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

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001009
Article Type:	Research
Date Submitted by the Author:	10-Feb-2012
Complete List of Authors:	Rapport, Frances; Swansea University, Medicine Seagrove, Anne; Swansea University, College of Medicine Hutchings, Hayley; Swansea University, College of Medicine Russell, Ian; Swansea University, College of Medicine Cheung, Ivy; Swansea University, College of Medicine Williams, John; Swansea University, College of Medicine Cohen, David; University of Glamorgan, Faculty of Health, Sport and Science
Primary Subject Heading:	Gastroenterology and hepatology
Secondary Subject Heading:	Qualitative research, Health services research
Keywords:	Gastroenterology < INTERNAL MEDICINE, QUALITATIVE RESEARCH, Endoscopy < GASTROENTEROLOGY, Adult gastroenterology < GASTROENTEROLOGY

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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Keywords: Barriers and facilitators to change; focus group research; service organisation and delivery; professional practice.

Word count: 3090

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 gastroenterological 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 group-working activities.

Setting: Secondary care gastroenterology units in England and Wales.

Participants: In England 13 GI professionals agreed to participate and five participated. In Wales 18 GI professionals agreed to participate and 15 participated. Participants were medical, surgical and nursing specialists in gastroenterology. Purposive sampling led to inclusion of senior people who held leadership and management roles and who were, therefore, directly involved in service modernisation, and exclusion of those involved in the Modernisation Endoscopy Programme.

Results: Four, one and a half hour focus groups took place in 2007. Summative and thematic analyses captured essential aspects of text in summative and thematic formats and achieved consensus on key themes. Four 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 lack of senior management support are barriers to effective change.

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

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 number of people participating in the 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 representative of the wider Gastroenterological professional population.

DATA SHARING

There is no additional data available

INTRODUCTION

Gastrointestinal disease is recognised as the third most common cause of death in the UK and the leading cause of cancer, and the burden of gastrointestinal disease on services in the NHS is at a record high,[1] The rise in gastroenterology service workloads is causing increasing difficulty in offering patients timely and appropriate appointments in hospitals, and in maintaining appropriate, timely patient assessment, and effective, long-term support.

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

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

Focus groups

The focus groups aimed to clarify professional understanding of changes that had already taken place and their impact on modernising service organisation and delivery, in order to assess the acceptability of innovative models of referral, diagnosis and follow-up. All focus groups examined barriers and facilitators to change and the impact of change on professional practice and self-identity.

The four focus groups were designed to help elicit views and opinions using consensus-building activities.[6,7] An observer was present, to observe proceedings, manage any equipment and examine issues of group dynamics. A facilitator familiar with the study and its aims facilitated the event, asking pertinent questions and, where necessary, giving prompts for answers.[8,9]

Each focus group lasted 90 minutes, and followed a pre-designed interview schedule to uphold rigour and maintain methodological consistency. The schedule was based on the study aims and an in-depth literature search, which had identified a wide range of issues relating to: staffing, funding, impact of change, facilitators and barriers to change, effects of modernisation on services, extent and rate of change and changes undertaken across units. A financial contribution was offered to all focus group participants in recognition of their time.

Four focus groups were conducted in 2007: one in England and three in Wales. In the English focus group (FG1), 13 gastroenterologists agreed to take part and five actually participated. In the 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

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

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 has led to disillusionment, particularly amongst senior GI physicians and surgeons. Individual autonomy has also been 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 has 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 has 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"* (FG1.1). Under-staffed units and staff deskilling is of particular concern, both for nurses and consultants. Thus, whilst expansion is helpful, units appear to be running without their full complement of staff with no major drives to recruit additional staff. In addition, greater staff specialisation, for example differences between GI physicians and surgeons, suggests the loss of the professional 'all-rounder', with people working in different specialisations working according to their own individual agendas and little clarity regarding who should be taking on which tasks:

> *I would like to see a Welsh health strategy that decides what's being done and where, so it actually happens, with enough people to do it sufficiently specialised and not everybody trying to do everything everywhere.* (FG4.2)

Nurses are particularly demoralised, spending less time caring for patients and more time doing paperwork: *"Nurse morale is really low and if they don't do something they'll all be leaving"* (FG1.4).

Low morale and low team spirit can be countered, to a certain extent, by strong medical and nurse leadership, with a few motivated individuals making a difference and pulling everyone

together. However, this sense of integration and belonging in the face of adversity was also described as the 'sinking ship' mentality, having the negative effect of bringing everybody down: *"People stick together because there is only one life raft"* (FG4.2).

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 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': "o*ur 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

toward performance-related goals and targets. Reduced waiting times were considered in accordance with the need to meet Government targets for improved service provision, and as something easily measured. This created: "*a depressed atmosphere*" and "*distressing times*" (FG3.1) and led to healthcare services that were unable to cater to even the most basic of patient needs. It was also mentioned that the implementation of the new consultant contract led to a decrease in working hours and consequently the quality of patient care that could be offered had fallen.

English focus group participants were keen to express their support for the modernisation of endoscopy units, the improvement of services through change and the innovation of service delivery.

Beside reduction in waiting times, other facilitators for change included: fast tracking of patients, more nurse endoscopists, new guidelines for referral and management of endoscopies, 'prep' nurses and more specialist staff. Longer waiting lists were also, paradoxically, seen as a facilitator for change, encouraging the generation of new resources and acting as an impetus for the fulfilment of waiting list targets.

Barriers to change related to lack of senior management support and understanding, lack of funds and the slow speed with which change was occurring: *"It's not change that is the problem it's the rate of change"* (FG1.3). Exacerbated by managerial decision-making bereft of unit input, focus group participants talked at length about: lack of funding, lack of leadership, poor skill mix, and the difficulties different specialties had sharing endoscopy facilities. The absence of a National Service Framework for gastroenterology, poor quality information at the point of referral from

general practitioners regarding prioritisation of patients, and lack of interest at an executive level did little to enhance a sense of self-worth. Endoscopy units were not recognised for their cutting edge work, and consequently were not at the top of the Trusts' lists of priority areas for funding. This was linked to managerial inertia: *"endoscopy as an area was never effectively managed"* (FG2.1). In Wales, lack of support from external sources such as the Welsh Assembly Government, was an additional problem.

4 Differences between English and Welsh units

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

> *We are lagging behind – the waiting times in England are much better than in Wales. Colorectal cancer screening we are lagging probably two years behind, and some of the technological developments, again we are lagging behind.* (FG3.6)

However this has had its advantages, as Welsh units could learn from their English counterparts, and could take care not to repeat their mistakes. No major differences were mentioned regarding clinical outcomes, indeed, Welsh units were seen as on a par with their English counterparts, learning from their experiences: *"We have been fortunate; various GI meeting speakers from*

these kinds of organisations came to Wales and presented case work" (FG3.3). Nevertheless, there was still a strong sense that Welsh units lacked recognition amongst the wider healthcare community for the excellent work they were doing and the changes they had already made toward an improved service. Lack of recognition led to a great deal of scepticism that funding and other resources would be made available from external sources.

DISCUSSION

This study has identified important issues that need to be addressed at a local level when modernising endoscopy services.

In recognition of the fact that effective change to complex systems such as hospital services requires team effort and close group working,[13] we believe the use of focus groups was a good method for addressing this study's aims, and we chose summative analysis to identify key themes.

Summative analysis aims to disclose essential elements of a text – the indispensable aspects without which the whole would lack meaning.[10] The technique moves from an essential to a broad canvas, unlike other qualitative analysis approaches, which start with a broad presentation and hone data down to their defining elements.[14,15] Thematic analysis aims to clarify complex textual data according to themes and concomitant categories, to remove any textual ambiguity through coding structures at the same time as retaining a text's unique nuance.[14,15] Combining these methods can ensure that core concepts are revealed in thematic format alongside brief summations of focus group content. In combination, these methods can add to the

veracity of a study's findings.[16] Analysed materials are fine-tuned through discussion and refinement that takes place through a number of group-working sessions following data capture, during which analysts work collaboratively and equitably.

Disadvantages of the study

The number participating was small but this is often the case in qualitative studies that aim for depth rather than breadth of data disclosure. Furthermore, we aimed to ensure participants covered the range of medical, surgical and nursing professions involved in gastroenterological endoscopy, and that the hospitals they were working in were both teaching and district general, and located in different regions (for example, in the north and south of the country and in the Midlands). We have no reason to believe their views were not representative of the wider gastroenterological professional population.

The approach we used enriched understanding across the group and suggested a wide range of methodological possibilities for using these techniques in other gastroenterological research. The findings indicate changes towards modernisation have taken place despite limited investment in innovation in units. However, with extensive barriers still being reported, this has led to a particularly disillusioned and dispirited workforce, especially noticeable in Welsh units, where people appear frustrated with the lack of Trust or hospital management systems in place to effectively support their work and the ambitions of their units. Add to this a sense of lack of visibility within Trusts, and the belief that decisions being made are not evidence based and do not take account of clinical expertise, and we find units that are unable to make appropriate, long-lasting changes to service delivery and organisation, aggravated by notions of resource deficit.

This study has indicated that to achieve the positive, sustainable effects of modernisation, senior management should actively support innovations, particularly by considering staff morale and appropriate funding. This is in keeping with guidelines developed to support a range of gastroenterological procedures and diseases, for example, Inflammatory Bowel Disease, which emphasise the value of strong team working and good administrative, clinical and managerial support to ensure units achieve optimal patient management.[17] The study emphasises the importance of staff being fully conversant with, and supportive of, managerial decision-making. Indeed, for change to service organisation and delivery to be both successful and sustainable in the longer-term, the literature emphasises the value of fully accommodating clinicians, towards: "a mixed clinico-managerial perspective".[18] This, it is argued, will ensure a positive approach to: "reengineering within clinical settings".[19] However, although professional morale is low, and staff appear frustrated by the lack of senior management support, the ambition to improve services amongst senior clinical staff is still strong.

This study was undertaken as part of a wide exploration of the effectiveness of the Modernising Endoscopy Services (MES) Programme of the NHSMA. Whilst the MES Programme was shown to have acted as a catalyst for change by affecting the way staff work, communicate and think, it was not shown to have been effective in heralding change itself. Nevertheless, participants identify the potential for real change and modernisation to units to the benefit of all. Changes alluded to in these focus groups, such as improvements to service allocation and waiting times, in keeping with greater observance of patient need, support quality improvement and assessment for endoscopy services. Along with the Global Rating Scale (GRS) [20] (an assessment tool for endoscopy units to assess how well they provide a patient-centred service), and Bowel Cancer Screening Programme [21] such changes, fully supported by clinical unit staff and managers,

could have a substantial impact on future targets and funding allocation, raising both the political visibility of the units and the image of units on the ground.

ACKNOWLEDGEMENTS

We would like to thank all those involved in this quasi-experimental study and those who agreed to take part in focus groups and in qualitative analysis sessions.

COMPETING INTERESTS

None

FUNDING

This work was supported by The National Institute for Health Research Service Delivery and Organisation Programme. Grant Number: SDO/46/2003.

Department of Health Disclaimer: The views and opinions expressed herein are those of the authors and do not necessarily reflect those of the Department of Health.

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.

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RATS guidelines have been adhered to:

R Relevance – research question explicitly stated

Research question linked to existing knowledge, current literature aims and objectives

A Appropriate – Focus Groups considered the most appropriate method of data collection, for non-sensitive topic, and convenient for a sample of busy gastroenterologists

T Transparent – Sampling strategy was transparent. Purposive sampling allowed for a wide-range of views from a mixture of gastroenterology specialists working in the field of endoscopy

S Sound – Analysis linked to methods of data collection. Groupwork with a range of health professionals, qualitative methodologists, academics and researchers using summative and thematic analysis techniques, facilitated by the lead methodologist (a qualitative research expert) ensured that the most appropriate approach was employed for considering rich in-depth material by the team.

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Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2012-001009.R1
Article Type:	Research
Date Submitted by the Author:	15-May-2012
Complete List of Authors:	Rapport, Frances; Swansea University, Medicine Seagrove, Anne; Swansea University, College of Medicine Hutchings, Hayley; Swansea University, College of Medicine Russell, Ian; Swansea University, College of Medicine Cheung, Ivy; Swansea University, College of Medicine Williams, John; Swansea University, College of Medicine Cohen, David; University of Glamorgan, Faculty of Health, Sport and Science
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Keywords: Barriers and facilitators to change; focus group research; service organisation and delivery; professional practice.

Word count: 3672

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

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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.

Conclusion: Despite ambitions to implement change, ineffective management support continued to hamper modernisation of service organisation and delivery. Whilst the National Health Service Modernisation Agency (NHSMA) Modernising Endoscopy Services Programme acted as a catalyst for change, affecting the way staff work, communicate and think, it was not effective in heralding change itself. However, gastroenterologists were keen to consider the potential for change and future service modernisation. The methodological framework of innovative qualitative inquiry offers 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 endoscopy 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 endoscopy nurses described 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 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

This paper describes a focus group study that was undertaken five years ago as part of a wider project designed to assess the impact of the Modernisation Agency's Modernising Endoscopy Services (MES) Programme. The focus group study was included as an important element of the mixed method study as it was recognised that it could offer a detailed understanding of how changes to GI service organisation and delivery were affecting professionals' work life and practices, their relationships with others within their units and with patients.

Gastrointestinal disease continues to be recognised as the third most common cause of death in the UK and the leading cause of cancer, and the burden of gastrointestinal disease on services in the NHS is at a record high,[1] The rise in gastroenterology service workloads is causing increasing difficulty in offering patients timely and appropriate appointments in hospitals, and in maintaining appropriate, timely patient assessment, and effective, long-term support.

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.

OBJECTIVES

This qualitative study aimed to:

- Consider the opinion of gastroenterologists and endoscopy 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 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,n 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

The focus groups aimed to clarify professional understanding of changes that had already taken place and their impact on modernising service organisation and delivery, in order to assess the acceptability of innovative models of referral, diagnosis and follow-up. All focus groups examined barriers and facilitators to change and the impact of change on professional practice and self-identity.

The four focus groups were designed to help elicit views and opinions using consensus-building activities.[6,7] An observer was present, to observe proceedings, manage any equipment and examine issues of group dynamics. A facilitator familiar with the study and its aims facilitated the event, asking pertinent questions and, where necessary, giving prompts for answers.[8,9]

Each focus group lasted 90 minutes, and followed a pre-designed interview schedule to uphold rigour and maintain methodological consistency. The schedule was based on the study aims and an in-depth literature search, which had identified a wide range of issues relating to: staffing, funding, impact of change, facilitators and barriers to change, effects of modernisation on services, extent and rate of change and changes undertaken across units. A financial contribution was offered to all focus group participants in recognition of their time.

Four focus groups were conducted: one in England and three in Wales. In the English focus group (FG1), 13 gastroenterologists agreed to take part and five actually participated. In the 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 three GI consultants, one GI surgeon and one endoscopy nurse. FG2 comprised one GI consultant and two endoscopy nurses, 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

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

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"*

(FG1.1). Under-staffed units and staff deskilling was of particular concern, both for nurses and consultants. Thus, whilst expansion was helpful, units appeared to be running without their full complement of staff with no major drives to recruit additional staff. In addition, greater staff specialisation, for example differences between GI physicians and surgeons, suggested the loss of the professional 'all-rounder', with people working in different specialisations working according to their own individual agendas and little clarity regarding who should be taking on which tasks:

> *I would like to see a Welsh health strategy that decides what's being done and where, so it actually happens, with enough people to do it sufficiently specialised and not everybody trying to do everything everywhere.* (FG4.2)

Nurses are particularly demoralised, spending less time caring for patients and more time doing paperwork: *"Nurse morale is really low and if they don't do something they'll all be leaving"* (FG1.4).

Low morale and low team spirit can be countered, to a certain extent, by strong medical and nurse leadership, with a few motivated individuals making a difference and pulling everyone together. However, this sense of integration and belonging in the face of adversity was also described as the 'sinking ship' mentality, having the negative effect of bringing everybody down: *"People stick together because there is only one life raft"* (FG4.2).

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*

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': "o*ur 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 toward performance-related goals and targets. Reduced waiting times were considered in accordance with the need to meet Government targets for improved service provision, and as something easily measured. This created: "*a depressed atmosphere*" and "*distressing times*" (FG3.1) and led to healthcare services that were unable to cater to even the most basic of patient

needs. It was also mentioned that the implementation of the new consultant contract led to a decrease in working hours and consequently the quality of patient care that could be offered had fallen.

English focus group participants were keen to express their support for the modernisation of endoscopy units, the improvement of services through change and the innovation of service delivery.

Beside reduction in waiting times, other facilitators for change included: fast tracking of patients, more nurse endoscopists, new guidelines for referral and management of endoscopies, 'prep' nurses and more specialist staff. Longer waiting lists were also, paradoxically, seen as a facilitator for change, encouraging the generation of new resources and acting as an impetus for the fulfilment of waiting list targets.

Barriers to change related to lack of senior management support and understanding, lack of funds and the slow speed with which change was occurring: *"It's not change that is the problem it's the rate of change"* (FG1.3). Exacerbated by managerial decision-making bereft of unit input, focus group participants talked at length about: lack of funding, lack of leadership, poor skill mix, and the difficulties different specialties had sharing endoscopy facilities. At that time, the absence of a National Service Framework for gastroenterology, poor quality information at the point of referral from general practitioners regarding prioritisation of patients, and lack of interest at an executive level did little to enhance a sense of self-worth. Endoscopy units were not recognised for their cutting edge work, and consequently were not at the top of the Trusts' lists of priority areas for funding. This was linked to managerial inertia: *"endoscopy as an area was never*

effectively managed" (FG2.1). In Wales, lack of support from external sources such as the Welsh Assembly Government, was an additional problem.

4 Differences between English and Welsh units

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

> *We are lagging behind – the waiting times in England are much better than in Wales. Colorectal cancer screening we are lagging probably two years behind, and some of the technological developments, again we are lagging behind.* (FG3.6)

However this had its advantages, as Welsh units could learn from their English counterparts, and could take care not to repeat their mistakes. No major differences were mentioned regarding clinical outcomes, indeed, Welsh units were seen as on a par with their English counterparts, learning from their experiences: *"We have been fortunate; various GI meeting speakers from these kinds of organisations came to Wales and presented case work"* (FG3.3). Nevertheless, there was still a strong sense that Welsh units lacked recognition amongst the wider healthcare community for the excellent work they were doing and the changes they had already made

toward an improved service. Lack of recognition led to a great deal of scepticism that funding and other resources would be made available from external sources.

DISCUSSION

Although conducted five years ago, this study identified important issues that needed to be addressed at a local level at that time when modernising endoscopy services. It revealed considerable concern regarding barriers to modernisation, particularly in Wales, where progress was slower than in England and these differences between England and Wales continue to have relevance to this day. In 2012, for example, only one unit in Wales, out of the full complement of 18, was formally accredited by the Joint Advisory Group on GI Endoscopy (JAG), responsible for inspection and accreditation of endoscopy units in the UK. This is compared to the majority of units accredited in England, where considerable efforts have been made to engage clinicians and management in modernisation. Accreditation of endoscopy units is essential, and clearly aligned to JAG's core objectives: To agree and set acceptable standards for competence in endoscopic procedures and training, and to quality assure services.

In recognition of the fact that effective change to complex systems such as hospital services requires team effort and close group working,[13] we believe the use of focus groups was a good method for addressing this study's aims, and we chose summative analysis to identify key themes.

Summative analysis aims to disclose essential elements of a text – the indispensable aspects without which the whole would lack meaning.[10] The technique moves from an essential to a

broad canvas, unlike other qualitative analysis approaches, which start with a broad presentation and hone data down to their defining elements.[14,15] Thematic analysis aims to clarify complex textual data according to themes and concomitant categories, to remove any textual ambiguity through coding structures at the same time as retaining a text's unique nuance.[14,15] Combining these methods can ensure that core concepts are revealed in thematic format alongside brief summations of focus group content. In combination, these methods can add to the veracity of a study's findings.[16] Analysed materials are fine-tuned through discussion and refinement that takes place through a number of group-working sessions following data capture, during which analysts work collaboratively and equitably.

Study limitations

A major study limitation was the poor representation of the NHS in England, through low focus group attendance numbers. Whilst 13 focus group members had originally signed up to take part in three English focus groups, planned for lunchtime sessions during the annual BSG Conference (in keeping with 15 members attending three focus groups in Wales), the actual number was greatly diminished to five. This was due to unforeseen clashes in timetabling. The study team decided to continue with a single focus group, recognising the opportunities for comparative data that would deepen understanding of data. In qualitative studies it is often argued that depth rather than breadth of data disclosure is the more desirable outcome.

The English focus group resulted in additional information substantiating the views of those based in Wales, and combined datasets yielded richer information than single datasets could have alone. Comparing views revealed important insights into the nuance of service delivery. For example, whilst GI services were developing along similar lines, Welsh services lagged behind in

terms of the pace of change. This was frustrating for those working in Wales, who perceived an imbalance in service priority whilst recognising the opportunities afforded by learning from the mistakes of their English counterparts.

Furthermore, whilst numbers were small, attendees from England represented medical, surgical and nursing professions involved in gastroenterological endoscopy, including endoscopy nurses, and GI practitioners based in both teaching and district general hospitals located in different English regions (for example, in the north and south of the country and in the Midlands). Whilst we cannot claim a representative sample, we can defend the data's reliability.

The study was conducted in 2007, at a time when the Global Rating Scale (GRS)[17] (an assessment tool for endoscopy units to assess how well they provide a patient-centred service) was just being implemented, and modernisation of endoscopy units was proving challenging. The gap in reporting these findings is a major limitation, but does provide a unique historical perspective of the trajectory of GI service development and modernisation of relevance to the present day. The challenges that service leaders and managers faced in 2007 add a new perspective to policy making today, as the NHS embarks on another period of modernisation, further challenged by considerable resource constraint.

This paper indicates that the impact of change on a GI professional's sense of self-worth, and the knock-on effects on GI unit cohesion can be exacerbated by a perceived lack of support from Trust management. In particular, the sense of disillusionment within the workforce in 2007 was intensified by the difficulties of senior clinicians and nurses, unable to share a common vision with those that had the power to make change in the NHS. Extensive barriers were reported,

especially noticeable in Welsh units, where people were frustrated with the limited Trust or hospital management systems in place to effectively support their work and the ambitions of their units. Added to this was a sense of lack of visibility within Trusts, and the belief that decisions were being made that were not evidence-based and did not take account of clinical expertise. Much has happened since this time, including the uptake and use of the GRS, and further divergence of NHS organisation between England and Wales, but we would be wise to keep abreast of the mood of clinicians and the difficulties they face.

Future opportunities

The approach we used enriched understanding across the group and suggested a wide range of methodological possibilities for using these techniques in other gastroenterological research. The findings indicate that changes towards modernisation can occur despite limited investment in innovation.

This study has indicated that to achieve the positive, sustainable effects of modernisation, senior management should actively support innovation, particularly by considering staff morale and appropriate funding. This is in keeping with guidelines developed to support a range of gastroenterological procedures and diseases, for example, Inflammatory Bowel Disease, which emphasises the value of strong team working and good administrative, clinical and managerial support to ensure units achieve optimal patient management.[18] The study also indicated the importance of staff being fully conversant with, and supportive of, managerial decision-making. Indeed, for change to service organisation and delivery to be both successful and sustainable in the longer-term, the literature highlights the value of fully accommodating clinicians, towards: “a

mixed clinico-managerial perspective".[19] This, it is argued, will ensure a positive approach to: "reengineering within clinical settings".[20]

This study was undertaken as part of a wider exploration of the effectiveness of the Modernising Endoscopy Services (MES) Programme of the NHSMA. Whilst the MES Programme was shown to have acted as a catalyst for change by affecting the way staff work, communicate and think, it was not perceived as effective in heralding change itself. Nevertheless, participants identified the potential for real change and modernisation to units to the benefit of all. Changes alluded to in these focus groups, such as improvements to service allocation and waiting times were in keeping with greater observance of patient need, and support for quality improvement and assessment for endoscopy services. Along with the Global Rating Scale (GRS)[17], and Bowel Cancer Screening Programme[21] such changes, fully supported by clinical unit staff and managers, could have a substantial impact on future targets and funding allocation, raising both the political visibility of GI units and the image of units on the ground.

ACKNOWLEDGEMENTS

We would like to thank all those involved in this quasi-experimental study and those who agreed to take part in focus groups and in qualitative analysis sessions.

COMPETING INTERESTS

None

FUNDING

This work was supported by The National Institute for Health Research Service Delivery and

Organisation Programme. Grant Number: SDO/46/2003.

Department of Health Disclaimer: The views and opinions expressed herein are those of the authors and do not necessarily reflect those of the Department of Health.

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 CI, 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.

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RATS guidelines have been adhered to:

R Relevance – research question explicitly stated

Research question linked to existing knowledge, current literature aims and objectives

A Appropriate – Focus Groups considered the most appropriate method of data collection, for non-sensitive topic, and convenient for a sample of busy gastroenterologists

T Transparent – Sampling strategy was transparent. Purposive sampling allowed for a wide-range of views from a mixture of gastroenterology specialists working in the field of endoscopy

S Sound – Analysis linked to methods of data collection. Groupwork with a range of health professionals, qualitative methodologists, academics and researchers using summative and thematic analysis techniques, facilitated by the lead methodologist (a qualitative research expert) ensured that the most appropriate approach was employed for considering rich in-depth material by the team.