better than in Wales.*

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33 *Colorectal cancer screening we are lagging probably two years behind, and some of the*
34 *technological developments, again we are lagging behind.* (FG3.6)
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39 However this had its advantages, as Welsh units could learn from their English counterparts, and
40 could take care not to repeat their mistakes. No major differences were mentioned regarding
41 clinical outcomes, indeed, Welsh units were seen as on a par with their English counterparts,
42 learning from their experiences: “*We have been fortunate; various GI meeting speakers from*
43 *these kinds of organisations came to Wales and presented case work*” (FG3.3). Nevertheless,
44 there was still a strong sense that Welsh units lacked recognition amongst the wider healthcare
45 community for the excellent work they were doing and the changes they had already made
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9 toward an improved service. Lack of recognition led to a great deal of scepticism that funding
10 and other resources would be made available from external sources.
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13 14 **DISCUSSION**

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17 Although conducted five years ago, this study identified important issues that needed to be
18 addressed at a local level at that time when modernising endoscopy services. It revealed
19 considerable concern regarding barriers to modernisation, particularly in Wales, where progress
20 was slower than in England and these differences between England and Wales continue to have
21 relevance to this day. In 2012, for example, only one unit in Wales, out of the full complement of
22 18, was formally accredited by the Joint Advisory Group on GI Endoscopy (JAG), responsible
23 for inspection and accreditation of endoscopy units in the UK. This is compared to the majority
24 of units accredited in England, where considerable efforts have been made to engage clinicians
25 and management in modernisation. Accreditation of endoscopy units is essential, and clearly
26 aligned to JAG's core objectives: To agree and set acceptable standards for competence in
27 endoscopic procedures and training, and to quality assure services.
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40 In recognition of the fact that effective change to complex systems such as hospital services
41 requires team effort and close group working,[13] we believe the use of focus groups was a good
42 method for addressing this study's aims, and we chose summative analysis to identify key
43 themes.
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49 Summative analysis aims to disclose essential elements of a text – the indispensable aspects
50 without which the whole would lack meaning.[10] The technique moves from an essential to a
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9 broad canvas, unlike other qualitative analysis approaches, which start with a broad presentation
10 and hone data down to their defining elements.[14,15] Thematic analysis aims to clarify complex
11 textual data according to themes and concomitant categories, to remove any textual ambiguity
12 through coding structures at the same time as retaining a text's unique nuance.[14,15]
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15 Combining these methods can ensure that core concepts are revealed in thematic format
16 alongside brief summations of focus group content. In combination, these methods can add to the
17 veracity of a study's findings.[16] Analysed materials are fine-tuned through discussion and
18 refinement that takes place through a number of group-working sessions following data capture,
19 during which analysts work collaboratively and equitably.
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28 **Study limitations**

29 A major study limitation was the poor representation of the NHS in England, through low focus
30 group attendance numbers. Whilst 13 focus group members had originally signed up to take part
31 in three English focus groups, planned for lunchtime sessions during the annual BSG Conference
32 (in keeping with 15 members attending three focus groups in Wales), the actual number was
33 greatly diminished to five. This was due to unforeseen clashes in timetabling. The study team
34 decided to continue with a single focus group, recognising the opportunities for comparative data
35 that would deepen understanding of data. In qualitative studies it is often argued that depth rather
36 than breadth of data disclosure is the more desirable outcome.
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46 The English focus group resulted in additional information substantiating the views of those
47 based in Wales, and combined datasets yielded richer information than single datasets could have
48 alone. Comparing views revealed important insights into the nuance of service delivery. For
49 example, whilst GI services were developing along similar lines, Welsh services lagged behind in
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9 terms of the pace of change. This was frustrating for those working in Wales, who perceived an
10 imbalance in service priority whilst recognising the opportunities afforded by learning from the
11 mistakes of their English counterparts.
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16 Furthermore, whilst numbers were small, attendees from England represented medical, surgical
17 and nursing professions involved in gastroenterological endoscopy, including endoscopy nurses,
18 and GI practitioners based in both teaching and district general hospitals located in different
19 English regions (for example, in the north and south of the country and in the Midlands). Whilst
20 we cannot claim a representative sample, we can defend the data's reliability.
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28 The study was conducted in 2007, at a time when the Global Rating Scale (GRS)[17] (an
29 assessment tool for endoscopy units to assess how well they provide a patient-centred service)
30 was just being implemented, and modernisation of endoscopy units was proving challenging.
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32 The gap in reporting these findings is a major limitation, but does provide a unique historical
33 perspective of the trajectory of GI service development and modernisation of relevance to the
34 present day. The challenges that service leaders and managers faced in 2007 add a new
35 perspective to policy making today, as the NHS embarks on another period of modernisation,
36 further challenged by considerable resource constraint.
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45 This paper indicates that the impact of change on a GI professional's sense of self-worth, and the
46 knock-on effects on GI unit cohesion can be exacerbated by a perceived lack of support from
47 Trust management. In particular, the sense of disillusionment within the workforce in 2007 was
48 intensified by the difficulties of senior clinicians and nurses, unable to share a common vision
49 with those that had the power to make change in the NHS. Extensive barriers were reported,
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9 especially noticeable in Welsh units, where people **were** frustrated with the limited Trust or
10 hospital management systems in place to effectively support their work and the ambitions of their
11 units. Added to this was a sense of lack of visibility within Trusts, and the belief that decisions
12 were being made that were not evidence-based and did not take account of clinical expertise.
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16 **Much has happened since this time, including the uptake and use of the GRS, and further**
17 **divergence of NHS organisation between England and Wales, but we would be wise to keep**
18 **abreast of the mood of clinicians and the difficulties they face.**
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24 **Future opportunities**

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26 The approach we used enriched understanding across the group and suggested a wide range of
27 methodological possibilities for using these techniques in other gastroenterological research.

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29 The findings indicate that changes towards modernisation **can occur** despite limited investment in
30 innovation.
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35 This study has indicated that to achieve the positive, sustainable effects of modernisation, senior
36 management should actively support innovation, particularly by considering staff morale and
37 appropriate funding. This is in keeping with guidelines developed to support a range of
38 gastroenterological procedures and diseases, for example, Inflammatory Bowel Disease, which
39 emphasises the value of strong team working and good administrative, clinical and managerial
40 support to ensure units achieve optimal patient management.[18] The study also indicated the
41 importance of staff being fully conversant with, and supportive of, managerial decision-making.
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48 Indeed, for change to service organisation and delivery to be both successful and sustainable in
49 the longer-term, the literature highlights the value of fully accommodating clinicians, towards: “a
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9 mixed clinico-managerial perspective”.^[19] This, it is argued, will ensure a positive approach to:
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11 “reengineering within clinical settings”.^[20]
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14 This study was undertaken as part of a wider exploration of the effectiveness of the Modernising
15 Endoscopy Services (MES) Programme of the NHSMA. Whilst the MES Programme was shown
16 to have acted as a catalyst for change by affecting the way staff work, communicate and think, it
17 was not perceived as effective in heralding change itself. Nevertheless, participants identified the
18 potential for real change and modernisation to units to the benefit of all. Changes alluded to in
19 these focus groups, such as improvements to service allocation and waiting times were in keeping
20 with greater observance of patient need, and support for quality improvement and assessment for
21 endoscopy services. Along with the Global Rating Scale (GRS)^[17], and Bowel Cancer
22 Screening Programme^[21] such changes, fully supported by clinical unit staff and managers,
23 could have a substantial impact on future targets and funding allocation, raising both the political
24 visibility of GI units and the image of units on the ground.
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39 to take part in focus groups and in qualitative analysis sessions.
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45 None
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11 authors and do not necessarily reflect those of the Department of Health.
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14 15 16 **CONTRIBUTORSHIP STATEMENT**

17 Frances Rapport was the lead author and helped run all the Focus Groups and analyse data

18 Anne Seagrove supported Focus Group running and observed some of the Focus Groups. She
19 also supported writing and reviewing the article.
20
21

22 Hayley Hutchings was involved in designing the qualitative elements of ENIGMA and took a
23 major role in reviewing drafts of this paper.
24
25

26 Ian Russell was the lead Trialist on ENIGMA and took part in the group work to analyse the
27 qualitative data as well as supporting all written drafts and iterations of this paper.
28
29

30 Ivy Cheung helped design the qualitative element of the ENIGMA study, took part in analysing
31 the qualitative data and input into all drafts of this paper.
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33

34 John Williams designed ENIGMA, was the study's CI, supported the qualitative element of study
35 development, took part in analysing the qualitative data and input into all drafts of this paper.
36
37

38 David Cohen was the lead health economist on ENIGMA. He helped develop the Focus Group
39 sessions, input into group-working underpinning data analysis and input into all drafts of this
40 paper.
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45 **References**

- 46
47 1 Williams JG, Roberts SE, Ali MF, et al. Gastroenterology services in the UK: the burden
48 of disease, and the organisation and delivery of services for gastrointestinal and liver
49 disorders: a review of the evidence. *Gut* 2007;**56**:1-113.
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54

- 2 Equity and Excellence: Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 date accessed: November 3rd 2011.
- 3 Together for Health: A five-year vision for the NHS in Wales
<http://wales.gov.uk/docs/dhss/publications/111101togetheren.pdf> date accessed: November 1st 2011.
- 4 Quinn-Patton M. (Ed.) Qualitative Research and Evaluation Methods Edition 3. Thousand Oaks, CA: Sage Publications.
- 5 Williams JG, Cheung WY, Cohen D, et al. Evaluating innovations in the delivery and organisation of gastroenterology services initiated directly or indirectly by the Modernising Endoscopy Services programme of the NHS Modernisation Agency: (ENIGMA) 2008. <http://www.sdo.nihr.ac.uk/files/project/46-final-report.pdf> date accessed: January 23rd 2012.
- 6 Bloor M, Frankland J, Thomas M, et al. Focus Groups in Social Research. London: Sage 2001:37-58.
- 7 Hutchings H, Rapport F, Wright S, et al. Obtaining consensus regarding patient-centred professionalism in community pharmacy: nominal group work activity with professionals and members of the public. *Int J Pharm Prac* 2010;**18**:149-58.
- 8 Kitzinger J. The methodology of focus groups: the importance of interactions between research participants. *Soc Heal Ill* 1994;**16**:103-21.
- 9 Pope C, Mays N, eds. Qualitative Research in Healthcare. Oxford: Blackwell Publishing Ltd 2006:21-31.
- 10 Rapport F. Summative Analysis: A new qualitative research method. *Int J Qual Method* 2010;**9**:270-90.

- 1
2
3
4
5
6
7
8
9 **11** Hammond CL, Thomas RH, Rees MI, et al. Implications for families of advances in
10 understanding the genetic basis of epilepsy. *Seizure – Diamond Issue* (Epub:20 Nov
11 2010), **19**:675-79.
12
13
14 **12** Iredale R, Rapport F, Sivell S, et al. Exploring the requirements for a decision aid on
15 familial breast cancer in the UK context: a qualitative study with patients referred to a
16 cancer genetics service. *J Eval Clin Prac* 2008;**14**:110-15.
17
18
19 **13** Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *J*
20 *Am Med Assoc* 2004;**291**:1246-51.
21
22
23 **14** Denzin N, Lincoln Y. *Handbook of Qualitative Methods*. Thousand Oaks, CA: Sage
24 Publications 2000:869-87.
25
26
27 **15** Robson C. *Real World Research*. Oxford: Blackwell 2002:465-95.
28
29
30 **16** Rapport F, Doel MA, Hutchings HA, et al. Through the looking glass: public and
31 professional perspectives on patient-centred professionalism in modern-day community
32 pharmacy. *FQS* 2010;**11**: Art. 7 <http://nbn-resolving.de/urn:nbn:de:0114-fqs100177> date
33 accessed: October 20th 2011.
34
35
36
37 **17** GRS Link <http://www.globalratingscale.com>.
38
39 www.grs.wales.nhs.uk/Documents/GRS/Wales_Actions_2007.doc date accessed:
40 December 4th 2011.
41
42
43 **18** Carter MJ, Lobo AJ, Travis SPL et al. Guidelines for the management of inflammatory
44 bowel disease in adults. *Gut* 2004;**53**:1-16.
45
46
47 **19** Berwick DM, Nolan TW. Physicians as leaders in improving health care: a new series in
48 *Annals of Internal medicine*. *Annal Intern Med* 1998;**128**:289-92.
49
50
51 **20** McNulty T, Ferlie E. *Reengineering Health Care: The Complexities of Organizational*
52 *Transformation*. Oxford: Oxford University Press 2004:45-77.
53
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9 21 NHS Bowel Cancer Screening Programme <http://www.cancerscreening.nhs.uk/bowel/>

10 date accessed: January 30th 2012.
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3 RATS guidelines have been adhered to:
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7 R Relevance – research question explicitly stated
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9 Research question linked to existing knowledge, current literature aims and objectives
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11 A Appropriate – Focus Groups considered the most appropriate method of data collection, for non-
12 sensitive topic, and convenient for a sample of busy gastroenterologists
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14 T Transparent – Sampling strategy was transparent. Purposive sampling allowed for a wide-range of
15 views from a mixture of gastroenterology specialists working in the field of endoscopy
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17 S Sound – Analysis linked to methods of data collection. Groupwork with a range of health
18 professionals, qualitative methodologists, academics and researchers using summative and thematic
19 analysis techniques, facilitated by the lead methodologist (a qualitative research expert) ensured
20 that the most appropriate approach was employed for considering rich in-depth material by the
21 team.
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