Conceptualization of Customer Experience within the NHS England hospitals:

A Netnography study

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ABSTRACT

The research topic focuses on identifying the critical dimensions and attributes of customer experience (CE) from a customer's view and the significant factors that influence positive and negative CE within the context of NHS England hospitals. This research is vital to the healthcare sector for several reasons. To improve the CE, NHS hospital management must consider the following: What defines the dimensions and attributes of CE? How are CE formed? And how important is it where the service experience takes place?

CE is a relatively new phenomenon, particularly in NHS Hospital trusts compared to private healthcare providers and corporations. In an ever-changing healthcare market, the New Public Management (NPM) market-based model advocates treating citizens or patients like customers in public services. The Francis Inquiry has recently addressed the significant failings in care identified at Mid Staffordshire NHS Foundation Trust in England. It has been pivotal in raising the importance of patient experience (Francis, 2013). This research will attempt to fill this gap by first identifying the underlying critical dimensions and attributes of CE within the context of NHS England hospitals. Second, identify the factors that significantly influence positive and negative CEs within the NHS England hospital context. Finally, a holistic conceptual framework for CE in NHS England hospitals should be developed.

The findings of this research will potentially assist managers in acute NHS England hospital trusts in understanding how their customers assess the CEs of their service. By developing the theoretical model and definition framework, this research will also offer common terminology and a shared mindset of CE constructs in the context of NHS hospitals.

The research lies with the interpretivist paradigm's ontological and epistemological assumptions. This research is designed to generate questions to explore rather than to test a model or hypothesis. This study is inductive and examines individual or collective customers' perspectives (thoughts and feelings) across NHS England hospitals, based on voluntarily written stories posted on the NHS Choices website. Qualitative patient stories data were collected from the NHS Choices feedback website and analysed using an innovative hybrid approach combining netnography and Critical Incident content analysis procedures. The researcher faces difficulties in reaching real customers or patients and interviewing them face-to-face to discuss their experiences after their hospital stay ends due to ethical issues; ethnography overcame those barriers. The research identifies and describes

30 dimensions and 131 subcategories (attributes) that underlie the CE concept in healthcare and presents them in a holistic classification or conceptual framework. The framework also suggests a relationship between customer experience, service quality, satisfaction, customer co-creation, customer centricity, and loyalty behaviours.

This research will also provide common terminology and a shared mindset regarding CE constructs within the NHS hospital context. The framework assists managers and healthcare professionals in defining, evaluating, and improving the memorable customer experiences of patients and their carers.

The main contributions of this study lie in, first, a holistic classification framework for CE in healthcare; second, attributes and dimensions that extend existing health service quality models and CE models; third, significant factors that influence positive or negative customer experiences in hospitals; fourth, dimensions and attributes that contextualise the generic concept of customer experience to healthcare.

AUTHOR'S DECLARATION

I declare that the work in this thesis was carried out in accordance with the regulations of the University of Gloucestershire and is original except were indicated by specific reference in the text. No part of the thesis has been submitted as part of any other academic award. The thesis has not been presented to any other educational institution in the United Kingdom or overseas. Any views expressed in the thesis are those of the author and in no way represent those of the University.

Signed A.Mswaka……

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Contributions to practice publications

4. The Chartered Institute of Marketing (2008). The real NHS: the benefits of a marketing approach. The white paper

5. The Chartered Institute of Marketing (2010) Measure for measure: metrics and marketers in the NHS. The white paper

6. Dr Foster Hospital Guides (2010, 2011) Guide rates best and worst hospitals on clinical and patient experience outcomes

7. Dr Foster, the Intelligence Board (2010), Patient Experience

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ABBREVIATIONS

CE	Customer experience
COPD	Chronic Obstructive Pulmonary Disease
DoH	Department of Health
ECBD	Experience-Based Co-Design
IOM	Institute of Medicine
NHS	National Health Service
NICE	National Institute
PhD	Doctor of Philosophy
UK	United Kingdom
WOM	Word of Mouth

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter aims to introduce the study's background and research problem. It also draws a general picture of the following chapters and the study, beginning with the introduction. The next section examines the research background, identifying gaps in the literature. Section 1.2 discusses the project background, and Section 1.3 discusses the genesis of customer-orientation in the NHS. Section 1.4 presents the research problem, and Section 1.5 discusses the study's objectives and identifies the research questions. Section 1.6 introduces the Definitions of the constructs, and Section 1.7 discusses the chapter summary and thesis structure. The remainder of the thesis is organised into four chapters. The second chapter reviews the existing literature on service constructs and customer experience. The third chapter describes the methodology adopted. The fourth chapter presents the research findings. The fifth chapter discusses the implications of the findings for theory and practice, suggests directions for future research, and highlights the study's limitations.

1.2 Research background

The focus on the consumption experience in marketing has a long history; it was proposed as early as 1940, but was not researched until the 1980s (Verhoef et al., 2015). Norris (1940) referred to the value created by the experience provided to the consumer, as cited in Holbrook (2000). Subsequently, in 1970, Toffler (1970) stressed the concept of consumption experience again. Later, Woods (1981) referred to the same topic (cited in Holbrook, 2000). Their approaches offer a new perspective that explains consumption as a primary subjective state of consciousness with miscellaneous symbolic meanings, hedonic responses, and aesthetic criteria (Holbrook and Hirschman, 1982). Similarly, Havlena and Holbrook (1986) and Westbrook and Oliver (1991) emphasised the role of emotions in the consumption experience. More recently, there has been an increasing tendency towards delivering a configuration of unique, rewarding, and fulfilling experiences to gain a competitive advantage, particularly for those in the service sector.

Interest in customer experience (CE) has increased exponentially over the past decades among service researchers and practitioners. Many researchers now consider CE a key research priority in the contemporary service and marketing literature (Jaakkola *et al.*, 2015). Likewise, managers recognize the need to invest in CE strategies across offerings, categories, and channels to remain competitive in a rapidly evolving service landscape (Ostrom *et al.*, 2015). Zomerdijk and Voss observe that, increasingly, "many service organizations are placing the CE at the core of the service offering" (2010, p. 67). Meaningful CEs play a pivotal role in enhancing a firm's competitive advantage (McColl-Kennedy *et al.*, 2015a) and engendering increased customer satisfaction, loyalty, and firm revenue (Klaus and Maklan, 2012; Lemke et al., 2011) and patient quality of care and clinical outcomes (Doyle, 2009; Institute of Medicine, 2001; Department of Health, 2008; Duggirala et al., 2008) essentially forming the fundamental premise of all business (Helkkula, 2011).

Despite this broad interest, CE requires further exploration (Lipkin, 2016). In particular, researchers call for further research into which attributes and dimensions constitute CE (Edvardsson *et al.*, 2005; Pareigis *et al.*, 2012; Klaus and Maklan, 2012; Lemke et al., 2011; La Vela and Gallan, 2014; Gentle et al., 2007). To fill the research gap, this study identifies the critical attributes and dimensions of the *customer or patient experience* (CE) construct in the NHS hospital context and the factors that significantly influence the positive and negative CEs. These will be realized through patients' and their carers' stories of their hospital experiences voluntarily posted online. Various researchers, such as Gentile et al. (2007), Verhoef et al. (2016), and Palmer (2010), argue that, in studying a concept as complex as CE, because of its multidimensionality and contextual nature, it is essential to increase the understanding of how such phenomena come to be, in addition to looking at what constitutes CE.

Creating a strong CE is now a leading management objective. According to a recent study by Accenture (in cooperation with Forrester, 2015), improving the CE received the most number-one rankings when executives were asked about their top priorities for the next 12 months. Multiple organizations, such as Amazon, Google, and NHS Trust Hospitals, now have Chief Customer/Patient Experience Officers, Director Customer Experience, or Patient Experience Managers responsible for creating and managing the experience of their customers or patients. Schmitt (1999) was one of the first scholars to emphasize the importance of CE, and Pine and Gilmore (1998) specifically addressed the importance of experiences in today's society and the opportunities for firms to benefit from creating strong and enduring customer experiences. Additionally, the increasing focus on CE stems from

customers now engaging with firms through myriad interactions or touchpoints across multiple channels and media, resulting in more complex customer journeys. Firms are confronted with accelerating media and channel fragmentation, and omnichannel management has become the new norm (Brynjolfsson, Hu, and Rahman, 2013; Verhoef, Kannan, and Inman, 2015). Moreover, customer-to-customer interactions through social media are creating significant challenges and opportunities for firms (Leeflang et al., 2013; Libai et al., 2010). CE is more social in nature, and peer customers also influence experiences. Firms also have much less overall control over the CE and the customer journey, resulting in behaviours such as showrooming (e.g., Brynjolfsson, Hu, and Rahman, 2013; Rapp et al., 2015).

Over the last 30 years, experiential marketing has been a topical issue, since Holbrook and Hirschman first introduced the influential idea that consumer behaviour has an experiential dimension (Holbrook and Hirschman, 1982) and postulated the experiential perspective as an alternative to the hegemonic information-processing view of consumer behaviour. There has been increasing recognition among academics and practitioners of the need for marketers to have a deeper understanding of CE's role. While academics have further developed these initial contributions (Grewal, Levy, and Kumar 2009; Verhoef et al., 2009; Healy et al., 2007; Frow and Payne 2007; Arnold and Reynolds 2003; Carù and Cova, 2003; Winsted, 2000; Thompson and Haytko 1997), marketing practitioners and consulting gurus have long displayed a similar interest in customer experiences and consistently advocated the importance of experience marketing with key contributions by Carbone and Haeckel (1994), Pine and Gilmore (1999, 1998), Gilmore and Pine (1997) and the consultant and academic Schmitt (2003a, 1999a and b). Equally, experience marketing has also been widely addressed in the practitioner press (Johnson, 2007; Leighton, 2007b; Event, 2006; Bielski, 2004). In a recent survey of marketing professionals, 70% of the respondents reported it to be very important to their organizations and indicated their intention to employ it more widely in the future (Bigham, 2008).

A careful and rigorous review of the extant marketing literature revealed that there have been few attempts to critically explore patients' experiences with long-term medical conditions, such as cancer and chronic obstructive pulmonary disease (COPD), as an academically robust construct within NHS hospitals in the UK. To date, academics have not significantly tackled the overall customer experience as an important phenomenon in the context of NHS hospitals. Definitions, dimensions, and attributes of CE are often circular in nature, and little guidance has emerged that is likely to be useful to practitioners

(Pullman and Gross, 2004). Palmer (2008) argued that the term "customer experience" has been so widely used and abused that a potentially important construct is in danger of being dismissed because of the ambiguous manner in which it has been applied. In other words, the concept is poorly defined (Carù and Cova, 2003; Gentile, 2007; Fatma, 2014). Therefore, this study aims to address the gap in the literature and to further increase understanding of the concept of customer experience, its dimensions, and their attributes from a customer's perspective within the UK NHS hospital context. Service researchers often use the terms user experience, customer experience, patient experience, service experience quality, and service experience interchangeably (Jaakkola *et al.*, 2015; Lemke et al., 2011; Klaus and Maklan, 2013; Ponsignon et al., 2015). For clarity, this thesis will use all these terms to depict patients' experiences with healthcare services.

Creating an outstanding CE is critical to marketers in today's global marketplace. Nowadays, competing in a global market has become increasingly difficult, and only the creation of enduring competitive advantages seems to offer a path to survival. But where should a company start when developing a competitive advantage? Many scholars argue that one of the main routes to it is a much stronger focus on the customer (Douglas and Craig, 2000; Farinet and Ploncher, 2002; Kotler and Keller, 2006; Peppers and Rogers, 2000). In addition, a similar position can be found in the managerial field; in fact, 85% of senior business managers believe that differentiating solely on the traditional elements, such as price, product, and quality, is no longer a sustainable competitive advantage, and even more senior managers hold customer experience as the next competitive battleground (Shaw and Ivens, 2005; Gentile, 2007, Lemon and Verhoef, 2016).

Despite such vibrant enthusiasm, however, the reality is very different, and far from being close to either what the literature advocates or what many companies claim in their statement of intent. In addition, the scientific literature on this topic (Gentile, 2007) shows the limitations and inadequacies that are typical of those research fields that are still far from their maturity, particularly as it lacks both a common definition and standardized conceptual models that can support the adoption of the above-mentioned practices. Similarly, Poulsson and Kale (2004) and Garg et al. (2011) observed that until 2011, there were no systematic literature review attempts to define exactly what constitutes an experience in marketing terms. A great deal of the disagreement and lack of clarity lies in the different ways in which the term "experiences", with its dimensions and attributes and factors that significantly influence positive and negative CEs, can be understood. It is important to understand positive and negative customer experiences because they have been linked to outcomes such as

emotional experiences, customer satisfaction and dissatisfaction, loyalty, and word-of-mouth (WOM).

1.3 Customer/patient experience in the NHS context

The NHS is not an exception to this emerging CE phenomenon that has been adopted by almost every industry. In recent years, consumer-driven policy changes have emerged, with many countries implementing patient-centric approaches to define and evaluate healthcare quality (Raleigh et al., 2012). For instance, the UK NHS applies the Experience-based co-design (ECBD) method, which involves patients in designing and improving the healthcare experience (Tsianakas, 2012). Finally, several studies suggest that the quality of the patient experience influences clinical outcomes, such as patient safety and clinical effectiveness, as well as operational efficiency (Riskind et al., 2011; Doyle et al., 2013). This evidence indicates that the customer or patient experience concept has become a core building block of healthcare providers' and policymakers' strategies (Bate and Robert, 2007).

The quality of patients' and carers' experiences has become a central concern in the provision of healthcare services. In the UK, healthcare practitioners, researchers, and policymakers are focused on defining, measuring, and improving the experience of patients and carers.[1] For instance, a leading report on two measures of hospital quality (Dr Foster, 2011) and an influential policy paper by the Department of Health (DoH) assert that greater emphasis is needed to improve healthcare for everyone (NHS, 2010). Moreover, the "voice of the patient" is increasingly being incorporated into service design initiatives. Traditionally, quality metrics have been based solely on available internal resources, and patient needs have received limited attention in the configuration of care delivery (Gruber and Frugone, 2011). In recent years, consumer-driven policy changes have emerged, with many developed countries implementing patient-centric approaches to define and evaluate healthcare quality (Raleigh et al., 2012).

Over the last decade, policy has emphasized the importance of a good patient experience as a cornerstone of high-quality health and social care in the UK, with many initiatives attempting to develop patient-centred practice. More recently, the Francis Inquiry has addressed the significant failings in care identified at Mid Staffordshire NHS Foundation

[1] www.institute .nhs.uk/nhs_alert/patient_experience/patient_experience.html; http://publications.nice.org.uk/patient-experiencein-adult-nhs-servicesimproving-the-experinceof-care-for-people-usingadult-cg138; wwww.healthcareconferncesuk.co.uk/patient-experience

Trust in England and has been pivotal in raising the importance of patient experience (Francis, 2013). The Francis Report made 290 recommendations, with many emphasizing the importance of patient or customer experience through their focus on specific ways in which the quality of experiences can be enhanced, for example, by improving support for compassionate, caring, and committed care, achieved through stronger healthcare leadership. The linkages between patient safety and clinical effectiveness have also been emphasized more recently as part of patient experience (Doyle, Lennox, and Bell, 2013). While policy has attempted to place patient experiences at the heart of care, significant challenges still remain before patient experience is fully integrated conceptually and organizationally.

The philosophy of "no decision about me, without me" now sits alongside several national policy drivers requiring NHS hospitals and professionals to continually measure and improve patient/customer experience, such as the outcomes framework and the National Institute for Health and Care Excellence (NICE) guidelines for patient experience (DoH, 2013).

Dr Gill Morgan, Chief Executive of the NHS Confederation, which represents over 90% of NHS organizations, said:

> "Customer focus is about doing everything we can to make the patient's experience as pleasant, straightforward and unstressful as possible...and in this age of rising expectations, customer focus has become a critical issue for all healthcare providers" (NHS Confederation, 2013).

He also commented on the NHS Confederation report:

> *"The report shows that there is a great deal of good practice on excellent customer service not only from the private and voluntary sectors, but also from within the NHS itself. We all need to learn from the best to deliver a first class, customer-focused NHS fit for the 21st century"* (NHS Confederation, 2013).

Similarly, internationally, patient or customer experience of healthcare is increasingly being recognized as essential to providing high-quality healthcare services (Robert and Cornwell, 2012). Recently, in England, the Department of Health and the National Quality Board published the NHS Outcomes Framework (which includes "ensuring that people have a positive experience of care") (DoH, 2012a), and NICE (National Institute for Health and Care Excellence) has published standards for improving patient experience. It is therefore

timely to examine issues of the provision of professional training and education in relation to patient experience. In this quality-focused, competitive environment, it is essential for NHS hospitals to understand the factors that influence patients' experience of care and other quality measures. Recognition is growing of the importance of customer-centred care, and of the evidence of its effectiveness in contributing to other system goals. To date, however, little research has examined the NHS hospital setting, or hospitals' customer or patient perspectives and characteristics and their links to patients' experiences (The Commonwealth Fund, 2010). Such research is critical to understanding what hospital characteristics impact patients' experience of care and how hospitals can improve patient experience or healthcare outcomes. This imperative is made ever more urgent by the Patient Reported Outcomes Measurements (PROMS) and Payment by Results (PbR) incentives in the NHS hospitals. The lack of empirical evidence to help policymakers, hospitals, and stakeholders to understand and identify the critical dimensions and attributes of patients' experience of care is a concern (Davis et al., 2005; Rathert et. al., 2012; Shaller, 2007; Davis, 2003).

Since 2008, the NHS has had a view that quality in health services should be made up of three components – clinical effectiveness, safety, and experience (Department of Health, 2008). Although NICE has published two patient experience Quality Standards (NICE, 2012), experience of care has arguably not been widely regarded in practice as equal to clinical effectiveness and safety by health professionals, managers, or commissioners.

An increased priority has been placed on patient experience in the NHS following the highlighting of unacceptable experiences in the Francis Report into Mid Staffordshire NHS Foundation Trust (Francis, 2013) and the uncovering of abuse at Winterbourne View (Department of Health, 2012). One reflection of this was that, at its inception in 2013, NHS England established a national Patient Experience team (NHS England, 2013) as one of five NHS Outcomes Framework quality domain teams, alongside patient experience staff in regional teams.

In a recent publication, the National Quality Board has updated the NHS Patient Experience Framework, seeking to develop a shared understanding among national NHS bodies of what is meant by the experience of care, why it is important, and what good experience looks like (National Quality Board, 2015). Central to NHS England's ambition is to place the patients and the public at the heart of all its work, including the development of national policy, new programmes of work, and direct commissioning (NHS England, 2013). This is supported by a statutory duty to make arrangements to involve the public in the commissioning of NHS

services and is strongly reinforced in the NHS Five Year Forward View (NHS England et al., 2014).

Transforming Participation in Health and Care has been published, and an NHS Citizen programme (NHS Citizen, 2015) was commissioned to address how the board of NHS England can be held to account and can better take into account the views of patients, service users, and the general public when making decisions about the NHS. In addition to NHS Citizen, NHS England is developing an online space (working title: Participation Academy) to support the learning and sharing of good practice in patient participation. It is also working with partners to build up youth voice and leadership input through the NHS Youth Forum, regional youth voices programmes, and an annual "Takeover Day" programme. We would observe that many people working in the English health system, in particular commissioners, conflate engagement and participation with improving the experience of care. The former is often assumed to be a substitute for patient experience, irrespective of whether the engagement activities have a specific focus on improving experience or the participants' contributions are grounded in lived experience.

Recent evaluations of healthcare quality suggest that a concerted effort to understand, measure, and enhance the patient experience is necessary. For instance, in a survey conducted on behalf of the NHS, healthcare providers self-assessed their performance across 10 areas of patient experience, averaging 28 points out of a possible 50 (Ipsos, 2012). According to another study, 91 per cent of physicians claim that their organizations do not have a clear strategy for managing the patient experience and improving patient satisfaction (Rozenblum et al., 2013). From the patient perspective, a recent survey suggests that overall satisfaction with the NHS remains low (61 per cent) (Park et al., 2013). Additionally, since the implementation of the new "Putting Things Right" plan, which measures how healthcare services perform, a 30 per cent increase in complaints has been observed (Ombudsman, 2013). This evidence supports the case for developing a robust understanding of the customer or patient experience concept to facilitate the measurement and improvement of healthcare service provision. How NHS provider organizations are collecting and making use of patient experience feedback is looked at in a recent report from Membership Engagement Services and InHealth Associates (2015). The report examines what patient experience data is being collected, how it is used to improve, and how patients are involved. It recognises that patients are becoming more involved in patient experience work, from gathering data to providing insights and working with staff on data-led improvement work (Membership Engagement Services with InHealth Associates, 2015)

1.3.1 Importance of the customer experience and healthcare context

The researchers assert that this rapid evolution of marketing 'paradigms' mirrors a real-world occurrence of marketplace competition, moving from products to services to a post-product, post-service phenomenon that is still evolving and not yet fully formed. It is argued that the most famous expression of this emerging marketplace reality is *customer experience* (Klaus & Maklan 2007; Gambetti & Graffigna 2010; Lemke *et al.*, 2010; Gilmore and Pine, 1997).

The concept of customer experience is evolving to an ever more imperative area of study within the services discipline. Several authors (see, for example, Pine and Gilmore, 1998 and 1999; Shaw and Ivens, 2002; Voss, 2003; Prahalad and Ramaswamy, 2004; Meyer and Schwager, 2007) have argued that the customer experience may provide a new means of competition. Providing a good experience is also important because it affects customer satisfaction (Liljander and Strandvik, 1997), delivers customer loyalty (Yu and Dean, 2001; Pullman and Gross, 2004; Mascarenhas *et al.*, 2006), influences expectations (Johnson and Mathews 1997; Flanagan *et al.*, 2005), instils confidence (Flanagan *et al.*, 2005), supports the brand (Grace and O'Cass, 2004; Berry and Carbone, 2007), and also creates emotional bonds with customers or, conversely, leads to emotional scarring (Pullman and Gross, 2004).

Despite these benefits, the limited research in this area suggests that good customer experiences are not prevalent. For example, a Bain & Co. survey of 362 companies and their customers found that 80 per cent of senior executives said they provided a superior customer experience, but just 8 per cent of their customers agreed (Coffman and Stotz, 2007). Two facts can then be regarded as the main reasons for such a slow adoption rate. One is the lack in the extant literature of models, interpretation, and conceptualization offering a common terminology and shared mind-set; the other is the lack of structured managerial approaches, which can only be overcome by a deeper comprehension of the role played by the customer experience (Gentile et al., 2007). A careful review of the extant marketing literature reveals only a few attempts to define the concept of customer experience and its dimensions and attributes. In other words, the concept has a poor definition (Carù & Cova, 2003; Gentile et al., 2007; Garg et al., 2013; Lemke et al., 2010).

NHS England hospitals context of study

According to a (Institute of Fiscal Studies, 2017) report, the NHS employs more than 1.5 million people, putting it in the top five of the world's largest workforce, together with the US Department of Defence, McDonalds, Wal-Mart and the Chinese People's Liberation Army. NHS England is the biggest part of the system by far, serving a population of 54.3 million and employing 1.2 million people. Of those, the clinically qualified staff include 150,273 doctors, 40,584 general practitioners, 314,966 nurses and health visitors, 18,862 ambulance staff, and 111,127 hospital and community health services.

When the NHS was launched in 1948, it had a budget of 437 million (roughly £15 billion at today's value). For 2015/16, the overall NHS budget was around £116.4 billion. NHS England is managing £101.3 billion of this. Figure 1.1 illustrates that last year £140bn was spent on health across the UK - more than 10 times the figure that was ploughed in 60 years ago (Institute of Fiscal Studies, 2017).

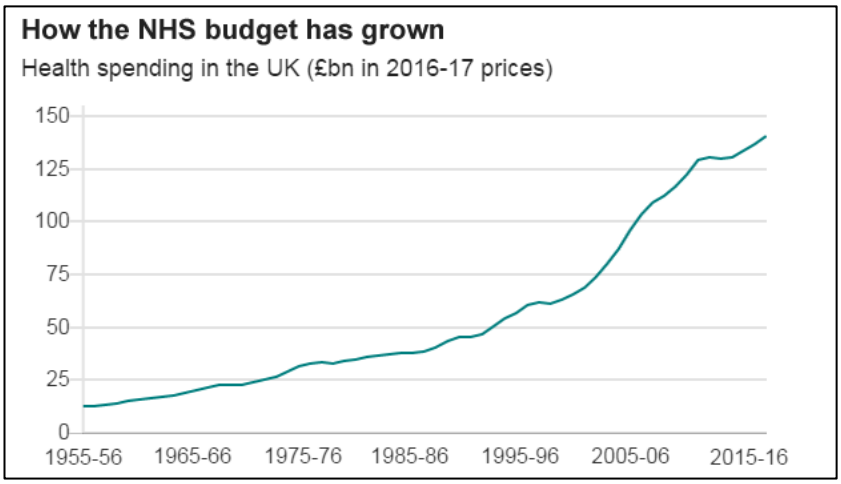


Figure 1.1: How the NHS Budget has grown over 60 years

Source: Institute For Fiscal Studies (2017) (www.ifs.org.uk)

The NHS England hospitals sector is one of the most complex organizations with multitudes of customer patient interactions across only 136 acute non-specialist hospital trusts (including 84 foundation hospital trusts). The complexity is exacerbated by the fact that these hospitals deal with over 1 million patients every 36 hours, total annual attendances of over 22 million at Accident & Emergency (A&E) departments and an annual total number of 86

million outpatient attendances (NHS Confederation, 2017). Despite all this service ecosystem complexity, the NHS England hospitals are still expected by the Government and its customers (public) to provide each patient or customer with great or positive customer experience outcomes

Despite its importance and the positive attention this concept is receiving in the literature, the explanation of customer experiences remains vague, and a thorough theoretical foundation is lacking. Staniszewska and Churchill (2014) argue for conceptualizing patient experience as a vital form of evidence inevitably leading to the question of the robustness of the patient experience evidence base. They further describe it as a "poor cousin", and that patient experience has suffered both conceptually and methodologically, with less development when compared with the clinical and economic forms of evidence. For the reasons above, the objective of this study is to develop a holistic conceptual model of customer experience in the NHS hospitals that considers the collective customers' perspective.

1.4 Statement of the research problem

The concept of CE is relatively new, particularly in NHS acute hospitals. In an ever-changing healthcare market, the New Public Management (NPM) market-based model introduced by the UK government in the early 1980s advocates treating citizens or patients as customers in public services (Clarke and Newman, 1997). The issue of treating citizens solely as customers in UK public services has also been addressed by others (deLeon and Denhadt, 2000; Kettl, 1997; Terry, 1998). It is now evident that, as healthcare budgets come under scrutiny that consumers in the UK have become more critical of the healthcare provided by NHS hospitals, organizing and claiming rights in the planning and evaluation of health services (Van Maanen, 1984; Health Services Journal, 2012). This paradigm shift has given rise to studies that demonstrated the importance of understanding customer experiences from the patient's or customer's point of view (e.g. Cartwright, 1964; Pine and Gilmore, 2001; Garg, Rahman, and Kumar, 2011). To improve customer/patient experience, practitioners and researchers need to consider: What dimensions and attributes constitute the construct of CE? How are customer experiences formed? And how important is it where the service experience takes place?

Most theory on customer experience in the service industry is built around the tourism and retailing sectors. Studies which focus on the dimensions and attributes of patient or

customer experience in healthcare, particularly in an NHS England hospital context, are. CE has been examined at different levels in the existing literature: attributes, dimensions, determinants, antecedents, aspects, and characteristics. Researchers (Mascarenhas et al., 2006; Garg et al., 2011) have suggested that although different authors have proposed and validated models that reflect either dimensions or attributes of CE, the variables across these models are sector-specific. It is also recognized that, despite the importance of customer experience and the positive attention this concept has received during the last few years, the explanation of customer experiences has remained vague and lacks a thorough theoretical foundation (Tynan and McKechnie, 2009; Gentile *et al.*, 2007; Maklan and Klaus, 2011). Moreover, several authors have argued that experience is a context-specific construct (Grawal et al., 2009; Verhoef et al., 2009). Drawing on rich qualitative data, Lemke et al. (2011) suggest that context-specific studies are needed to refine their generic model of CE, such as in healthcare. There have been a few attempts to define the concept of customer experience and its dimensions and attributes across diverse contexts, including healthcare services (Garg et al., 2011).

Despite the UK government's push for NHS hospitals to provide positive patient experiences, currently, there is a lack of conceptual clarity regarding what constitutes a customer's or patient's positive or negative experience. Berry and Bendapudi (2007) encourage scholars to re-examine in detail how patients perceive and evaluate health services. This void leaves managers and researchers alike with insufficient information to answer the question of what truly constitutes the construct of CE and factors that significantly influence positive or negative CEs from a customer's perspective in the context of NHS hospitals. Although several frameworks for health service quality and customer satisfaction have been proposed in the service management and healthcare literature (e.g. Taylor and Cronin, 1994; Wisniewski and Wisniewski, 2005; Fottler et al., 2006; Dagger et al., 2007; Duggirala et al., 2008), these models do not focus on the broader concept of CE and cannot assess the emotional aspects (Voss et al., 2008; Lemke et al., 2011). Against this background, this thesis sets out to fill the research gap by identifying the critical dimensions and attributes of CE and factors that significantly influence positive and negative CEs in an NHS hospitals context from a patient's/customer's perspective. Additionally, it develops a holistic conceptual framework for the customer experience in NHS hospitals.

1.5 Research aims, questions, and objectives

The overall aims of this project are to critically examine the underlying dimensions and attributes of the customer experience construct in the context of patients' or customers' hospital experiences in NHS hospitals in the UK.

The research objectives are stated as follows and emerged from defining the above-described research questions. This research aims to identify the critical dimensions of customer experience and to explore the attributes of customer experience in the healthcare sector, with NHS hospitals, from a customer's perspective. To conform to those overall aims, the following list of more precise objectives is addressed.

1. To identify the critical dimensions and attributes of customer experience in the NHS England hospitals context.
2. To identify the factors that have a significant influence on positive customer experiences in the NHS England hospitals context.
3. To identify the factors that have a significant influence on negative customer experience in the NHS England hospitals context.
4. To develop a holistic conceptual or classification framework that constitutes the construct of customer experience in the NHS England hospitals context.

The specific research questions are presented below to further exhibit how the study objectives are integrated into the current research. From a customer or patient's perspective:

1. What are the underlying critical dimensions and attributes that constitute the construct of customer experience within the NHS England hospitals context?
2. What are the factors that have a significant influence on positive customer experience in the NHS England hospitals context?
3. What are the factors that have a significant influence on negative customer experience in the NHS England hospitals context?

CE dimensions and attributes have been examined at different levels in the existing literature; these terms are used interchangeably with determinants, antecedents, domains, components, and characteristics depending on the study context or research aim. There is a plethora of descriptions and definitions of the dimensions and attributes of CE, and there is currently no real consensus on what these really mean. However, there is consistency with

definitions from different dictionaries; for instance, according to the Oxford English Dictionary, attribute is defined as *"a quality or feature regarded as a characteristic or inherent part of someone or something"* and dimensions as *"an aspect or feature of a situation"* (Ask Oxford 2012). Maklan and Klaus (2011), in their study to identify dimensions and attributes of customer experience, describe their aim as to identify "the dimensions, and their attributes", which explains why they present 19 items (attributes) that represent four CE dimensions. Similarly, Lemke et al. (2011) present 15 categories (dimensions) comprising 23 subcategories (attributes), and Gentle et al.'s (2007) seven dimensions and their attributes are described as main components that constitute other dimensions.

1.6 Definitions of the constructs

Service encounter

The model of service encounter evaluation relies on Shostack's (1985, p. 243) definition of the term "service encounter" as "a period of time during which a consumer interacts with a service." Shostack's definition encompasses all aspects of the service with which the consumer may interact – including its personnel, physical facilities, and other tangible elements – during a given period.

Service environment

Environment appears to have two general meanings in the literature. Environment is used to designate the total surroundings of an organism (Allee and Park, 1939) –essentially the rest of the universe – or, more commonly, environment is taken to mean only those portions of the surroundings which "may" or do directly affect the organism (Oosting, 1958; Daubenmire, 1959; Kendeigh, 1961; Hanson, 1962).

Customer involvement

Involvement has been defined as “the general level of interest in the object or the centrality of the object to the person's ego structure” (Day, 1970, p. 10). Involvement depends on three factors (Engel, Warshaw & Kinnear, 1987): needs, externally prompted feelings of self-relevance, and personal responses to the product (Celsi & Olson, 1988; Zaichowsky, 1985).

Customer emotions

Past research has explored the role of customer emotions in understanding the consumption experience (Oliver, 1997). As suggested by Richins (1997), many specific consumption experiences involve a broad range of mixed emotions or ambivalence. In this instance, consumer ambivalence has been defined as the experience of multiple positive and/or negative emotions within a single consumption episode (Otnes et al., 1997).

Customer-contact employee performance

Customer-contact employee performance is an intrinsic cue that significantly impacts customers' perceptions of service quality (Bitner, 1990; Darden and Babin, 1994; Gronroos, 1984; Hartline and Jones, 1996; Keaveney, 1995; Parasuraman et al., 1985; Zeithaml et al., 1996). In the current study, the performance of customer-contact employees is thought to serve as an intrinsic cue for customers to assess the customer experience.

Servicescape

Servicescape, or atmospherics, comprises both tangible elements (the building, carpeting, fixtures, and point-of-purchase decorations) and intangible elements (colours, music, temperature, and scents) that together comprise service experiences (Hoffman and Turley, 2002, p. 35). The three dimensions of ambient factors, design factors, and social factors (Baker et al., 1994) will be used in the current study.

Core service

This is also known as substantive service, which is best understood as the essential function of a service (Sasser et al., 1978) as cited in Palmer (1994, p. 127). In the resort context, the core services will be food, accommodation, and the leisure services and activities provided.

Pre-consumption mood

Mood is defined as a mild, pervasive, and generalized affective state rather than intense emotions (Mattila and Wirtz, 2000) that are easily induced (Schwarz and Clore, 1983). The customer mood prior to the consumption experience is hypothesized to affect his/her perception of the service consumption experience (Mattila and Wirtz, 2000).

Past experience

A customer's past experience with the firm would positively or negatively affect his/her expectations for the next service experience (Bitner, 1990).

Word-of-mouth/e-word of mouth

WOM communications is the message about an organization, its credibility and trustworthiness, its way of operating and its services, communicated from one person to another (Gronroos, 1990, p. 158). In the current study, WOM is established as a powerful source of influence in helping customers predict the consumption experience. There is no distinction between traditional WOM and online (electronic-WOM).

Customer experience

This is the internal, subjective response customers have to any direct or indirect contact with a company. "Direct contact generally occurs during purchase, use, and service, and is usually initiated by the customer. Whereas, indirect contact most often involves unplanned encounters with representations of a company's products, services, or brands and takes the form of WOM recommendations or criticisms, advertising, news reports, and reviews" (Meyer and Schwager, 2007, p. 2).

Perceived service quality

This is a consumer's judgement about an entity's overall excellence or superiority (Zeithmal, 1987).

Customer loyalty

Customer loyalty is often referred to as purchase behaviour, whereas customer satisfaction is an attitude (Griffin, 1996). Customer loyalty, a key mediating variable in explaining customer retention (Pritchard and Howard, 1997), concerns the likelihood that a customer will return, make business referrals, and provide strong WOM, as well as provide references and publicity (Bowen and Shoemaker, 1998). Loyal customers are less likely to switch to a competitor given a price inducement, and they make more purchases than less loyal customers (Baldinger and Rubinson, 1996).

Customer co-creation

In the contemporary marketing literature, "co-creation" is often used with reference to the joint creation of offerings (Hoyer et al., 2010) or value (Aarikka-Stenroos and Jaakkola, 2012; Vargo and Lusch, 2008), typically conceptualized as occurring through the exchange and integration of resources (Jaakkola and Alexander, 2014).

1.7 Chapter summary and thesis structure

This research was developed to explore the critical dimensions and attributes of CE in the NHS England hospitals context. To investigate the research questions, a narrative literature review of customer experience, patient experience, and related service marketing constructs and theories was conducted. The thesis contains a total of six chapters, as detailed below:

In *Chapter 1*, a step-by-step approach is taken to 'set the scene' for the rest of the study and thesis. The chapter outlines the specific research problems, scope, research questions, research objectives, and research approach. Sections 1.2 to 1.3 discuss the customer-orientation culture, profile of customer, NHS policy, customer imperatives, and online customer reviews in the context of the study. The chapter concludes with an overview.

The second chapter comprises a scrutiny and critical review of the pertinent literature on customer experience. The chapter begins with a discussion on the origins of the 'customer experience' phenomenon, one which is based on several streams of literature, including experiential consumption, the experience economy, service quality, service experience, customer co-creation, and experiential marketing. The research clarifies what is meant by the term 'customer experience' by exploring different conceptualizations, definitions,

perspectives, and dimensions of the concept through a narrative review and discusses the development of an initial conceptual framework.

The *third chapter* delineates the philosophy, research strategy, methodology, study design, data collection and method of interpretive approach. In addition, it explores netnography and the Critical Incident Technique (CIT), which the study will adopt to triangulate methods and data. The researcher highlights the strengths of each methodological technique and explains that, by combining several data generation methods, the overall result is a more holistic, rich, in-depth, and rigorous approach. In that section, it is demonstrated why interpretivism is suitable for a study in which context and lived experience are essential. The researcher will outline the actual execution of the research approaches, providing details on gaining research access, data gathering, data collection, and data analysis. The researcher also clarifies the epistemological and ontological underpinnings and their implications for the nature and content of the knowledge generated. Further, details are provided on the ethical issues associated with the study, including access, informed consent, confidentiality, and non-attribution. The grey areas which still surround the ethics of online-based research are also examined.

Chapter 4 presents the findings and discussion of the case study based on patient stories of their hospital experiences. The findings for each research question will be discussed and will present the proposition, design, and development of the new framework, based on the case study and literature review described in the previous chapters. In addition, the study findings and the new framework are evaluated in order to establish a basis for generalizations, broader conclusions, and contributions to theory and practice.

Chapter 5 is the concluding chapter of the thesis. It draws conclusions by attempting to combine the study's different meanings and insights into an integrated whole. This chapter also considers implications for theory and practice. Additionally, consideration is given to the limitations of this research thesis. Furthermore, a comprehensive conceptual framework will illustrate the link between the research questions and summarize the results. In the chapter, the researcher therefore answers the “so what?” question regarding the study's findings.

Finally, *Chapter 6* concludes by reflecting on my DBA journey diary. The journey diary was, for me, a very important part of my DBA because it provided a platform to reflect on the loneliness of my long-distance DBA journey and influenced my ontological perspective.

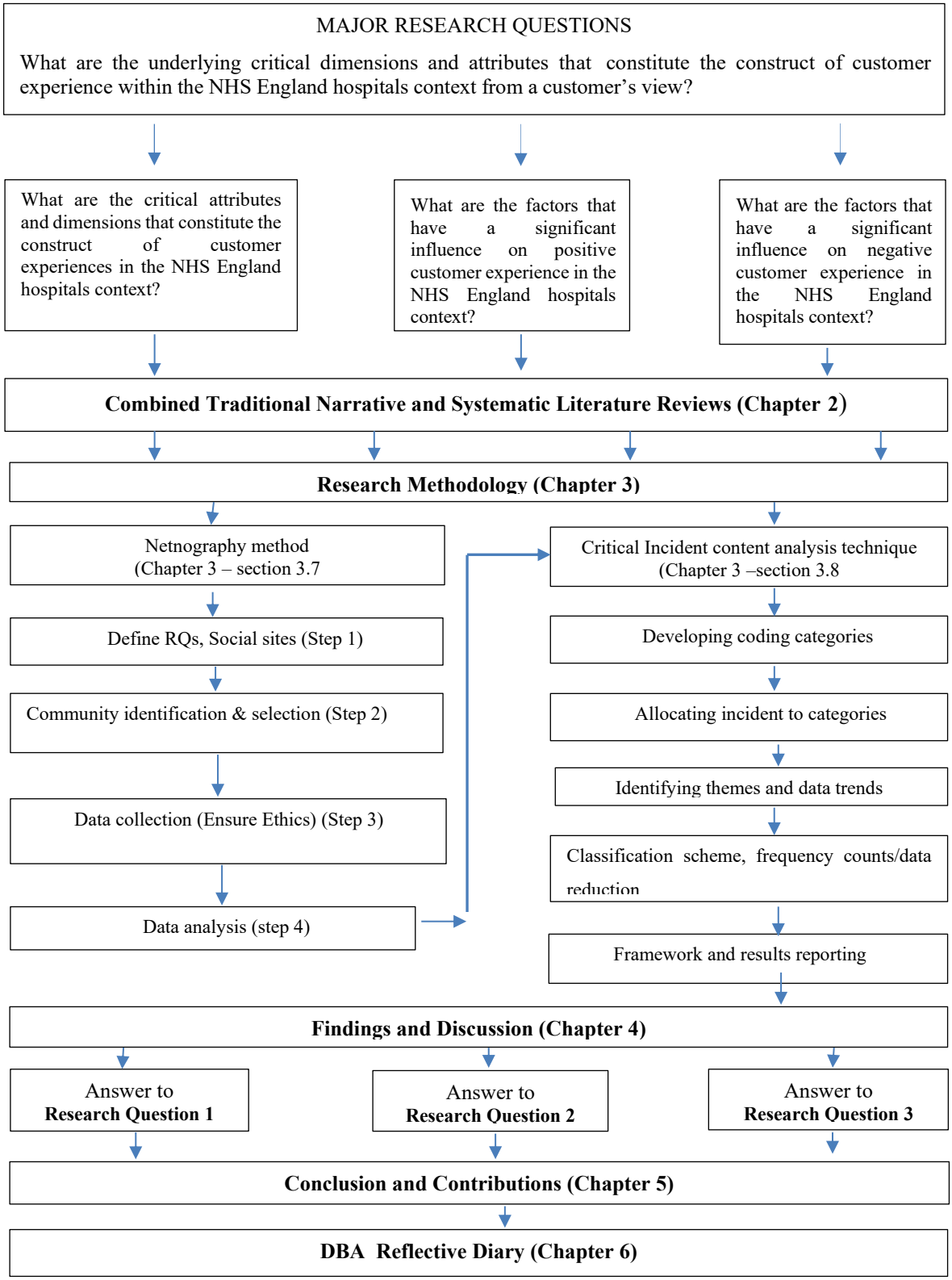


Figure 1.2: Schematic view of the research

1.8 Chapter summary

This chapter laid the foundations for this thesis by introducing the research background and problem, as well as the research aims and objectives. As discussed, there is little research that has been done on the dimensions and attributes of the customer/patient experience

construct within the NHS hospitals context. The next chapter will examine the literature relevant to this research problem.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter synthesizes relevant literature on customer experience. The first section 2.2. and 2.3 of this chapter reviews the customer experience phenomenon. It will start by investigating customer experience, definitions, and emerging experience themes, as well as the consumption experience as a holistic experience, and eventually the importance of customer experience in today's market. The second section will provide the theoretical foundation of the current study which is considered the departure point for this thesis; this section will start by introducing identified dimensions and attributes of CE and move to identify emotions as a major component in CE, and examine different related theories, models, and frameworks. The third section will shed light on patient experience. Finally, the author provides a critical presentation of several theories as a basis for creating a synthetic model that melds and extends distinct conceptual elements from different disciplines. Apart from that, this section contributes to developing a coherent initial model that serves as a research model to guide the subsequent research process.

2.2 Background

Over the past decade, practitioners and academics alike have argued that an essential strategy for success in the marketplace is to create and maintain satisfied customers (Parasuraman *et al.*, 1985; Reichheld and Sasser, 1990). However, the term *customer experience* was popularized in marketing literature by Pine and Gilmore (1998a) and Carbone and Haeckel (1994). It is gaining increasing interest among academicians and practitioners nowadays, especially because of the shift from a service-based economy to an experience-based economy (Kim, Kim, Kim, Kim, & Kang, 2008; Pine & Gilmore, 1998a; Verhoef et al., 2009). Gilmore and Pine (2002) noted that factors such as advanced technology, sophisticated and demanding customers, and an increasingly competitive business environment have made services appear more like commodities, requiring firms to move beyond goods and services to create memorable experiences. Recognizing its significant role, research on customer experience is gaining momentum in healthcare literature to establish a framework. In past research, experience is primarily considered as an integral part of satisfaction and thus not much work is seen on its conceptualization in the literature. Since creating favourable and memorable experiences is widely regarded as of the utmost

importance for sustaining business performance, there is a significant need to comprehensively understand the concept. In the context, this void leaves managers and researchers alike with insufficient information to answer the question of what the truly dimensions and attributes of CE are in the context of NHS hospitals. In an effort to answer this question, it is claimed that customer experience has not been treated as a separate construct and requires theoretical underpinning (Johnston and Kong, 2011; Verhoef et al., 2009; Frow and Payne, 2007). It is further advised that researchers and practitioners must understand the dimensions of customer experience as a construct (Barsky and Nash, 2002; Berry *et al.*, 2002).

A review of the relevant literature portrays the growing significance of customer experience in marketing literature from the late 1990s. Johnston and Kong (2011), Verhoef et al. (2009), and Frow and Payne (2007) have highlighted the need for research on customer experience, integrated with service quality, satisfaction, and loyalty. Verhoef et al. (2009) have published a detailed future research agenda on customer experience creation, focusing on its determinants, dynamics, and management strategies. They remarked that customer experience has not been treated as a separate construct and needs to be explored for theoretical underpinning. Similarly, in 2007, Frow and Payne reflected on the need to understand the relationship between customer experience and co-creation of value. They specifically proposed the need for an appropriate measurement tool to help manage the delivery of the customer experience. Literature on measuring customer experience remains scarce today. For instance, Pine and Gilmore (1998a) contemplated that the customer experience concept has gone largely unmeasured, and there is a need for grounding the concept in terms of its distinct economic offering. Further, firms need to see how they can establish progression of economic value, that is, how customizing a good turns it (good) into a service, customizing a service turns it (service) into an experience, and customizing an experience turns it (experience) into a transformed value-added service good. Recently, Helkkula (2011) undertook a systematic review and analysis of how the concept of CE has been characterized in the service marketing literature. Helkkula remarked that the challenge for future studies is to develop a more multidimensional typology of CE that links it more closely to other important concepts in service marketing and management. In light of the existing research gap, this thesis addresses the conceptual development of the customer experience, particularly in the context of healthcare services.

2.3 The concept of customer experience

More recently, there has been an increasing tendency to create 'experiences' for customers to gain a competitive advantage, particularly in the service sector. The service economy has been altered to an experience economy (Pine and Gilmore, 1999; Schmitt, 1999). Thereafter, the existing economy has been described as "the new experience economy" (Pine and Gilmore 1999; Smith, 2003). The researcher has come to realize that the notion of customer experience is hardly a new concept, because market researchers have tended to focus on the consumption experience for the past few decades. However, this phenomenon has not been an essential part of the economy in recent decades. Therefore, this study will address the re-emergence of experience and its importance at the present time. Pine and Gilmore (1999) were among the first to write about the emergence of a new service economy called the experience economy: "A new, emerging economy is coming to the fore, one based on a distinct kind of economic output: goods and services are no longer enough" (Pine and Gilmore, 1999, p. 11). Schmitt (1999, p. 3) reiterated the opinion of Pine and Gilmore (1999) when he stated that "We are in the middle of the revolution, a revolution that will render the principles and models of traditional marketing obsolete, a revolution that will replace traditional feature-and-benefit marketing with experiential marketing".

2.3.1 The context-dependent nature of the customer experience concept

The literature calls for studies that enhance our understanding of how customers perceive their experiences in specific service contexts (Roth and Menor, 2003; Voss et al., 2008; Verhoef et al., 2009; Ostrom et al., 2010; Helkkula, 2011). Lemke et al. (2011) develop a model of customer experience quality based on 40 consumer interviews. While the framework is positioned as generic and universally applicable, its data strongly suggests that the dimensions of customer experience quality differ across service contexts. The CE concept is assumed to be context-dependent because the ways in which customers judge their experiences in different environments vary (Zomerdijk and Voss, 2010). Healthcare is a relevant context for studying CE because, as with other professional services, the quality of the medical act and outcome (i.e. the "curing") is more difficult to assess than the quality of the service process (i.e. the "caring") (Wisniewski and Wisniewski, 2005). Healthcare recipients are likely to pay particular attention to the process of service delivery, emphasizing the experiential aspects of service provision.

2.3.2 Different disciplines of the definition of experience

The word experience, in all languages, has become an all-embracing term often used to refer to experiences a person has in everyday life (Carù and Cova, 2003). A useful place to start a formal treatment of experience is with a dictionary definition of the term, as, from a linguistic perspective, the term has a diverse range of meanings. According to the *American Heritage Dictionary of the English Language* (2000), an experience is "The apprehension of an object, thought, or emotion through the senses or mind" or "Active participation in events or activities leading to the accumulation of knowledge or skill". Another definition of experience, according to the *Cambridge Advanced Learner's Dictionary* (2008), is "Something that happens to you that affects the way you feel". Additionally, according to the *Compact Oxford English Dictionary* (2008), an experience is "practical contact with and observation of facts or events" or "knowledge or skill acquired over time" or "an event or occurrence which leaves an impression on one". From these definitions, a conclusion has been made that experience as a general term consists of knowledge of or skill in or observation of something or events acquired through involvement in that thing or exposure to that event. Furthermore, the main component of experience is the emotions, feelings, or sensations provoked during the experience (Schmitt, 1999). The notion of experience varies across scientific disciplines, as shown in Table 2.1. However, in the marketing discipline, experiences are private events that occur in response to some stimulation. "Experiences involve the entire living being. They often result from direct observation and/or participating in the event – whether they are real, dreamlike or virtual" (Schmitt, 1999, p. 60).

Scientific discipline	Definition
Science	In the generic sense inherited from positive sciences, an experience is similar to an experiment based on objective facts and data that can be generalized. It is important to recognize a distinction between experience in general and a scientific experience. A common experience provides the individual with particular knowledge; a scientific experience provides universal knowledge valid for all.
Philosophy	An experience is a personal trial which generally transforms the individual: "experience something" ("I tried…") usually leads to the accumulation of "experience" ("I have experience in…") and thus of knowledge. Moreover, this is singular (of a given individual) and not universal (outside the individual) knowledge. Experience is therefore gained when what happens is translated into knowledge (common sense), not only when it remains a simple lived occurrence. Thus, "reality only exists for us in the facts of consciousness given by inner experience" (Dilthey, 1976). But in our (post)modern world, this type of personal knowledge seems increasingly rare, as it has been undermined and replaced by scientific knowledge. The attempt to translate the everyday into experience is becoming ever more difficult
Sociology and psychology	An experience is a subjective, cognitive activity that allows the individual to develop. The notion of experience is generally defined (Dubet, 1994) as "a cognitive activity", "a test", "a means to construct reality and, above all, to verify it". As such, there is (Dewey, 1934) an intrinsic connection between experience, whether natural or social, and aesthetic form.
Anthropology and ethnology	Experience is the way in which individuals live their own culture and, more precisely, "how events are received by consciousness" (Bruner, 1986). Experience is something singular which happens to the individual (Abrahams, 1986). It also differs from mere individual behaviour, which an external observer can describe and concerns a routine the consumer simply passes through. An experience not only involves an intensity of personal feeling that takes it out of the flow of everyday life but also a framing operation by which the ongoing activity is translated into a reportable story.

Table 2.1: The definition of experience in different disciplines

Source: Adopted from Schmitt (1999)

The fields of philosophy, science, sociology, psychology, and anthropology and ethnology have made important contributions towards understanding the nature of experience. For example, Danish philosopher Søren Kierkegaard tied experience to emotions (albeit, mostly negative existential ones such as anxiety and despair). Moreover, Kierkegaard stressed that experiences are subjective. For him, subjectivity is the unique relation that a person has with

the outside, objective world. Subjectivity also includes the consciousness of a self which has a past, a present, and a future. For Kierkegaard, not only do objective matters have truth. A subjective experience also has truth for an individual. Alluding to a popular aphorism, one might say "experience is reality". Marketing researchers must closely consider and understand this subjective reality and the truth that it holds for an individual. Hence, this study aims to explore the dimensions and attributes of CE from a customer's perspective. In current marketing research, affect and emotions are considered important experiences that guide consumer decisions (Schmitt, 1999).

Philosophers and psychologists in the phenomenological tradition, for example, Husserl (1931) and Brentano (1874, 1973), argue that experiences are "of" or "about" something; they have reference and intentionality.' According to Dewey (1925), intellectual determinations result from knowledge, and individuals also have sensory perceptions, feelings, and actions resulting from experiences. However, in the marketing discipline, experiences are private events that occur in response to some stimulation: "Experiences involve the entire living being. They often result from direct observation and/or participating in the event – whether they are real, dreamlike or virtual" (Schmitt, 1999, p. 60).

Experiences have evolved from being a random phenomenon towards becoming an engineered perception (Carbone and Haeckel, 1994). A focus on experiences has arisen in response to the limitations of seeing consumer behaviour purely in terms of cognitive information processing: "Today's customers consider functional features and benefits, product and quality, and a positive brand image as given. What they want are products, communication and marketing events that dazzle their senses, touch their hearts, and stimulate their minds. They want products, communications and campaigns that they can incorporate into their lifestyles. They want products, communications and marketing to deliver an experience" (Schmitt, 1999, p. 22). In line with Schmitt's statements, Pine and Gilmore (1999) defined experience from a business perspective: "Experiences are events that engage individuals in a personal way" (p. 12). Similarly, Robinette et al. (2002) defined experience as "the collection of points at which companies and consumers exchange sensory stimuli, information, and emotion" (p. 60). The multiple definitions of the customer/patient experience are presented in Table 2.2.

Authors	Year	Definitions
Abbott	1955	…what people really desire are not products, but satisfying experiences. Experiences are attained through activities. To carry out activities, physical objects for human use are usually needed. Here lies the connecting link between men's inner world and the outer world of economic activity. Cited in Holbrook (2006, p. 40).
Dewey	1963	Experience involves progression over time, anticipation, emotional involvement, and a *"uniqueness that makes an activity stand out from the ordinary"* (Palmer, 2008).
Maslow	1968	Defined peak experience as "…moments of the highest happiness and fulfilment" (p. 73). In the peak experience, one can feel his/her true identity as Maslow (1968) stated that "In moments like this we feel more powerful than usual and experience unusual focus, joy, intensity, creativity, in other words being more fully human" (p. 72).
Csikszentmihalyi	1977	An individual is experiencing flow when he has "a unified flowing from one moment to the next, in which he is in control of his actions and in which there is little distinction between self and environment, between stimulus and response, between past, present and future" (p. 36).
Holbrook and Hirschman	1982	Experience is defined as a personal occurrence, often with important emotional significance, founded on the interaction with stimuli which are the products or services consumed, as cited in Carù and Cova (2003).
Csikszentmihalyi	1990	Flow is a state of experience which is characterized by an experience of intense concentration and enjoyment.
Arnould and Price	1993	An extraordinary experience is characterized by a high level of emotional intensity and is triggered by an unusual event.
Carbone and Haeckel	1994	"…the take-away impression formed by people's encounters with products, services, and businesses; a perception produced when humans consolidate sensory information" (p. 8).
	1998	Described experiences as being those that "a customer finds unique, memorable and sustainable over time" (p.12).
Pine and Gilmore	1999	From a business perspective, "experiences are events that engage individuals in a personal way" (p. 12).
Schmitt	1999	States that experiences "…Provide sensory, emotional, cognitive, behavioural and relational values that replace functional values" (p. 26).
Schmitt	1999	From customer perspective: "Experiences involve the entire living being. They often result from direct observation and/or participating in the event – whether they are real, dreamlike or virtual" (p. 60).

Bergmann	1999	"Experience is specific knowledge that has been acquired by an agent during past problem solving. Experience is therefore always situated in a certain, very specific problem solving context. Therefore, experiences are stored knowledge" (p.83)
Gupta and Vajic	2000	"…an experience occurs when a customer has any sensation or knowledge acquisition resulting from some level of interaction with different elements of a context created by the service provider" (p. 34).
Lewis and Chambers 2000		Consumer experience is "the total outcome to the customer from the combination of environment, goods and services purchased" (p.28)
Seybold et al. (2001)		"A total customer experience is a consistent representation and flawless execution, across distribution channels and interaction points, of the emotional connection and relationship you want your customers to have with your brand" (p.15).
Robinette et al.	2002	"…..the collection of points at which companies and consumers exchange sensory stimuli, information, and emotion" (p. 60).
Haeckel et al.	2003	By 'total experience' we mean the feelings customers take away from their interaction with a firm's goods, services, and 'atmospheric' stimuli.
Harris et al.	2003	"Total customer experience emphasises the importance of all contacts that a consumer has with an organization and the consumer's holistic experience" (p.33).
Hogan et al.	2005	A brand is the sum of the customer's experiences with the product of a company [. . .] An effective customer experience programme analyses rich customer feedback to determine not just what customers say, but also what they do.
Shaw	2005	A customer experience is an interaction between an organization and a customer. It is a blend of an organization's physical performance, the senses stimulated and emotions evoked, each intuitively measured against customer expectations across all moments of contact.
American Heritage Dictionary of English Language	2006	The feeling of emotions and sensations as opposed to thinking" and "…involvement in what is happening rather than abstract reflection on an event.
OUP	2006	Experience is the active participation in events or activities, leading to the accumulation of knowledge or skills.
Mascarenhas et al.	2006	Total customer experience is a totally positive, engaging, enduring, and socially fulfilling physical and emotional customer experience across all major levels of one's consumption chain and one that is brought about by a distinct market offering that calls for active interaction between consumers and providers.

Shaw and Ivens	2007	"An interaction between an organization and a customer. It is a blend of an organization's physical performance, the senses stimulated and emotions evoked, each intuitively measured against customer experience across all moments of contact" (p. 6).
Meyer and Schwager	2007	"The internal and subjective response that customers have of any direct or indirect contact with a company. Direct contact generally occurs in the course of purchase, use and service, and is usually initiated by the customer. Whereas, indirect contact most often involves unplanned encounters with representations of a company's products, services, or brands and takes the form of word-of-mouth recommendations or criticisms, advertising, news reports and reviews" (p. 2).
Gentile et al.	2007	"The customer experience originates from a set of interactions between a customer and a product, a company, or part of its organization, which provoke a reaction. This experience is strictly individual and implies the customer's involvement at different levels (rational, emotional, sensorial, physical and spiritual). Its evaluation depends on the comparison between a customer's expectations and the stimuli coming from the interaction with the company and its offering in correspondence of the different moments of contacts or touch-points" (p. 397).
Frow and Payne	2007	The perfect customer experience addresses that advocacy typically implies achieving a very high score on customer satisfaction.
Collins	2007	"The accumulation of knowledge or skill that results from direct participation in events or activities" and "… the content of direct observation or participation in an event" (p. 78).
Sundbo and Rasmussen	2008	The customer experience is a mental journey that leaves the customer with memories of having performed something special, having learned something or just having fun.
	2009	Emotions provoked, sensations felt, knowledge gained and skills acquired through active involvement with the firm pre, during and post consumption.
Verhoef et al.,	2009	"The customer experience construct is holistic in nature and involves the customer's cognitive, affective, emotional, social and physical responses to the retailer. This experience is created not only by those elements which the retailer can control (e.g. service interface, retail atmosphere, assortment, price), but also by elements that are outside of the retailer's control…the customer experience encompasses the total experience, including the search, purchase, consumption, and after-sale phases of the experience, and may involve multiple retail channels" (p. 32).
Fern et al.	2009	The patient experience refers to the quality and value of all of the Interactions—direct and indirect, clinical and non-clinical—spanning the entire duration of the patient/provider relationship.

Bleich et al.	2009	Bases its view of patient experience around the concept of health system responsiveness, which specifically refers to the manner and environment in which people are treated when they seek healthcare. Patient experience as responsiveness is found in domains including Autonomy, Choice, Communication, Confidentiality, Dignity, Prompt attention, and Quality of basic amenities.
Tynan and McKechnie	2009	"Consuming an experience can be viewed as a process that takes place across stages including pre-consumption, the purchase and core experiences, to the remembered consumption experience. The value created is both enabled and judged by customers throughout this consumption process and not merely at the point of exchange" (p. 508).
Weiss and Tyink	2009	Experience is based on the components of a patient-centric culture which encompasses competent, high-quality care, personalized care, timely responses, care coordination, and is reliable and responsive. Experience is about a brand experience and is driven by what happens at the point of contact between the patient, the practice, and the provider.
Ghose	2009	Customer experience acts as the user's interpretation of his or her total interaction with the brand.
Zomerdijk and Voss	2010	"An experience occurs when a customer has any sensation or acquires knowledge from some level of interaction with the elements of a context created by a service provider" (p. 67).
Walter et al.,	2010	A customer experience is defined as the customer's direct and indirect experience of the service process, the organization, the facilities and how the customer interacts with the service firm's representatives and other customers. These in turn create the customer's cognitive, emotional and behavioural responses and leave the customer with memories about the experience.
Robinson	2010	The ideal experience is created by meeting four basic emotional needs: confidence, integrity, pride, and passion. Experience is about engaging patients. Engaged healthcare is better healthcare, for everyone. And that's the best definition of the patient experience.
Lemke et al.,	2011	"Customer experience is conceptualized as the customer's subjective response to the holistic direct and indirect encounter with the firm" (p. 846).
Frampton	2012	Patients' experiences of care occur in two main areas of focus: human interactions and the care environment. Suggests that patient-centred care lives in the space between what care and treatment are provided and how they are experienced by patients and their loved ones.

Bowling et al.,	2012	Patients' experiences are their direct, personal observations of their healthcare. Expectations of experience included cleanliness; information about where to go; convenient and punctual appointments; being seen on time and choice of hospital/doctor and helpful reception staff; the doctor to be knowledgeable, clear and easy to understand; to be involved in treatment decisions and to experience a reduction in symptoms/problems; the doctor being respectful and treating the patient with dignity; being given reassurance; receiving advice about health/condition and information about the cause and management of the condition and about benefits/side effects of treatment; and being given an opportunity to discuss problems.
Needham	2012	Patient experience is about managing both the emotional and physical roller coaster a patient experiences while undergoing a healthcare procedure and about maximizing the patient's social, mental, and physical health and wellness. To support this effort, it is suggested to personalize medicine, partner with patients, and empower employees.
Staniszewska and Bullock	2012	Identifies the dimensions of patient experience included in the publication Patient experience in adult NHS services; improving the experience of care for people using adult NHS services. They include knowing the patient as an individual; essential requirements of care; tailoring healthcare services for reach patient; continuity of care and relationships; and enabling patients to actively participate in their care.
Pemerton and Richardson	2013	Provided a patient experience vision framed by a series of six active steps, which include reputation, arrival, contract, stay, treatment, and after stay. The importance of culture and staff engagement in driving an effective patient experience effort is suggested.
Stempniak	2013	The patient experience can be viewed in total as reducing suffering and reducing anxiety across the entire continuum of care, from the first phone call to discharge.
Shale	2013	Warns us about equating patient experience with satisfaction and explains, there is a complex relationship between patient knowledge, patient expectations of care, patient experiences of care, patient assessment of care, and objective measures of patient benefit. Suggests there are three dimensions or domains of patient experience including the physiologic illness experience (rash, bleeding, etc.), customer service (not satisfaction), and the lived experience of the illness (coping/dealing with the condition).
Staniszewska et al.	2014	The Warwick Patient Experiences Framework identifies seven key generic themes that are important to a high-quality patient experience: patient as active participant, responsiveness of services, an individualized approach, lived experience, continuity of care and relationships, communication, information, and support.
Wolf	2014	The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care.

Hewitson et al.	2014	Experience is described as patients' self-reports of their experience of inpatient care, including staff–patient interactions, information provision, involvement in decisions and support for self-care, and overall ratings of care.
The Free Dictionary by Farlex		How the patient feels/felt, i.e. good or bad, as/after he or she undergoes/went through an episode of care.
De Keyser et al.	2015	Describe CE as "comprised of cognitive, emotional, physical, sensorial, spiritual, and social elements that mark the customer's direct or indirect interactions with (an) other market actor (s)" (p. 23).
Researcher	2016	Define CE as " subjective response to the sum of all direct, indirect, unexpected service encounters, shaped by organisation's service ecosystem that influence perceptions, across the stages of customer's continuum of care which turn create the customer's stimuli, resulting positive or negative memories about the experience"

Table 2.2: Multi-Definitions of Customer Experience

Source: Developed by the researcher for this study

Over the last 30 years, several researchers and scholars have attempted to define the terms "experience," "customer experience," and "patient experience" to better understand what these experiences are all about. Over the last decade, there has been a rapid expansion in the use of the terms "customer experience" and "patient experience" in the general healthcare vernacular and across both clinical practice and research. In context, this has been driven by both shifts in public policy that have put the experience of patients front and centre with public reporting that has an impact on incentives or payments by results (PbR) and a significant transition in healthcare with an evolving and engaged patient and family population and the corresponding emergence of a consumer mindset. In the wake of this expansion, there has been increasing recognition that the customer/patient experience is now a top priority for healthcare management (Wolf et al., 2014). Yet, in practice and research, the concept of patient experience has had varied uses and is often discussed with little more explanation than the term itself. However, very little has been published on the complexities of defining customer/patient experience. The question this raises is that as customer/patient experience is identified as a priority item, would healthcare efforts be best served by having a formally accepted definition of customer/patient experience? Multiple definitions of customer experience exist in the literature, as shown above in Table 2.2. The crux of all these definitions is that firstly customer/patient experience is an emotional connection between the

customer and the organization. Secondly, it is completely internal to a customer. Lastly, it largely depends on all the interactions. But, this non-figurative and elusive notion (Knutson et al., 2007) of customer/patient experience prompts some questions, such as what are the critical dimensions, attributes, and outcomes that constitute the CE construct? What factors significantly influence the positive and negative CEs?

In most the recent works on CE in the marketing literature, there tends to be a general consensus that CE is an internal, subjective, and emotional response customers have from interactions with a product, a company, or part of its organization (e.g. Carbone and Haeckel, 1994; Gentile, et al., 2007; Lemke et al., 2011; Meyer and Schwager, 2007; Pine and Gilmore, 1999; Shaw and Ivens, 2002; Tynan and McKechnie, 2009; Verhoef et al., 2009; Zomerdijk and Voss, 2010). While some authors believe that CE originates from individual interactions, moments of contact or touch points (e.g. Carbone and Haeckel, 1994; Meyer and Schwager, 2007; Pine and Gilmore, 1999; Shaw and Ivens, 2002; Zomerdijk and Voss, 2010), other authors take a more universal perspective, arguing that CE results from a cumulative assessment of all the interactions customer encounter over the customer journey (e.g. Gentile et al., 2007; Lemke et al., 2011; Tynan and McKechnie, 2009; Verhoef et al., 2009). Another variable aspect of the CE definition is whether the experience accounts for direct and indirect interactions with a company. Several authors assert that CE involves both direct (initiated by the customer) and indirect (unplanned) encounters (e.g. Lemke et al., 2011; Meyer and Schwager, 2007; Verhoef et al., 2009) from which customers form evaluations of their experience. Others contend that CE is shaped only by direct encounters which the firm primarily controls (e.g. Carbone and Haeckel, 1994; Gentile et al., 2007; Pine and Gilmore, 1999; Shaw and Ivens, 2002; Tynan and McKechnie, 2009; Zomerdijk and Voss, 2010). As the scientific contributions are rich and diverse, so are the different interpretations and conceptualizations of the CE offered by each author; nevertheless, despite the differences of perspectives and the various definitions proposed, the researcher identified some common core characteristics of the CE that are useful in his development of a new definition of CE in the context of healthcare. Researcher define, CE as:

> "the subjective response to the sum of all direct, indirect, unexpected service encounters, shaped by organisation's service ecosystem that influences perceptions, across the stages of the customer's continuum of care, which turns into the customer's stimuli, resulting in positive or negative memories about the experience"

In sum, in a recent and subsequent piece of work, a more comprehensive and conclusive definition of CE is suggested by Gentile *et al.* (2007, p. 397) based on contributions from other authors (LaSalle and Britton, 2003; Schmitt, 1999; Shaw and Ivens, 2005):

> "The customer experience originates from a set of interactions between a customer and a product, a company, or part of its organisation, which provoke a reaction (LaSalle and Britton, 2003; Shaw and Ivens, 2005). This experience is strictly personal and implies the customer's involvement at different levels (rational, emotional, sensorial physical and spiritual) (LaSalle and Britton, 2003; Schmitt, 1999). Its evaluation depends on the comparison between a customer's expectations and the stimulus coming from the interaction with the company and its offering in correspondence with the different moments of contact or touch-points (LaSalle and Britton, 2003; Shaw and Ivens, 2005)" (p. 397).

There is some similarity between the CE definitions of Gentile et al. (2007), Meyer and Schwager (2007) and De Keyser et al. (2015). Meyer and Schwager (2007) define CE as:

> "The internal and subjective response that customers have to any direct or indirect contact with a company. Direct contact generally occurs in the course of purchase, use and service, and is usually initiated by the customer. Whereas, indirect contact most often involves unplanned encounters with representations of a company's products, services, or brands and takes the form of word-of-mouth recommendations or criticisms, advertising, news reports and reviews" (p. 2).

Whereas De Keyser et al. (2015) describe CE as "comprised of cognitive, emotional, physical, sensorial, spiritual, and social elements that mark the customer's direct or indirect interactions with (an) other market actor (s)" (p. 23). Additionally, the researcher acknowledges Wolf et al.'s (2014) definition for patient experience – *"the sum of all interactions, shaped by an organisation's culture that influence patient perceptions, across the continuum of care"* (p. 8). Hence, based on the definitions of Gentile et al. (2007), Wolf et al. (2014), Meyer and Schwager (2007), and De Keyser et al. (2015), the researcher considers CE holistic in nature, incorporating the customer's cognitive, emotional, sensory, social, physical, and spiritual responses to all interactions across the continuum of encounters or interactions with a firm (e.g. Bolton et al., 2014; Gentile et al., 2007; Lemke et al., 2011; Verhoef et al., 2009; Wolf et al., 2014). In addition, the language of healthcare is expanding in the experience space, reaching beyond the facets of a clinical encounter, as exemplified in the term "across the continuum" in its broadest sense. The research intent was not to critique or validate these definitions, but rather to explore the elements key to an effective framing of this phenomenon. As the customer/patient experience movement progresses and a field of practice emerges, as exemplified in literature, the idea of definition

is important, but also complicated. The researcher's aim is not to spark debate over exact words, but rather to reinforce that some level of consensus is critical to moving the conversation forward. The researcher also acknowledges that definitions can change over time, especially in the dynamic, rapidly changing healthcare environment, and therefore does not want an aspiration for academic consensus to impede. Thus, CE is a complex concept that lacks a common terminology and a shared mindset.

Based on the review of the literature above, CE is usually broadly defined, with multiple definitions of customer experience in the literature. In the next section, the researcher provides an in-depth discussion of emerging themes identified from the CE definitions, such as "sum or continuum of all interactions or encounters (direct and indirect)", "expectations", "individualism", "customer-centricity", and "satisfaction".

2.3.2.1 Emerging themes from customer experience definition

As the review of literature and sources showed, there is no commonly accepted definition of customer/patient experience. While there have been increasing numbers of articles, research, and writing on the subject in recent years, little has been seen in the way of coalescing around an accepted definition. Much of this is due to the reality that, in all but a few cases, a truly concise, applicable, and replicable definition was not offered. Other influences may include competing interests that affect businesses' day-to-day operations. The literature generally has concluded that there are six competing themes: focus on *the set or sum of all interactions/encounters (direct and indirect encounters), focus on expectations, focus on subjectivity or individualism, negative and positive experiences, alignment with customer-centrism or patient-centred principles, and satisfaction*. The following section will discuss these themes.

Focus on the sum or continuum of all interactions or encounters (direct and indirect)

Several authors argue that the customer/patient experience is not just one encounter or interaction but spans over time and includes many touch points (Wolf et al., 2014; Lemke et al., 2011; Gentile et al., 2007; Mayer and Shwager, 2007; Verhoef et al., 2011; Wolf et al., 2014; Stempniak, 2013; Ghose, 2009: Frampton, 2012; Walter et al., 2010; Fern et al., 2009). Fern et al. (2009) contend that organizations need to focus on the patient experience to gain and maintain a competitive advantage. They define the patient experience as much broader than the care itself, describing specific touch points or times when there is interaction with

the organization and the patient. Their definition, "patient experience refers to the quality and value of all of the interactions—direct and indirect, clinical and nonclinical—spanning the entire duration of the patient/provider relationship" (p. 143), represents a continuum of interactions. Similarly, Carù and Cova (2007) identified a "continuum of consuming experiences" ranging from direct to indirect experiences. Additionally, De Keyser et al. (2015) describe CE as "comprised of cognitive, emotional, physical, sensorial, spiritual, and social elements that mark the customer's direct or indirect interactions with (an) other market actor (s)" (p. 23).

Focus on expectations

Some customer experience definitions place heavy emphasis on expectations (Gentile et al., 2007; Walter et al., 2010; Verhoef et al., 2016; Mascarenhas et al., 2006). Bowling et al., (2012) conducted a comprehensive review of patient experience expectations from 2000 to 2009. They evaluated two concepts: (1) pre-visit expectations and (2) post-visit experience in general practitioner patients and hospital outpatients. Similarly, Mattila and Wirtz (2000) and Maklan and Klaus (2011) named pre-visit expectations as "pre-consumption experience" as customer mood/expectations prior to the consumption experience is hypothesized to affect his/her perception of the service consumption experience positively or negatively. Additionally, Bitner (1990) referred to post-visit experience as "past experience": a customer's last experience with the firm would positively affect his/her expectations of the next service experience. Bowling et al. (2012, p.30) further defined patients' experiences as "their direct, personal observations of their healthcare" and measured patient experience in terms of whether patients 'expectations were met. Expectations of experience included cleanliness; information about where to go; convenient and punctual appointments; being seen on time and choice of hospital/doctor and helpful reception staff; the doctor to be knowledgeable, clear and easy to understand; to be involved in treatment decisions and to experience a reduction in symptoms/problems; the doctor being respectful and treating the patient with dignity; being given reassurance; receiving advice about health or condition and information about the cause and management of the condition and about benefits/side effects of treatment; and being given an opportunity to discuss problems (Bowling et al., 2012).

Focus on individualism

Like customer-centric or patient-centred care, several articles focused on the personal aspect when defining the customer/patient experience. Gentile et al. (2007) posit that experience is strictly personal, as subjective lived experience implies. Similarly, Meyer and Schwager (2007) described the subjective nature of CE as "…the internal and subjective response that customers have of any direct or indirect contact with a company". They added internal to refer to the "emotions": an important component of CE. Using the Institute of Medicine Framework (IOM) (which includes the themes of compassion, empathy and responsiveness, coordination and integration, information, communication and education, physical comfort, emotional support, relieving fear and anxiety, and involvement of family and friends) as a model to compare and contrast themes, Staniszewska and colleagues offered a set of generic themes associated with patient experience (Staniszewska et al., 2014). The Warwick Patient Experiences Framework (WaPEF) identifies seven key generic themes that are important to a high-quality patient experience: patient as active participant, responsiveness of services, an individualized approach, lived experience, continuity of care and relationships, communication, and information and support. Staniszewska and Bullock (2014) report that, through an extensive review of research and policy, the NICE Guidance Development group, comprising six patients, identified dimensions of patient experience included in the publication Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. The dimensions identified in the guidance include knowing the patient as an individual; essential requirements of care; tailoring healthcare services for each patient; continuity of care and relationships; and enabling patients to actively participate in their care. They reinforce their findings with a position outlined by Richard Doll, the eminent epidemiologist, who stated that there is no point in providing clinically effective and economically efficient care that no one wants.

Aligned with customer centricity or patient-centred principles

Other definitions focus on patient-centred care principles. Weiss and Tyink (2009) discuss the opportunity to provide the ideal patient experience through creating a patient-centric culture. The components of a patient-centric culture encompass competent, high-quality care, personalized care, timely responses, care coordination, and are reliable and responsive. They suggest that the patient experience is about a brand experience and is driven by what happens at the point of contact between the patient, the practice, and the provider. While Frampton does not offer a direct definition for patient experience, she alludes to its alignment

to patients' experiences of care and suggests that this occurs in two main areas of focus: human interactions and the care environment. She adds that patient-centred care lies in the space between the care and treatment provided and how patients and their loved ones experience them (Frampton, 2012).

More than satisfaction

A few articles define patient experience and caution against equating it with satisfaction. Shale argues that the concept of the "patient experience", although usually measured by "service experience", differs between patients, clinicians, politicians, managers, and academics (Shale, 2013). Shale believes that patient experience is a clinical quality indicator; however, she cautions against paralleling patient experience with satisfaction. She explains, "there is a complex relationship between patient knowledge, patient expectations of care, patient experiences of care, patient assessment of care, and objective measures of patient benefit" (p. 287). She postulates that there are three dimensions or domains of patient experience, including the physiologic illness experience (e.g., rash, bleeding), customer service (not satisfaction), and the lived experience of the illness (e.g., coping with the condition).

In examining the situation further, while numerous indirect statements were offered about what could comprise or shape the context of customer/patient experience, the researcher believes a more significant effort should be made to align around a consistently identified definition. This is offered not to promote one idea or concept over another but rather recognizing that with a rapidly expanding exploration into this topic academically and intensifying efforts to address customer/patient experience in practice, a common footing will strengthen and align efforts overall.

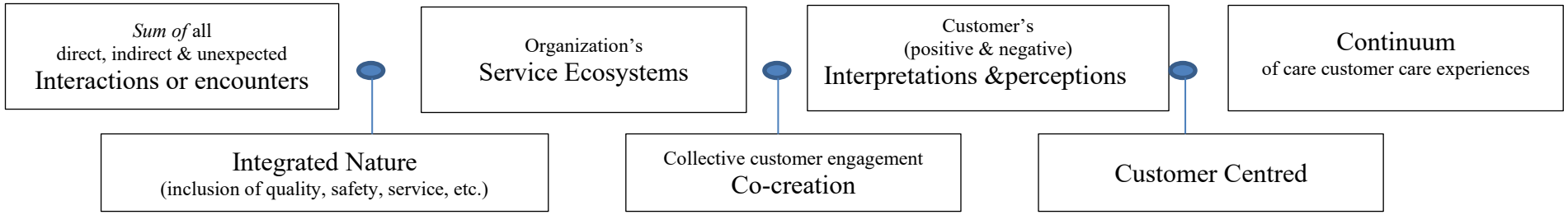
For one, the researcher cannot, nor should they attempt to define customer/patient experience without considering the perspective of the patient (and family) member themselves (Wolf et al., 2014). For example, healthcare quality, safety, and service efforts are often addressed as distinct efforts in healthcare settings, but we have yet to see where customers/patients or family members draw these forced distinctions. Wolf et al. (2014) argue that they have but one experience, shaped by the various facets of every healthcare encounter. In the context, the definitions that the researcher identified and synthesized spans a range of customer/patient setting/environment experiences, overall lived experiences, care experiences, clinical and non-clinical interactions or encounters, organizational features of

care, customer satisfaction customer/patient engagement and process measures. The “sum of all interactions or encounters” of the definitions of Gentile et al. (2007), Verhoef et al. (2011), and Wolf et al. (2014) reflects the interactive, dynamic nature of the CE, as a whole.

In sum, the language of healthcare is expanding in the experience space, reaching beyond the facets of a clinical encounter, as exemplified in the term “across the continuum”. With this context, the researcher suggests that, while consistency in the use of a single definition was not evident in the study review, there was strong alignment on central themes considered critical to the customer or patient experience. This reinforces the researcher’s call for a coalescence of ideas rather than a perpetuation of distinction. In the definitions review above, some specific ideas appeared on multiple occasions. The most consistent concepts or phrases found across reviewed sources (see Table 2.2) included emotional and physical lived experience, personal interactions or encounters, spanning across the continuum of encounters, shaped by the organization/culture, and the importance of partnership/patient involvement. Other concepts frequently mentioned touched on perceptions, information, and responsiveness. As noted above, these themes included the need to move beyond survey results, as customer/patient experience is more than satisfaction; continuum of encounters; focus on expectations, individualized care and tailored services; and that patient experience is commonly aligned with customer-centric or patient-centred care principles. With the proliferation of studies on the subject, the implementation of policy driving action, and the expansion of the customer/patient experience as a field of study and practice, the lack of stated alignment, accompanied by a clear emergence of common ideas, leads the author to suggest the need for a formally accepted definition. The researcher acknowledges that while some attempts to create a clear definition have been made and are noted in Table 2.2, most efforts still do not frame the idea beyond measures, domains of practice, or applied strategies. The researcher believes that this hinders the customer/patient experience effort and, in doing so, creates an unstable foundation for the future of both research and practice, particularly in the NHS. In reviewing the alignment of emerging concepts and overarching themes, the researcher found much of what could be included in a potential shared definition of the customer/patient experience. Of interest to the researcher was the recurrence of themes found in the definitions offered by Gentile et al. (2007), Wolf et al. (2014), De Keyser et al. (2015), Meyer and Schwager (2007), Lemke et al. (2011), Mascarenhas et al. (2006), and Carù and Cova (2007) that include “sum of all interactions”, ”the influence of organizational culture”, “customer perceptions”, “involvement”, “emotions”, “personal”, and the importance of considering experiences “across the continuum of encounters”. The integration of interactions, culture, perceptions, involvement, and the broad cross-continuum reach in

Gentile et al.'s (2007) and Wolf et al.'s (2014) definitions bring together the themes the researcher mentioned and offers a few concepts for consideration to guide actionable customer/patient experience improvement efforts. The researcher believes that there is a significant and practical need for a clear, comprehensive, and shared definition and that the definitions of Gentile et al. (2007) and Wolf et al. (2014), along with the themes identified in this review, provide a means by which to frame a concise, practical definition to guide future action.

Three consistent themes identified in the study narrative synthesis are active patient and family partnership and engagement, the integral need for person-centeredness, and an acknowledgement of the broad and integrated nature of experience overall. While these concepts may be implicit in the framing of the definitions of Gentile et al. (2007), Wolf et al. (2014), De Keyser et al. (2015), Meyer and Schwager (2007), and Lemke et al. (2011) and can be made clear through further explanation, the emergent themes along with other commonly recurring constructs from reseacher synthesis suggest that it would be beneficial to develop a framework to provide clarity and reinforce applicability. Further work is required to develop a framework that ultimately provides a structure within which to consider key principles that may be applied to optimize customer/patient experience across NHS healthcare settings. Meanwhile, as discussed above, the researcher has identified important themes and recurring constructs that prevail in current definitions, which the researcher recommends be considered to improve understanding and the customer experience in an NHS hospital context (Figure 2.1).



Expanded Description	The orchestrated touch-points of people, processes, policies, communications, actions, and environment	The vision, values, people (at all levels and in all parts of the organization) and community engaged and involved with the organization	What is recognized, understood and remembered by patients and support people. Perceptions vary based on individual experiences such as beliefs, values, cultural background, etc.	In all facets of the healthcare system, in all encounters, in all settings, from non-clinical proactive experiences to long-term or hospice, and across the spectrum of services.
Supporting Themes (for customer experience improvement) and alignment with elements	**Integrated Nature** reinforces that the patient experience is singular and aligned, not simply a collection of distinct or disparate efforts. It is encompassing of all encounters whether they include quality, safety or service and these efforts should be coordinated and aligned to support a "one experience" mindset. [Includes: Beyond survey results, more than satisfaction]		**Customer-centeredness** recognizes that the recipient and deliverer of healthcare experience are at their core human beings. As a component of experience, this reinforces that process or protocol should not trump the broader needs of people engaged (in almost all cases) at any point on the healthcare spectrum. [Includes: Aligned with patient-centered care principles]	
		Collective customer (engagement or involvement) acknowledges that patients, families, and members of their support network are active participants in the care experience and must be engaged as participant-owners in their encounters. The voices of these individuals are not only significant in situations of care, but also in planning, ongoing operations and change/improvement efforts. [Includes: Focus on expectations, focus on individualized care]		

Figure 2.1: Definitional themes and recurring constructs for inclusion and consideration in customer experience improvement efforts

In conclusion, as customer/patient experience continues to emerge as an area of research and practice in healthcare, the need for a standard, consistent definition becomes even more critical. Without a common foundation or at least a cornerstone on which to build or adapt, the efforts that follow are set on shaky ground. The researcher offers these ideas not in the promotion of one idea over another, but in recognizing that in existing work and in the shared themes the researcher uncovered, there is a strong set of related concepts from which to grow. This will be critical to ensure customer/patient experience remains a viable, respected, and highly embraced part of the healthcare conversation, as the researcher believes it should.

In the marketing literature, the term "customer experience" has been used in diverse ways. However, this field of research has not witnessed remarkable progress, which arguably accounts for the lack of clear critical dimensions and attributes that constitute the construct of CE, and for factors that significantly influence positive and negative CEs. In reviewing the multiple definitions of customer/patient experience, a number of dimensions, a few attributes and other related service marketing concepts emerged from some of the definitions. Therefore, the following section will detail the different dimensions and attributes of customer/patient experience and other service marketing concepts that significantly influence CE.

2.4 Theoretical foundation

Customer experience is widely recognized as a multidimensional construct (e.g. Brakus, Schmitt, and Zarantonello, 2009; Gentile, Spiller, and Noci, 2007; Tynan and McKechnie, 2009). Different dimensions or attributes contribute to form a holistic view of customer experience (Verhoef et al., 2009; Maklan and Klaus, 2011), and may be experienced by customers at the conscious or subconscious level (Gentile, Spiller, and Noci, 2007; Schmitt, 1999). Therefore, the following section will discuss the dimensions and attributes of customer experience and emotions, as major components of experience. In order to study different variables appearing in the previous studies of CE, researcher had focused on the three mentioned categories of findings as depicted in Table 2.3. As the experiences of the customer differ according to the sector, some distinction exists among some variables (as they are important according to their particular service sector), and moreover, different researchers have named and defined these variables in their own way. So, researcher have decided on some criteria in this study, i.e. the variables which are synonyms or act as a subset of the particular group or sub-group are kept in one cluster, and the variable which has

appeared at least twice or more is considered only. The “selection of variables” is divided into three categories: dimensions, attributes, and outcomes of CE.

2.4.1 Multidimensionality of customer experience

The “multi-aspect” conceptualization of experience can be traced back to Holbrook and Hirschman (1982) when they conceptualized the consumption experience under the heading of “Fantasies, feelings and fun”. Later, in research by Arnould and Price (1993) on customers' experiences of river rafting, they identified three aspects of the experience: personal growth, communitas, and harmony. These were derived from a series of research methods ranging from focus groups to observation over a seven-month period. Participants and guides of the river rafting adventure were used as the sample. Arnould *et al.* (1993) argue that experience factors range from positive to negative states and group these factors into interpersonal and non-interpersonal categories. It was found that employees' interpersonal effort and engagement accounted for the largest share of positive and negative emotions, and hence satisfaction. But the authors claimed that the findings could not be generalized beyond the sample. Moreover, river rafting requires specialized skills, and the customer is partly responsible for the experience. Therefore, the experiences arising from this context may not apply in other situations where the customer is the full recipient of the service.

Through a comparative table (2.3), key elements of the selected studies were divided into different categories, such as details of the paper (author/journal/year of publication; type of application/country (sample drawn); methodology and sample details; and objective of each study and findings. In the fifth category, findings presented in the table were further sub-categorized into two categories: dimensions and attributes of CE. The simplification of the available data and the categorization of all the key elements helped the researcher to make a straight comparison among studies. This tabulation would also serve as a basis for future researchers seeking to construct and test the complete conceptual framework for CE.

To achieve the objectivity and consistency of the constructed table and to minimize its subjectivity, the table was checked again and again for articles considered in the study. This re-examination ensured that the observations drawn from the articles were consistent with the study's theme. To test the legitimacy and applicability of the observations that emerged from the table, they were rechecked against the articles listed in the table. “Such rigorous

cross-checking was viewed as the only viable, if imperfect way of attempting to create valid comparable data" (Athanasopoulou, 2009). Table 2.3 summarises the dimensions and attributes of the customer/patient experience explored by the researcher.

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
1	Rowley (1994) LR	Library	To identify the factors that influence the customer experiences		*Speed, convenience, choice quality*	*Customer satisfaction*
2	Otto & Ritchie (1996)/ TM	Tourism/Vancouver	To measure the customer satisfaction with the service exp across the tourism industries	*Hedonic, safety interactive, novelty, comfort and stimulation*	*Service escape, service delivery and human interaction*	*Customer satisfaction*
3	Johnson & Mathews (1996)/IJSIM	Fast food/UK	To measure the expectations of customer to evaluate quality dimensions of services	*Speed*	*Person-specific, servicescape ambience, speed. staff*	*expectations*
4	Grove & Fisk (1997)/JR	Tourism/Central Florida	To measure the expectations of customers to evaluate quality dimensions of services exp		*Presence of others, waiting lines, social interactions, service escape and demographic variables.*	*Customer satisfaction*
5	Pine & Gilmore (1998)/HBR	General	Welcome to the experiences economy	*Emotional, memory*		
6	Sarel & Marmostein (1999)/IJBM	Bank	To analyse the reaction of customers on the service delay		*Prior waiting experiences, perceived employee behaviour and employee apology*	*Customer satisfaction*

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
7	Rowley (1999)/IJCHM	Museum	To identify the factors that influence the customer's experiences,		*Speed convenience, age, choice, valuable adding, lifestyle, quality, technology services and discounting.*	
8	Tseng et al.(1999)/BPMJ	General	To identify the improvement in services operations by mapping the services experiences on the customer.		*Physical environment. Other customer, service personnel, and service process.*	*Customer satisfaction*
9	McIntosh (1999)/JTTM	Heritage/UK	The aim of the study I to identify the value attained through the visitors' experiences dimension	*Affective, reflective and cognitive*	*Presence of other visitors and environment.*	*Immediate & long term benefits*
10	Johnston (1999)/MSQ	General	Identify a service design technique design technique to analyse the quality of service process from customer's perspective,		*Service process, employee's behaviour and speed.*	*Customer satisfaction*
11	Schmitt (1999)/JMM	General	The aim is to provide the new approach of marketing i.e. Experiential marketing.	*Sense, feel. Think. act and relate*		
12	Novak et al. (2000)/MS	Online	To measure the customer experience		*Arousal, challenge, control, Focused, attention, interactivity, skill*	Positive effect

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
13	Fulbright et al (2001)/AJR	Pain	To propose a model to identify whether the pain experience includes the sensory and effective components.	*Sensory, affective and cognitive*		Balance of pain
14	Sun (2002)/AJC	Online Canada	To identify experiential dimension of online shopping.	*affective responses and flow experiences*		Customer loyalty social gains
15	Jenkinson et al. (2002) QSHC	Healthcare	To determine what aspects of health provisions are most likely to explore the extent to which satisfaction is meaningful indicator of patient experience of health services.	*Caring, empathy, comfort, decision sharing.*	*Pain management., waiting time, discharge policy*	
16	Petkus (2002) IJNVSM	Arts/US	To introduce and explain the Pine and Gilmore experiential marketing framework and its relevance to arts marketing.	*Emotional, sensory*		
17	Greenwell et al(2002) SMR	Sports/USA	To identify how the physical facility perception of the customers influence customer satisfaction in context of service experience.		*Physical facility, core product and service personnel*	Customer satisfaction
18	Caru and Cova (2003) MT		To give an overview of the different meanings ascribed to the word 'experience' in various scientific discipline and to detail the different meanings ascribed to the notion of consumption experiences.	*Behavioural, relational, direct and indirect*		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
19	Grace and O'Cass (2004)/JSM	Bank	To identify the impact of services on the satisfaction aroused feelings and brand attitude		*Care service, employee service and servicescape*	Satisfaction, aroused feelings, brand attitude
20	Constantinindes (2004)/IR	Web	To identify and classify the web experiences elements		Usability, interactivity, trust, aesthetics and marketing mix	
21	Stadlmayr et al. (2004)/EJOGRB	Birth experience/ German	To examine the result of obstetric variables on the dimensions of birth experience.	Physical discomfort, fulfilment experinces and emotional adaptation.	Negative emotional	Overall satisfaction
22	Marscarenhas et al (2006)/JCM	General	To understand and deliver the total customer experience to sustain lasting customer loyalty	*Physical moments, Emotional involvement, moments, Value chain moments*		loyalty
23	Williams (2006)/IJCHM	Tourism and hospitality	To identify the affect of experiential marketing in the tourism and hospitality sector	*Education. esthetic, entertainment and escapist*		Customer satisfaction
24	Rahman (2006)/DMCSM	Banks/India	To identify the customers' ratings regarding automate telling machines(ATMs) and employees.	*Cognitive. Emotional and physical*	*Availability of facilities, environment, working conditions of equipment speed and employment*	Loyalty, profitability

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
25	Berry et al. (2006) AMP	General	To explore how clue management can impact and different types of clues play in creating the total experience.		*Touchpoints, serviceescape*	
26	Mizrahi et al (2006)/SR	Healthcare/To onto	To investigate' how antipsychotic treatment acts differentially over time on separate dimension of Psychosis'.	*Cognitive preoccupation, emotional, involvement, behavioural, impact, ecternal, perspective and, conviction*		
27	Frow and Payne (2007) JBM		To examine the concept of CE and consider how and 'outstanding' or 'perfect' CE might be achieved at an affordable cost.	*Other customer, relational*		
28	Palmer (2007) JSM	General	To critically assess the conceptual validity of CE as a construct and propose a model which integrates inter-personal relationship, service quality and brands,	*Reliability, communication, competence, caring, After service*		
29	Olorunniwo and Hsu (2007) SMQ	Professional services	To investigate customer experiences with professional service.	*Reliability, acees, communication, environment*	*Servciescape, waiting time*	
30	Knutson et al. (2007)/JHLM	Hospitality	To develop the scale in order to measure the consumers, experience.		*Environment, benefit, accessibility, convince, utility, incentive and trust*	Customer satisfaction

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
31	Patterson et al. (2007) JHLM	Retail/UK	To analyse and interpret multiple customer introspections' that detail truly appalling customer experience offering,	*Cognitive, physical, affective staff attitude, past experience*	*Ambience, speed*	
	Oh et al. (2007)/JTR	Bread industry/USA	To develop the scale in order to test the model of experience economy concept	*Educational, esthetic, entertainment, escapist.*		Customer satisfaction, memories
32	Gentile et al. (2007)/EMJ	General	The purpose of the research is to provide a model which will be helpful for the managers to understand the complex experiences	*Sensorial, emotional, cognitive, pragmatic, lifestyle and relational.*		Loyalty, value
33	Ralston et al,(2007)/EMJ	Major	The aim of this study is to investigate the amalgamation of services factors with experience factors.	*Education, esthetic, entertainment, escapist*		
34	Jani & Bagdare(2008)	Retail	To review the concept of customer experience and identify its major determinants in the context retail by analysing customer expectations.	*Physiological, cognitive, social, behavioural/emotional*	*Physical environment, customer services, visual scape, convenience, amenities*	
35	Liu & Liu (2008)/IEEE			*Physiological, affective and correlative*		Repeat patronage intention

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
36	Lee et al. (2008)/IJCTHR	Night market/Taiwan	The aim of this study is to determine the difference of night market experiences and foreign visitors and to investigate the relationship between them.	*Sense, feel, think, act and relate*	*Physical environment, services personnel, self-services technology*	image
37	Bridges and Floshheim(2008) JHR	Online	To identify whether the hedonic flow elements can be useful according to the markets' perspective		*Skill, control, interactivity, time, arousal.*	
38	Mahfouz et al.(2008)/CHB	Online dating	To explore the 'evolutionary, social, psychological, and social interactions' in this dating.	*Sensory, emotional, cognitive, behavioural and collaborative*		
39	Takatalo et al.(2008)/CHB	Online Finland	To identify 'a way to profile patterns of various experiences received from the VE by using different components of both physical presence and flow.	*Physical presence, situational involvement and competence.*	*arousal, control challenge, personal relevance, interaction speed, skill.*	
40	Tynan and McKechanie (2009)JMM	General	To review and assess the extent work on services experience marketing.	*Value, emotions, sensory, Behavioural, physical., cognitive, affective*		
41	Nagasawa (2008)/TQMJ	General/Japan	To identify the relationship between Kansei with the management of technology.	Sense, feel, think, act and relate		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
42	Biedenbach and Marrell(2009)	B2bSrvices/Sweden	To investigate the impact of customer experiences on brand equity in a b2d services setting.	Access, reliability, outcomes.	After-sales services, speed.	
43	Jeong et al, (2008)/JCTR	Online shop/USA	To examine whether website features affects four realms of Pine and Gilmore.	Educational, esthetic, entertainment and escapist		
44	Zhang et al. (2008)/JCTR	Hotel/China	To develop model and to identify the dimension of brand experiences in context of economy hotels in China.	Functional, emotional and psycho-social	Physical, environment, social interaction-	
45	Ojiako & Maguire (2009) SC	Telecom/UK	To seeking the perfect customer experiences- a case study of the British Telecom.	Functional, value, cognitive, affective		
46	Verhoef et al. (2009)/JR	Retail	For the creation of the customer experiences a conceptual model has been proposed along with the determinants and moderators that influence the CE	*Cognitive, affective social and physical*	*Social environment, services interface, atmosphere, price, assortment, channels, and past experiences.*	
47	Sundo (2009)/TSIJ	General/Denmark	To present a taxonomy of different experiences firms on the basis of their dynamic drivers.	*Educational, esthetic, entertainment, escapist*		
48	Brakus et al, (2009)/JM	Brand	To develop a scale which can measure the strength by which a brand can evoke each experiences dimension.	*Sensory, affective, intellectual and behaviour*		Customer satisfaction

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
49	Petit (2009) BE&A	Education/ USA	To determine how effectively incorporating customer experience.			
50	Kamaladevi (2009)BIJ	Retail	Focus on the role of micro factors in the retail environment and how they can shape customer experiences and behaviour	*Sensory, affective, physical*	*Speed, ambience, cleanliness, staff attitude*	
51	Grewal et al. (2009)/JR		Identify the contributions of seven articles on retail customer experience.		*Political, economic, promotion, price, merchandise, supply chain, location*	Customer satisfaction
52	Jain and Bagdare (2009)/JMC	Retail	To identify the determination of customer experience in new format retail stores.	*Physiological, cognitive, social, behaviour and emotional*	*Physical environment, customer service, visual scape, customer delight, convenience, audio visual.*	
53	Yu and Fang (2009)/TQMBE	Retail/India	To identify the impact of product quality, contextual experience quality and service quality on perceived customer value and intention to shop.	*Educational. esthetic, entertainment and escapist*		Intention to shop
54	Chan (2009)/JMC	Coffee shop market/Taiwan	To identify the key benefits attained by the visitors.	*Cognitive, affective and reflective*		benefits
55	EK et al.(2008)/SJHT	Tourism	To discuss the tourist's experience with the help of proposed conceptual model.	Educational, esthetic, entertainment and escapist		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
56	Sheu et al. (2009)/ESA	Online gaming	To develop the scale for online players through data mining techniques.	Sense, feel. Think. Act and relate		Customer satisfaction & loyalty
57	Slatten et al (2009)/MSQ	Winterpark/Norwegian	To identify the types of atmospheric experiences this touches the visitors emotionally.		Ambience, interaction and design	loyalty
	Lin et al. (2009)WTBE	Hot-spring hotel/Taiwan		Sense, feel, think, act and relate		
58	Hosany and Gibert (2009)/SM	Holiday destination	To identify significant dimension of tourist emotional experiences.	*Joy, love and positive surprise*		*satisfaction, intention to recommend*
59	Smidt-Jensen et al. (2009)/EPS	Cities/Denmark	The aim of the study is to empirically prove the spatial dynamics of experiences economy in Denmark	*Educational. esthetics, entertainment and escapist*		
60	Hollyoake(2009)/EPS	General/B2B	To investigate how B2C consumer experience differs from B2B experience		*Trust, interdependence, integrity and communication*	
61	Walter et al (2010)/MSQ	Restaurant/Sweden	To identify and analyse the drivers which influence the customers' experience (as described by the customer)		*Social interaction, core service, physical environment, atmosphere, procedure*	

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
62	Hogstromet al. (2009) MIP	Tourism	Quality dimension and how these contribute to experienced quality and satisfaction among users.	*Environment, physical, emotional*	*Ambience, layout*	
63	McGuire et al. (2010) JSM	General services	Environment variables in the servicescape on customer reaction to the wait experiences	*Communication*	*Length of ques, speed, information*	
64	Dawood and Gallini(2010)NM	Healthcare/UK	Undertake to examine patients' experiences of dignity and care	*Sense, feel, safety, respect, comfort, competences, caring*		
65	Zarantonello and Schmitt (2010)/IJMR	Brandy/Italy	To 'develop a typology of consumer with different experiential profiles....'	*Sensory. Affective, intellectual and behavioural*		
67	Ferguson et al. (2010)/JSM	Healthcare/Canada	To analyse the antecedents of positive word of mouth intentions in context to the socially oriented individuals.	*Information, pain/discomfort, patient/patient interaction, patient/personnel interaction.*		
68	Maklan and Klaus (2010) IJMR	Bank/UK	To measure the right things for customer experiences			*Satisfaction, WOM,*
69	Lee (2010) IJMR	Food I/ Georgia	To propose walk-through audit as one of methods improving customer's experiences	*Sensory, affective, intellectual and behavioural*		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
70	Wallis et al (2010)/IJHM	Hospitality and tourism	To propose a conceptual framework for the better, understand of the composition of tourism and hospitality consumer experience.	*Ordinary, extraordinary, cognitive and emotive*	*Physical, human interaction elements, individual*	
71	Johnston and Kong (2011)MSQ	General/UK	To investigate how organisation actually go about designing and improving CE			
72	Lemke et al. (2011) AMA	B2B and B2C	To explore customer experience quality using repertory grid technique	*Accessibility, Knowledge, Caring, communication, Personalisation*	*Helpfulness, friendliness, honest, competence.*	*Satisfaction, loyalty, WOM*
73	Chang and Horng(2010)SIJ	Service setting	To conceptualize and measure the concept of experience quality.	*Reliability. Knowledge, caring, communication*	*Speed, physical facility*	
74	Harrison and Beaty(2011)JBR		To explore the anticipation consumers, have before services experiences.			
75	Su (2011)/TSIJ	Ethnic restaurant	To identify and understand the relationship between services innovation, customer experiences and behavioural intention	*Sense, feel, think, act and relate*		
76	Ng et al. (2011) MSQ		To investigate the effects of relationship benefits on relationship quality and aspects of services quality.	*Reliability, knowledge, emotions, communication*		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
77	Grag et al. (2011)	General	To develop a CE framework	*Sensory, cognitive, affective, behavioural, relational*		*Satisfaction, Loyalty*
78	Lemke et al. (2011)	General	To validate the theoretical argument that customers construe experience quality and not just product and service quality	*Communication encounter, service encounter, usage encounter, experience context*		*Commitment, retention, word of mouth*
79	Robert et al. (2012) NET	Healthcare/UK	To ascertain the extent and nature on improving patient experience in England and its future development.	*Cognitive, emotional, affective, social*	*Competence, caring*	*Satisfaction, WOM*
81	Doyle et al. (2013) BMJ	Healthcare/NHS/UK	To explore evidence on the links between patient experience and clinical safety and effectiveness outcome.	*Sense of safety, reliability, caring, empathy*		*Satisfaction, WOM*
82	Fatma(2014)IJBC	General/USA &Canada	To explore how patent experience fit into the overall healthcare picture,		*Speed to response, skills, mood, timing*	
83	Luxford and Sutton (2014) PEJ	Healthcare/USA		*Cognitive preoccupation, emotional, involvement*		

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
84	LaVela and Gallan(2014)PEJ	Healthcare/USA	To explore and describe what is known about measure and measurement of patient experience and (2) describe evaluation approached/methods used to assess patient experience.	*Staff attitude, caring, knowledge, competence, sense of safety*	*Waiting time, discharge information, follow up. Pain management*	
85	Becker et al (2014) PEJ	Healthcare/California	To seek to evaluate patients' hospital-care experience by (1) analysing patients' experience care score in light on these hospitals' patient profiles, structural characteristics, and outcomes in 2011	*Patient discomfort, patient interaction*		
86	Wolf et al. (2014) PEJ	General healthcare	To identify the key elements, constructs, and themes that were commonly cited in existing definition of patients experiences	*Empathy, caring, comfort, safety, knowledge, competence*	*Previous experience*	
87	Staniszewska and Churchill (2014) PEJ	Healthcare/UKNHS	To examine the current state of patient experience research, practice and policy in the UK context	*Personailsation, decision sharing, caring, staff*		
89	Chahal and Dutta (2014)	General	To focus on customer experience conceptualisation and specific factors that can influence in creating memorable customer experiences	*Sensory,cognitive, affective, relational, behavioural,*		*Satisfaction, brand equity, discontinuation of patronage, WOM, complaints*

#	Author/Yr/ Journal	Application area/ country	Objectives	Findings		
				Dimensions	***Attributes***	***Outcomes***
90	Ponsignon et al (2015)	Healthcare/UKNHS	To explore the concept of experience quality in healthcare to inform a classification framework of experience quality dimensions	*Competence, communication, persolization, Attitude and behaviours, staff reliability, procedures and processes*		*Satisfaction, wOM*

Table 2.3: Literature review of customer experience dimensions and attributes

Different studies have highlighted diverse dimensions of CE. These dimensions of customer experience are shown in Table 2.3. Several studies had mentioned the *sensory, cognitive, emotional, affective, social/relational, behavioural, and physical* based on Gentile et al. (2011), Robert et al. (2012), Carù and Cova (2003), Petkus (2002), Fulbright et al. (2001), Schmitt (1999), Tynan and McKechnie (2009), Petterson et al. (2007), Rahman (2006), Mascarenhas et al. (2006), Verhoef et al. (2009), Brakus et al. (2009), Kamalalevi (2009), Chan (2009), Robert et al. (2012), Sheu et al. (2009), Jani and Bangdare (2008, 2009), Luxford and Sutton (2014), Zarantonello and Schmitt (2010), Su (2011); and Lin et al. (2009); therefore it is constructive to classify the rest of the multidimensions into Gentile et al.'s (2017) and Schmitt's (1999) dimensions of *Sensory, Cognitive, Affective, Behavioural, Relational/social, and Reflective* in the present study since CE is defined as holistic in nature and contextual. Moreover, the CE literature lacks empirical support; standardized dimensions of CE have yet to be established. However, some researchers have explored its dimensions, which are discussed next.

Holistically, Gentile *et al.* (2007) viewed the customer experience construct from a different angle. They conceptualized customer experience as a multidimensional structure, and its components are as follows: (1) a sensorial component, a component of the customer experience whose stimulation affects the senses; i.e. sight, hearing, touch, taste, and smell so as to arouse aesthetical pleasure, excitement, satisfaction, sense of beauty; (2) an emotional component, this involves the customer's affective system through the generation of moods, feelings, and emotions; (3) a cognitive component, this is connected with thinking processes or engaging customers through using their creativity in problem-solving, i.e. Barbie, the first doll with the image of a young woman; (4) a pragmatic component, this includes the practical act of doing something – in other words, the concept of usability does not only refer to the use of the product in the post-purchase stage, but it extends to all the product life-cycle stages; (5) a lifestyle component, in this component of experience, the product itself and its consumption or use becomes a means of adhesion to certain values the company and the brand symbolize and the customers contribute to; and (6) a relational component, a component of the customer experience that involves the person, and the consumption or use of a product with other people (i.e. Disneyland parks). To sum up, the plethora of different definitions and dimensions of customer experience are such that there is currently no real consensus as to what these dimensions might be.

Based on Schmitt's (1999) five dimensions, sensory experiences (*sense*); affective experiences (*feel*); creative cognitive experiences (*think)*; physical experiences, behaviours, and lifestyle (*act*); and social identity experiences that result from relating to a reference group or culture *(relate)*, Gentile et al. (2007) identified six dimensions of customer experience by adding the pragmatic component of customer experience: *sensorial component, emotional component, cognitive component, lifestyle component, pragmatic component, and relational components*, broadening the scope of experiential appeal and elaborating on the implications of creating holistically integrated experiences that possess those values. Other researchers have also extended and modified these dimensions (Brakus et al., 2009; Tynan & McKechnie, 2008; Bagdare & Jain 2009). De Keyser et al. (2015, p. 23) describe customer experience as "comprised of the cognitive, emotional, physical, sensorial, spiritual, and social elements that mark the customer's direct or indirect interaction with (an) other market actor(s)." According to Mascarenhas et al. (2006), total customer experience encompasses both physical and emotional elements. They argue that experiences are customer-dependent and context-specific. Despite the numerous definitions and dimensions of CE in the literature, no consensus has emerged concerning what constitutes a good experience.

Within the marketing literature, researchers have cited various components of CE (see Table 2.4), which can be broadly classified into six main dimensions: sensory, cognitive, affective, behavioural, relational, and reflective. A summary of the main dimensions and their components (sub-dimensions) of customer experience is presented in Table 2.4.

Main dimensions	Reference articles of sub-dimensions
Sensory: these experiences appeal to all the five senses of the customer (Schmitt, 1999; Gentile et al., 2007).	*Sensory* (Fulbright et al., 2001; Tsai, 2005; Mahfouz et al., 2008; Brakus et al., 2009; Zarantonello and Schmitt, 2010)/*Sense* (Schmitt, 1999; Nagasawa, 2008; Lee et al., 2008; Sheu et al., 2009; Lin et al., 2009; Su, 2011)/*Sensorial* (Gentile et al., 2007*Physiological* (Liu and Liu, 2008; Jain and Bagdare, 2009).
Affective: these experiences appeal to the feelings, emotions and moods of the customer (Gentile et al., 2007)	*Affective* (McIntosh, 1999; Fulbright et al., 2001; Sun, 2002; Liu and Liu, 2008; Verhoef et al., 2009; Chan, 2009; Brakus et al., 2009; Zarantonello and Schmitt, 2010)/*Feel* (Schmitt, 1999; Nagasawa, 2008; Lee et al., 2008; Sheu et al., 2009; Lin et al., 2009; Su, 2011)/*Emotional* (Stadlmayr et al., 2004; Tsai, 2005; Mascarenhas et al., 2006; Gentile et al., 2007; Mahfouz et al., 2008; Zhang et al., 2009; Jain and Bagdare, 2009; Hosany and Gilbert, 2009; Walls et al., 2010
Cognitive: these types of experiences are linked to the conscious mental or thinking process of the customer (Gentile et al., 2007).	*Cognitive* (McIntosh, 1999; Fulbright et al., 2001; Rahman, 2006; Mizrahi et al., 2006; Gentile et al., 2007; Mahfouz et al., 2008; Verhoef et al., 2009; Chan, 2009; Jain and Bagdare, 2009; Walls et al., 2010)/*Think* (Schmitt, 1999; Nagasawa, 2008; Lee et al., 2008; Sheu et al., 2009; Lin et al., 2009; Su, 2011)/*Intellectual* (Tsai, 2005; Brakus et al., 2009; Zarantonello and Schmitt, 2010)/*Functional* (Zhang et al., 2009*Stimulation* (Otto and Ritchie, 1996)/*Comfort* (Otto and Ritchie, 1996; Stadlmayr et al., 2004; Ferguson et al., 2010).
Behavioural: these types of experiences generate from the alternative methods of doing the things and also from the values and beliefs the customer possesses in his/her lifestyle and behaviour (Schmitt, 1999; Gentile et al., 2007).	*Physical experiences, behaviours, and lifestyle* (Stadlmayr et al., 2004; Mascarenhas et al., 2006; Rahman, 2006; Mizrahi et al., 2006; Gentile et al., 2007; Mahfouz et al., 2008; Verhoef et al., 2009; Jain and Bagdare, 2009; Brakus et al., 2009; Zarantonello and Schmitt, 2010)/*Act* (Schmitt, 1999; Nagasawa, 2008; Lee et al., 2008; Sheu et al., 2009; Lin et al., 2009; Su, 2011)/)/*Physical presence* (Takatalo et al., 2008).
Relational: these experiences are generated from beyond the private life of any individual (Schmitt, 1999; Gentile et al., 2007).	*Relational* (Gentile et al., 2007)/*Social* (Tsai, 2005; Verhoef et al., 2009; Jain and Bagdare, 2009) /*Relate* (Schmitt, 1999; Nagasawa, 2008; Lee et al., 2008; Sheu et al., 2009; Lin et al., 2009; Su, 2011)/*Collaborative* (Mahfouz et al., 2008)/*Psycho-social* (Zhang et al., 2009)/*Interactive* (Otto andRitchie, 1996; Ferguson et al., 2010).
Reflective: this experience is generated by the comparison of the present and past lifestyles (Garg et al., 2011).	*Reflective* (McIntosh, 1999; Chan, 2009)

Overall, the researcher concludes that customer experience is a multidimensional construct

Table 2.4: Classification of multidimensions of customer experience

encompassing a customer's cognitive, emotional, behavioural, sensorial, and social responses to a firm's offerings throughout the customer's journey.

Holbrook and Hirschman (1982) pioneered the idea that the CE construct is multidimensional. Conversely, Schmitt (1999) proposes that CE comprises five dimensions: sensory, affective, cognitive, physical, and social-identity experiences. Gentile et al. (2007, p. 398) extend Schmitt's (1999) conceptualization of CE by adding a further component, "pragmatic", which is defined as the "practical act of doing something". More recently,

Brakus et al. (2009, p. 52) conceptualized CE with brands as *"sensations, feelings, cognitions, and behavioural responses evoked by brand-related stimuli that are part of a brand's design and identity, packaging, communications and environments".* The authors distinguished several experience dimensions, including sensory, affective, intellectual, and behavioural.

In the conceptual article by Tynan and McKechnie (2009), the authors extend prior conceptualizations of CE by suggesting that, in addition to the sensory, emotional (affective), utilitarian (cognitive), and relational (social) dimensions, CE also comprises informational, novelty, and utopian components. They recognize that customers also experience informational value via traditional and online media; i.e. they acquire value through experiences that have a novelty component and from utopian meanings with respect to the consumer's experienced relations with place and space (Maclaran and Brown 2005). Verhoef et al. (2009) review the literature on brand experience, service experience, and retail experience, concluding that a richer conceptualization of customer experience should not only capture cognitive evaluations and affective responses but also encompass social and physical components. In the context of online customer experiences, Rose et al. (2012) indicate that there are only two experiential states: affective and cognitive. The authors contend that customers engage in cognitive and affective processing of incoming sensory information from the website, resulting in the formation of an impression in memory.

While the researcher has attempted to broadly classify the CE components mentioned in past studies into seven dimensions (i.e., sensory, cognitive, affective, physical, social, relational, and functional), there remains a plethora of additional CE dimensions. Consequently, there is no general consensus in the marketing literature on the dimensions of CE. The aforementioned literature review establishes that marketing services literature has yet to reach a consensus on CE dimensions. Thus, this study extends the dimensions of Gentile et al. (2007) and Schmitt (1999) – it ticks all five classifications of dimensions (Sensory, Affective, Cognitive, Behavioural, and Relational) and one additional dimension (Reflective) of McIntosh (1999) and Chan (2009) (refer to Table 2.4).

2.4.2 Attributes of customer experience

The attributes of customer experience, examined in different studies, comprise several variables as shown in Table 2.3. These variables are classified into six major groups of factors shown in Table 2.5 (Pine and Gilmore, 2007; Constantinides, 2004; Lemke et al., 2009; Maklan and Klaus, 2011). These groups are functionality factors, psychological factors, and interactions. The sub-categories in these groups are consistent with the studies (Parasuraman et al., 1989; Lemke et al., 2007; Duggirala et al., 2008; Klaus and Maklan, 2013; NICE, 2014) mentioned earlier in the narrative review section.

A few studies have attempted to describe the attributes of CE interchangeably as components, aspects, antecedents, and determinants of CE dimensions. Additionally, Klaus and Maklan (2013), Lemke et al. (2011), and Ponsignon et al. (2015) refer to attributes as items that represent their customer experience dimensions. Service quality is considered the most important attribute in the customer experience (Conway & Willcocks, 1997; Klaus & Maklan, 2011; Lemke et al., 2011; Chahal & Butta, 2014). It is described as the comparison between customers' expectations and their perceptions about service performance (Parasuraman, Zeithmal, & Berry, 1985, 1988, 1994). In this context, Gunawardane (2011) suggested that customers' perceptions of the quality of a service encounter depend on the customer's perceived service expectations and post-service perceptions. Boulding et al. (1993) blended the perception of service quality with customers' prior expectations of what will and should happen during the service encounter. They remarked that customers form expectations about what will happen in their next service encounter (that is, *will expectation*) and what should happen (that is, *should expectation*). In this context, Lloyd and Luk (2011) and Urban (2010) also believed that when a customer evaluates a service experience, he compares his expectations against perceptions with various dimensions of service quality, to either confirm or disconfirm satisfactory outcomes. However, Frow and Payne (2007) posit that service quality and customer satisfaction may be declining, as customers often receive service and quality that falls below their expectations. Hence, there is a need to examine the concept of customer experience and consider how an outstanding or perfect customer experience might be achieved at an affordable cost. Verhoef et al. (2009) and Pareigis et al. (2011) have mentioned factors influencing customer experience in different contexts.

Verhoef et al. (2009) identified six factors of customer experience: social environment, service interface, assortment, price, alternative interface channels, and past experience in a

retail context. They suggest that, since a customer often visits retail service providers with friends or family, social interaction affects not only the customer's own experience but also that of fellow customers. They also note that past and ongoing affective experiences further guide customers' future decisions. They consider affective experience to be influenced by emotions, moods, and other subjective states, like pleasure and pain, liking and disliking, and hope and dread. Multichannel environments and assortments are two other factors that influence customer experience. The availability of different service delivery options, such as colours, brands, styles, models, and sizes, for each product line influences a customer's experience. Parsuraman et al. (1988) operationalized personal interaction as face-to-face interaction between employees and customers, which is mediated by technology. A customer's experience is also impacted by the design of a service environment. Bitner (1992) introduced the terms *service* and *landscape* and described how the physical environment affects both employees and customers in a service organization. He suggested three different environmental dimensions: (1) *ambient conditions*, which include background characteristics of the environment such as temperature, lighting, noise, music, and scent; (2) *spatial layout*, which refers to the ways in which machinery, equipment, and furnishings are arranged; and (3) *signage* – signs, symbols and artefacts, which act as clues in the servicescape that communicate information and messages about the environment to the customers. He further remarked that the perceived servicescape may elicit cognitive, emotional, and physiological responses related to customers' past experiences. Pareigis et al. (2011) also discussed factors, including physical artefacts, intangible artefacts, technology, customer placement, customer involvement, and interaction, which constitute experience with employees.

Among these factors, researchers have focused more on the placement and involvement of customers, as well as their ability to interact with staff and technology. Further, Conway and Willcocks (1997) discussed access, choice, information, redress, and representation as other supportive factors for a better understanding of the creation of the customer experience. They hold that experience would be quite satisfactory when customers have easy access to services, contact, and information. They also remarked that the delivery of required information, both before and after service consumption, can enhance the value of the customer experience. Redress, the next dimension of experience, refers to remedial action for service failures across service delivery systems. Effective remedial actions always pave the way for good/favourable experiences and expectations. Lastly, choice and representation are the other two dimensions of customer experience.

Groups	Attributes variables reference articles
Functionality attributes: these attributes emphasize the usability and interactivity elements of the environment (Pine and Gilmore, 2007; Ponsignon et al., 2015; Lemke et al., 2009; Klaus and Maklan, 2013; Parasuraman et al., 1998)	*Service process* (Johnston, 1999; Tseng et al., 1999)/*Service delivery* (Otto and Ritchie, 1996; Chan, 2009)/*Operations* (Nowak and Newton, 2006) *Customer interaction* (Otto and Ritchie, 1996; Grove and Fisk, 1997; Flanagan et al., 2005; Zhang et al., 2008; Chan, 2009; Walter et al., 2010; Walls et al., 2010/*Communication* (Hollyoake, 2009) *Speed* (Rowley, 1994, 1999; Johnston, 1999; Flanagan et al., 2005; Arnold et al., 2005; Rahman, 2006)/*Waiting lines* (Grove and Fisk, 1997; Sarel and Marmorstein, 1999) *Employees* (Johnston, 1999; Sarel and Marmorstein, 1999; Grace and O'Cass, 2004)/*personal service* (Tseng et al., 1999; Greenwell et al., 2002; Arnold et al., 2005; Flanagan et al., 2005; Rahman, 2006; Liu and Liu, 2008)/*Customer service* (Rowley, 1994, 1999; Jain and Bagdare, 2009) *Core service* (Greenwell et al., 2002; Grace and O'Cass, 2004; O'Cass and Grace, 2004; Walter et al., 2010)/*Working condition of equipment* (Rahman, 2006) *Customization* (McIntosh and Siggs, 2005)/ *Convenience* (Rowley, 1994, 1999; Knutson et al., 2007; Jain and Bagdare, 2009; Knutson et al., 2009; Kim et al., 2011)/*Location* (Grewal et al., 2009)/*Accessibility* (Flanagan et al., 2005; Knutson et al., 2007; Kimet al., 2011) *Skil*l (Novak et al., 2000; Mathwick and Rigdon, 2004; Constantinides, 2004; Takatalo et al., 2008; Bridges and Florsheim, 2008; Wu and Liang, 2010; Constantinides et al., 2010)
Psychological attributes: these variables affect the psychology of the customers especially in the form of benefits and trustworthiness (	*Involvement* (Novak et al., 2000; Mathwick and Rigdon, 2004; Takatalo et al., 2008) *Safety*; *Presence of other customers* (Tseng et al., 1999; McIntosh, 1999; Arnold et al., 2005; Dorwart et al., 2010)*Presence of other customers* (Tseng et al., 1999; McIntosh, 1999; Arnold et al., 2005; Dorwart et al., 2010)/*Social environment* (Verhoef et al., 2009; Kaplanidou and Vogt, 2010) *Incentive* (Knutson et al., 2007, 2009; Kim et al., 2011) *Arousal* (Novak et al., 2000; Takatalo et al., 2008; Bridges and Florsheim, 2008) Trust (Constantinides, 2004; Constantinides et al., 2010)
Environmental attributes: these factors include the variables which refer to the marketing mix and creative related elements (; Lemke et al., 2011; Parasuraman et al., 1998; Chahal and Dutta, 2014)	*Servicescape* (Otto and Ritchie, 1996; Grove and Fisk, 1997; Grace and O'Cass, 2004; Slatten et al., 2009)/*Visualscape* (Jain and Bagdare, 2009)/*Physical environment* (Tseng et al., 1999; McIntosh, 1999; Greenwell et al., 2002; Knutson et al., 2007; Liu and Liu, 2008; Jain and Bagdare, 2009; Chan, 2009; Knutson et al., 2009; Walter et al., 2010; Kaplanidou and Vogt, 2010; Walls et al., 2010; Kim et al., 2011)/*Atmosphere* (Arnold et al., 2005)/*Availability* (Flanagan et al., 2005; Rahman, 2006)

Table 2.5: Classification of attributes of customer experience

Source: Author's own

In Table 2.3, a variety of results appear in the form of attributes of CE. The summarized results are shown above in Table 2.5. In Table 2.3, out of 90 CE studies, 58 studies mentioned the dimensions of CE, but the attributes of CE were given by only 42 studies. Among these

attributes, the most widely applied are employees, speed, servicescape, responsiveness, deliverability, and the marketing mix. Out of 90 studies, only 38 mentioned the variables in both categories of findings (please refer to Table 2.3), and these variables are sector specific. Therefore, this study will be very helpful for future researchers because the general variables of CE, identified in both categories, will act as the base for future research.

2.4.3 Emotions as a major component of customer experience

A common denominator in any type of previously mentioned experience is the production of emotions (Gentile *et al.*, 2007; Meyer and Schwager, 2007; Shaw and Ivens, 2002). In addition, emotional experience or emotion is often cited as the heart of the consumption experience. Addis and Holbrook (2001, p. 50) highlighted that "the roles of emotions in behaviour – the fact that consumers are feelers as well as thinkers and doers, the significance of symbolism in consumption, the consumer's need for fun and pleasure, and the roles of consumers go beyond the act of purchase – in product usage as well as brand choice, and so forth". Moreover, emotional arousal is considered an important factor motivating customers to consume certain products, such as novels, plays, and sporting events (Hirschman, 1982). Therefore, the next paragraphs will shed light on emotions as a major component of the customer experience by detailing the different theories, definitions, dimensions, and measurements of emotions, drawing on an extensive review of the literature in two disciplines: marketing and psychology.

The role of emotion is gaining attention as a central element in understanding the consumption experience (Oliver, 1997). Little consistency can be found in the use of terminology related to emotions. The term 'emotion' is often used interchangeably with the term 'affect'. However, affect is a much broader term, conceived as an umbrella term for a set of more specific mental processes, including emotions, moods, and feelings (Batra and Ray, 1986).

Interestingly, researchers have defined emotion in various ways. According to Bagozzi *et al.* (1999), emotion means a mental state of readiness that arises from cognitive appraisals of events or thoughts; has a phenomenological tone; is accompanied by physiological processes; is often expressed physically (e.g. in gestures, posture, facial features); and may result in specific actions to affirm or cope with the emotion, depending on its nature and meaning for the person having it. Clore *et al.* (1987) also defined an emotion as "A valenced

affective reaction to perceptions of situations" (p. 752). The term 'valence' is used in the sense of positive or negative; thus, the definition implies that an emotion involves a positive or negative feeling (Plutchik, 2003).

"The line between an emotion and mood is frequently difficult to draw, but often by convention involves conceiving of a mood as being longer lasting (from a few hours up to days) and lower in intensity than an emotion. Yet, exceptions to this construal can be found. Still another distinction between emotions and moods is that the former typically is intentional (i.e. it has an object or referent)" (Bagozzi *et al.*, 1999, pp. 184, 185). For example, a consumer becomes pleased when a new detergent removes grass stains from clothing, and he/she is angered by poor service in a restaurant (Bagozzi *et al.*, 1999), whereas moods are generally non-intentional and global or diffused (Frijda, 1993) as cited in (Bagozzi *et al.*, 1999). In addition, emotions differ from moods in the way they arise and in their representation in memory (Bagozzi *et al.*, 1999). Emotions occur in response to changes in specific plans or goal-relevant events. As Oatley (1992) points out, emotions are manifest as "transitions from one sequence of action to another", but moods occur "when the cognitive system is maintained in an emotion mode for a period" (p. 64). Indeed, moods are often resistant to changes in events surrounding them. One reason for this is that moods "depend on the dissociability of control emotion signals from semantic information about causation" (Oatley 1992, p. 64). In general, moods are elicited by "(a) after-effects of emotions; (b) organismic conditions such as illness, fatigue, previous exercise, and good health, or pharmacological agents; (c) general environmental conditions and side-effects of activities: heat, noise, environmental variety, stressful conditions" (Frijda, 1986, p. 289) cited in (Bagozzi *et al.*, 1999, p. 188).

Consumption emotions are specific affective states elicited during product consumption (Westbrook and Oliver, 1991). However, the kinds of emotions people experience in interpersonal relationships are less likely to occur in consumption situations (Richins, 1997). Over the last two decades, marketing scholars have begun to study the emotions evoked by marketing stimuli, products, and brands (Holbrook and Hirschman, 1982). Studies on consumer emotions have examined aspects such as consumers' emotional responses to advertising (e.g., Derbaix, 1995) and the mediating role of emotions in consumer satisfaction (e.g., Phillips and Baumgartner, 2002).

When consumers perceive product performance as good, they are likely to experience positive emotions (Westbrook, 1987). In contrast, when consumers perceive product performance as poor, they are likely to experience negative emotions. Mano and Oliver (1993) also found that consumption emotions occur immediately after the consumption and before customer satisfaction. Similarly, Richins (1997) found consumption emotions occurring during the consumption, and even before the consumer has had a chance to evaluate the experience. Table 2.6 presents a sample of the dimensions of emotions identified by researchers.

As noted by Richins (1997), the range of emotions experienced by consumers is very broad. Indeed, many specific consumption experiences involve mixed emotions or ambivalence. Otnes *et al.* (1997) defined consumer ambivalence as the experience of multiple positive and/or negative emotions within a single consumption episode. These mixed emotions may co-occur or occur sequentially (Ortony *et al.*, 1988). Previous studies have discovered that mixed emotions are associated with consumption experiences such as river rafting (Arnould and Price, 1993), gift exchange (Otnes *et al.*, 1994), and consumer response to advertising (Edell and Burke, 1987).

Today's customers focus on needs such as emotional fulfilment. Therefore, companies should be aware of this and strive to create emotional experiences and values. Various studies have found significant influences of affect on post-purchase behaviour. As a result, marketers are increasingly interested in understanding the nature of affect and its contribution to consumer decision-making and response to marketing variables (Donovan and Rossiter, 1982; Gardner, 1985). Early attempts to examine the affective influence on satisfaction were conducted by Westbrook (1987) and Westbrook and Oliver (1991). Westbrook (1987) investigated the extent to which positive and negative affect influenced satisfaction and other satisfaction-related consequences.

Table 2.6: A sample of dimensions of emotions by researchers

Researchers	Number of adjectives/subscales	Dimensions
Borgatta (1961)	40 adjectives	Lonely (depressed), warm hearted, tired thoughtful, defiant (aggressive), startled (anxious)
Clyde (1963)	132 adjectives	Friendly, aggressive, clear thinking, sleepy, unhappy, dizzy
Zuckerman and Lubin (1965)	89 adjectives	Depression, hostility, anxiety
Plutchik (1966)	8 adjectives	Happy, agreeable, fearful, angry, interested, disgusted, sad, surprised
McNair, Lorr, and Dropleman (1971)	57 adjectives	Anger-hostility, depression-dejection, vigour-activity, fatigue, inertia, friendliness, confusion
Izard (1972)	30 adjectives	Interest, joy, surprise, distress, disgust, anger, shame, fear, contempt, guilt
Plutchik and Kellerman (1974)	66 adjectives	Sociable, trusting, decontrolled, timid, depressed, distrustful, controlled, aggressive
Curran and Cattell (1975)	96 adjectives	Anxiety, stress, depression, regression, fatigue, guilt, extraversion, arousal
Lorr and McNair (1984)	72 adjectives	Composed, anxious, agreeable, hostile, elated, depressed, confident, unsure, energetic, tired, clearheaded, confused
Howarth and Young (1986)	60 adjectives	Concentration, anxiety, anger, depression, potency, sleep, control, cooperation, optimism, skepticism
Watson, Clark, and Tellegen (1988)	20 adjectives	Positive and negative

Source: Adapted from Plutchik (2003)

Westbrook (1987) identified two major dimensions of positive and negative affect using factor analysis. His study found that positive affect positively influences customer satisfaction and WOM. Negative affect negatively influences customer satisfaction and WOM (Westbrook, 1987). Westbrook and Oliver (1991) recognized that affect was an important part of the satisfaction judgement by attempting to measure the impact of affect on customer satisfaction. Other studies established that consumers can experience both positive and negative affect during the consumption (Mano and Oliver, 1993; Oliver, 1993). In summary, the categorization of emotions into positive and negative affect seems to be the most popular conceptualization. However, the two-factor concept - positive and negative affects - cannot capture the diversity and the nature of consumption emotions (Westbrook and Oliver, 1991).

Finally, the current research aims to explore the customer experience construct, its dimensions, attributes, and significant factors influencing positive and negative CE in the context of NHS hospitals. Therefore, customer experience in a service context such as the healthcare sector is a critical ingredient in this thesis, and the previous chapter shed more light on the NHS hospitals healthcare experience.

2.5 Customer experience in a services context

As the service sector is growing, the attention paid by marketing researchers encompasses many aspects of service marketing, including experiences, design, and delivery (Brown *et al.*, 1994). Before moving to the next section, which further explains service marketing literature development, service characteristics, and service classification, it is reasonable to start by defining services and explaining the differences among services, goods, and experiences. A large number of definitions of the concept of service exist. Kotler *et al.* (2002) defined service as “the next section that further explains what can be offered to another, which is essentially intangible and does not result in the ownership of anything” (p. 832).

Another commonly used definition of service is proposed by Gronroos (2000). o another which is essentially intangible and does not result in intangible activities that take place in interactions between customer and service employees” (p. 46). One common characteristic of the two definitions is the reference to the proportion of a service's intangible component. This leads to a more sophisticated distinction between goods and services. Gronroos (2000) argued that customers buy not only goods or services but also offerings that include goods,

services, information, personal attention, and other components. Service components can be a minor or a major part of the total offering. In fact, the offer can range from a pure good on one hand to a pure service on the other, with service or good placed on a horizontal axis, or continuum, known as an "intangibility continuum," based on the dominant aspects of tangibility or intangibility (Kotler *et al.*, 2002).

Initially, problems in the service businesses began to prove that the differences between providing goods and providing services required further investigation. This further investigation has led to the development of services marketing literature, as well as a unique body of knowledge that has developed quickly. Major research topics covered in the literature include service quality (Zeithaml *et al.*, 1990), customer satisfaction (Bitner, 1990; Shostack, 1992), customer engagement (Van Doom et al., 2010; Kumar et al., 2013), customer focus (Sheith et al., 2000; Shah et al., 2006; Gulati and Oldroyd, 2005), customer behaviour (Howard and Sheith, 1969; Lavidge and Steiner, 1961), and customer relationship management.

2.5.1 Patient experience and consumerism of healthcare

Although the experience economy emerged in the business field, it has crossed its frontier to healthcare, which has been identified as one of the fastest-growing examples of the experience economy (Quan and Wang, 2004), and patient experience has been an established area for studies during the last decade (Wolf et al., 2014; Ponsignon et al., 2015;

In this section, the researcher reviews the genesis of consumerism and the profile of customer online reviews within the NHS. Today's healthcare is a business, and the economic cost of providing healthcare must always be considered when seeking solutions to healthcare problems. From a purely business perspective, focusing on the bottom line, efficiency, and productivity (and, in private care, on profit) is the norm. Torpie (2014) argues that healthcare is not like other businesses, and patients are unlike other kinds of customers. 'Customers' are generally well people who enjoy elevated status by virtue of their potential to purchase goods or services. Patients, on the other hand, are (by current definition) not well. Their status is greatly reduced by illness or injury that renders them vulnerable, frightened, often in pain, medicated, exhausted, and confused. Despite these limitations, patients sometimes must make important, often complex decisions in a short time frame. Based on the new marketized healthcare economies, every "customer" is a potential patient.

According to Mazurenko et al. (2016), the customer satisfaction element forces hospitals to focus on non-clinical aspects of hospitalization, including customer service techniques common to other service sectors, to improve the overall patient experience (Ford & Fottler, 2000; Fottler, Ford, Roberts, Ford, & Spears, 2000; Mazurenko, Zemke, Lefforge, Shoemaker, & Menachemi, 2014). They assert one reason for the lack of success is hospitals' failure to identify who the customer is and what is important to that customer or consumer.

A consumer or customer is an individual who, through a process of decision-making, obtains goods and services for personal consumption (Page and Connell, 2006, p. 65). To date, no uniformly agreed-on definition of *healthcare customer* has emerged, but the previous definition could apply to a patient. With the advent of these and other products in the healthcare marketplace, individuals are motivated to shop for providers based on publicly available price and quality information, which may be influencing the shift in labelling from patient to customer (Powell & Laufer, 2010). Importantly, the use of the term "customer*"* has long depended on the person or organization using the term (Bastian, 1998). For instance, healthcare administrators might refer to customers rather than patients when negotiating privileges with physician groups (Boote, Telford, & Cooper, 2002). Administrators might refer to insurance providers as customers, as insurers often influence where patients seek treatment (Telford, Beverley, Cooper, & Boote, 2002).

Is a patient a customer?

Webster's Online Dictionary (n.d.) defines *patient* in the verb form as "bearing pains or trials calmly or without complaint" and in the noun form as *"a person who is a Hospital's "Customer" who receives medical care or treatment."* In healthcare, this term often carries connotations of passivity and deference to doctors (Deber, Kraetschmer, Urowitz, & Sharpe, 2005). Hence, a patient is viewed as an individual who grants authority to the doctor, whereby the doctor or clinician is presumed to be the sole decision-maker regarding the services provided (Mazurenko et al., 2016).

Conversely, *customer* is defined as "someone who buys goods or services from a business" (*Webster's Online Dictionary,* n.d.), implying that medical services are commodities to be managed in the market. When an individual is a customer, he or she purchases services and is fully responsible for checking the quality of the goods before purchase (Brookes & Stodin, 1995). If the patient is labelled a customer, the provider assumes the role of *seller*, whose

aim is to satisfy the customer's needs (Matusitz & Spear, 2014; Reeder, 1972). Switching the labels alters the nature of the relationships between healthcare practitioners and their clients/patients. If the *patient* label is used, the provider holds ultimate decision-making authority, whereas if the customer label is used, the recipient of care may dominate negotiations regarding the treatment plan (Hyeyoung, 2014).

Family members or carers as customers

A limited body of literature explores the role of family members as customers, particularly in healthcare. Most of this work examines family member satisfaction in paediatric hospital experiences (Bragadottir & Reed, 2002; Kuo et al., 2012) or end-of-life or hospice care (Rappaport, Ketterer, Nilforoshan, & Sharif, 2012; Renzenbrink, 2011). However, patients of all ages and stages of life are hospitalized, and many have family members who are intimately involved with the experience. Family members can influence the patient's recollection of their hospital experience, possibly altering the patient's perception of satisfaction with the experience and colouring the patient's responses to satisfaction (Mazurenko et al., 2016). Thus, for the purposes of this study, the patient's family members, friends, and carers are also considered customers, and their perspectives are equally important in addressing this study's research questions.

Mazurenko et. al. (2016) argue that assigning the label *customer* to a patient was strongly associated with the power to select the specific hospital or treatment facility, choice of appointment and hospitals' performance comparative information (Mazurenko et. al., 2016). Additionally, Sir Bruce Keogh, NHS England Medical Director, states that:

> *"*In the NHS and across the public sector, we are committed to making sure information about the quality of our services is available and accessible to all. Making information readily available in one place allows people to hold us to account, not just for the amount of money we spend providing care but for how it is spent and what it delivers for the public." My NHS (2016)

The relationship between patients and healthcare professionals has changed significantly in the past two decades or so in the UK and beyond. Today's patients are 'consumers' of 'services' who can read reviews of healthcare professionals and increasingly also 'performance measures', such as mortality rates of surgeons, before choosing where to go, and 'rate' (Lunich, Rossler & Hautzer 2012) the care they received on the National Health Service's 'NHS Choices' website and other online spaces. They are also at the same time

increasingly recognized as 'experts' in their own right (Fox et al., 2005; Shaw & Baker 2004), who ought to participate in decisions previously made by doctors and other healthcare professionals alone. Where previously many patients relied primarily on doctors for information about symptoms, conditions, and treatments, they now also turn to online health information sites and social networking sites, where they can 'tell their stories' and talk to other patients, discussing experiences, learning from and advising others. Given the now central role of the Internet in healthcare, some commentators have started to refer to the contemporary patient as an 'e-patient' (Ferguson & Friedman 2004). One effect of the rise of the 'e-patient' is that we now have publicly available, 'user-generated', 'naturally occurring', written records of patients' experiences: patient blogs, discussion threads in forums, reviews of services, and so on. These might provide a useful (qualitative) data source for social researchers conducting studies on patients' interactions with NHS hospital providers. Research councils, such as the National Data Strategy, encourage research use of such new types of data arising from digitization (Elias, 2009). Hence, this study aims to analyse online NHS hospital customers' or patients' experience reviews to identify the critical dimensions and attributes of CE in the context of NHS England hospitals.

2.5.1.1 New Public Management (NPM) Reform Policies

Over the last two decades, in response to political and financial pressures, the NHS has been subjected to considerable changes in its organization. According to Newman and Clark's (2009) book, Bolton (2002) states that

> "There has been an increasing emphasis on containing the costs of hospital provision and making the treatment available from hospitals more responsive to consumers' needs. New public sector management (NPM) philosophy clearly reflects an ideological shift toward newly valued entrepreneurial attitudes and behaviours, where patients and health service users are redefined as customers and consumers". (p. 129)

The reform of public services in the UK has been driven in part by a conception of citizens as consumers of public services, a conception that is lodged in narratives about the wider social transition to a consumer society and consumer culture (Clarke and Newman, 2005). Since the end of the 1970s, there has been an increasing emphasis on containing the costs of hospital provision and on making hospital treatment more responsive to consumer needs. Public sector management (sometimes referred to as NPM) has been tasked with changing hospital culture and making service provision more efficient, effective, and accountable

(DHSS, 1983; DoH, 1997, 2000; Reed and Anthony, 1993; Strong and Robinson, 1990). Accompanying changes in work organization, whereby greater numbers of patients are treated while using broadly the same amount of resources, premises, technology, and labour, there has also been a transformation of managerial beliefs and values (Bolton, 2002). NPM philosophy clearly reflects an ideological shift, beginning in the early 1980s with the proposed marketization of the NHS and continuing today with the current government's NHS plan, towards newly valued entrepreneurial attitudes and behaviours (du Gay, 1996). More importantly, 20 years of emphasizing the sovereignty of the customer (du Gay and Salaman, 1992) has also altered the perceptions of the general public and redefined patients and service-users as customers and consumers.

The cultural crusade (du Gay, 1996; Clarke and Newman 2005) of the NPM includes an increasing focus on issues of quality service, and there have been direct attempts to imbue health service employees with a new deference to the needs of consumers. The emphasis on a patient-centred health service is, of course, not new (DHSS, 1976; 1979). During the 1980s and early 1990s, the Conservative government's ideological preference for market principles saw the reinvention of public services as demand-driven markets. The White Papers Promoting Better Health (DHSS, 1987) and Working for Patients (DoH, 1989) introduced a consumer rhetoric and proposed the introduction of an internal market, with implementation to take effect from 1991. In line with this, the publication of the Citizen's Charter (Cabinet Office, 1991) established the public service user as customer, with the then Conservative Prime Minister (John Major) claiming it would "give the customer more clout".

The NHS originated in the UK in the post-war era of shortage, when queuing and rationing were signs not of inefficiency but of fairness (Newman et. al., 2005). Yet today, within the NHS, there remains an era of rationing. Healthcare costs are subject to a much higher budget deficit in the NHS than in the rest of the public sector, due to the current Conservative government's austerity cuts of over £20 billion. Nevertheless, the external environment, where consumerism reigns, has an impact in terms of patient expectations (Clarke and Newman, 2010). Patients are becoming increasingly active participants in their healthcare. Marquand (2004), for example, points to the centrality of marketization and privatization as central strands in the remaking of public and private realms. The rise of consumer culture in the NHS is much debated in academic circles (Edwards, 2000; Gabriel and Lang, 1995; Hilton, 2006; Lury, 1996; Miller, 1998; Mort, 1996; Trentmann, 2006b). The NHS is no exception to the government's determination to foster competition and enhance the power

of the consumer (Leavey, Wilkin, and Metcalfe,1989). The White Paper *Working for Patients* recommends ways of using the power of the market to improve health services (HMSO, 1989). There has been an increased tendency in recent times to apply marketing, business, and consumerist models to the provision of care in modern medicine (Lupton, 1997). Along with these changes have come alterations in the terminology employed by the health services and those observing it (Jinnett *et al.*, 2001). A typical example is Mulhall, Ahmed, and Masterson (2002), who refer to people as "clients" or "customers" of the hospital. Much of the management effort in the NHS over the last few years has been directed towards increasing the service's responsiveness to consumers or customers (Clarke and Newman, 2010).

With the early adoption of the NPM, the policy context in the NHS has shifted away from collaboration towards competition, choice, patient experience, and patient empowerment, although paradoxically, both collaboration and competition continue to co-exist today. Competition is ultimately about hospitals competing for patients, supported by a financial system in which money follows patients. Clarke and Newman attest that "this has been reinforced by major policy reforms such as the NHS Plan (Department of Health, 2000), the White Paper, Our Health, Our Care, Our Say (Department of Health, 2006), and Our NHS, Our Future (Department of Health, 2007b)" (2010, p. 131). The most recent advice reiterates emphasis on choice as a key mechanism and says that this should be "embedded within the full spectrum of NHS funded care" (Department of Health, 2007b, p. 6), and similar guidance states that healthcare organizations should offer "individuals greater choice over the services and treatments available to them" (Department of Health, 2007a, p. 18). Together, these reforms have reintroduced competition among a diverse range of NHS and private hospitals for patients. A major part of the previous Labour government's reform programme was the "marketization" of public services, which includes healthcare, education, and other public services (Clarke and Newman, 2010).

Many healthcare systems internationally aim to deliver customer-centred care (Shaller, 2007), which has been described as "care that is respectful of and responsive to individual patient or customer preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001). The challenges in delivering and improving patient-centred care include finding ways to capture and make sense of patient experience (Gerteis et al., 1993) and to translate these into service improvements (Goodrich and Cornwell, 2008).

Clarke and Newman (2010) argued that the second feature of consumerism as constitutive of new relationships is linked to the discourse of 'choice' and the narrative of change into which it is inserted. Over the past decade, the government introduced a set of market-based reforms into the NHS with the aim of increasing efficiency, reducing inequities in access to care, and increasing the responsiveness and quality of services. Their policies included the introduction of fixed-price reimbursement (PbR), greater devolution of central control (foundation trusts), encouragement of a more pluralistic mix of public and private provision, and an emphasis on patient choice and competition (Picker Institute, 2009). Since January 2006, patients requiring a specialist referral have been entitled to a choice of four or five providers. Since April 2008, patients in England have been able to choose treatment from any hospital listed in a national directory of services, which includes NHS acute trusts, foundation trusts, and independent sector providers, a so-called 'free choice' of provider. And in 2009, the NHS Constitution made this a right for patients. The model of patient choice that underpins the policy requires that patients are aware of their ability to choose, want to choose, and consider choice important. According to a Picker Institute (2010) patient survey, 75 per cent of respondents said choice was either 'very important' or 'important' to them; older respondents, those with no qualifications, and those from a mixed and non-white background were more likely to value choice. The policy assumes that patients are offered a range of options (including private sector providers), that they use quality as the major factor when choosing a hospital, and that they have relevant and appropriate information on quality to inform their decision.

Patient Choice Policy?

Patient Choice Policy was intended to create competition between hospitals for NHS-funded patients and thereby increase efficiency and improve quality. Picker Institute's interviews with NHS and private hospitals management revealed that there was some competition between providers, but the dynamics of competition differed depending on the local configuration of providers, their proximity to each other, the population they served, the type of services they provided, and whether there were local agreements in place (Picker Institute, 2010). Evidence shows that the ability to choose hospital services is intrinsically valued by people and enhances patients' experiences (Dixon et al., 2010). Three-quarters of respondents in the 2009 British Social Attitudes Survey thought that they should have some choice over which hospital they went to (Appleby and Phillips, 2009). There is some evidence that increasing choice does increase providers' focus on quality of care and positive patient experience (Dixon et al., 2010), although the evidence suggests that this is a function of the public reporting of performance information (and providers' response to the associated reputational risk of poor performance) rather than a direct consequence of patients making choices about where to go (Hibbard et al., 2003).

The 2014/15 Choice Framework (Department of Health, 2014) outlines the occasions on which patients can choose who provides their care, including the recently launched NHS e-Referral Service in Fig 2.2., a secure and free NHS appointment booking service that facilitates patient choice. If you're referred to a hospital or clinic for your first outpatient appointment, the NHS e-Referral Service lets you book the appointment at a hospital or clinic of your choice, on a date and time that suits you. NHS England patients have the legal right to choose the hospital or service they would like to go to, and this will include many private hospitals, as long as they provide services to the NHS. The NHS e-Referral Service will then provide patients with information about appointment dates and times available from the shortlisted healthcare providers, allowing them to make a decision that is most suitable for them. This level of customer service is popular in the business or commercial sectors, where customer care is fundamentally important for competitive advantage.

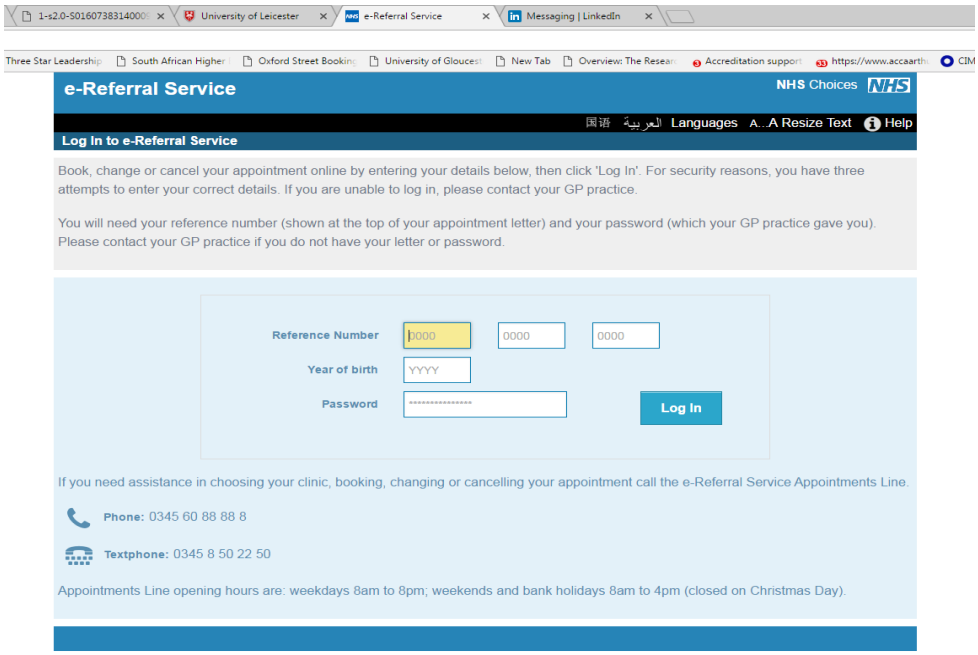


Figure 2.2: NHS e-Referral Service system

Source: NHS Choices (www.nhs.uk)

Comparing waiting times, and Quality Accounts

Few patients as yet make use of performance measures to inform their choice of provider, relying instead on their own or others' experience, or the advice of health professionals (Dixon et al., 2010). Nevertheless, a fundamental element in enabling fully informed choice is the ready availability of high-quality, transparent information. A second element is the ability to compare provider information about a few different factors, for example, using the My NHS comparison website tool in Fig 2.3 (NHS Choices, 2014a). Waiting times may vary between hospitals, and one should consider this when choosing a hospital. When patients are referred for their first outpatient appointment, the NHS e-Referral Service lets them book the appointment at a hospital or clinic of their choice, on a date and at a time that suits them. They can also compare waiting times for hospitals on this site. A Quality Account is a report about the quality of services by an NHS healthcare provider, showing all indicators such as safety, food quality, infection control, mortality rates, and financial information. The reports are published annually by each provider, including the independent sector, and are available to the public so that they can make an informed choice.

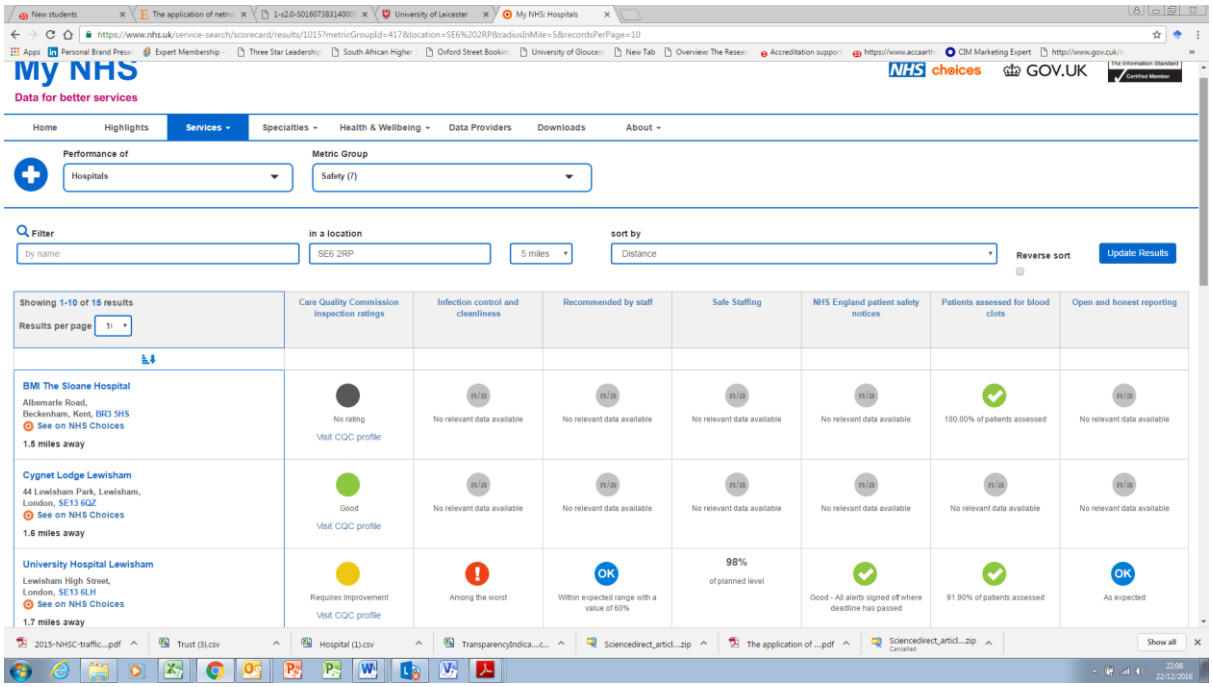


Figure 2.3: My NHS comparison website tool

Source: (www.nhs.uk/Service-Search/performance/search)

Customer or patient experience feedback – and its importance

Patients' feedback on their experience of using healthcare services is recognized internationally as a key marker of the quality of those services and a vital source of information for quality improvement. Patient feedback is a component in the healthcare quality frameworks of the United States (US) Agency for Healthcare Research and Quality (AHRQ) and the Organisation for Economic Co-operation and Development (OECD), and in most countries in the developed world (AHRQ, 2015; Arah, 2006). It was first explicitly embedded in the English NHS in 1999 as one of six domains in the NHS Performance Assessment Framework, which was designed to deliver high-quality, cost-effective care that would improve people's health (Department of Health, 1999).

The focus on patient experience as a key element of quality in the NHS has been reinforced over the past decade through numerous reviews and policies. These include the Darzi review and its three domains of quality (effectiveness, safety, patient experience) (Department of Health, 2008); the report on service failures at Mid Staffordshire NHS Foundation Trust (Francis, 2013); the coalition government's White Paper (Department of Health, 2010); the NHS Outcomes Framework (Department of Health, 2014b); and the NHS mandate (Department of Health, 2014a).

The individual patient is the only witness to all his or her care experiences, making him or her essential source for information across services and care settings (O'Hara and Isden, 2013). Feedback from individuals (patients, carers, family members) about services can take a number of forms – in real time or in retrospect, formally or informally, at a national or local level, prompted or unprompted, in depth or high level, in person, on paper, on a mobile device or online – and serves varying purposes (Coulter et al., 2009).

The Friends and Family Test is a single-question national survey (with free text) carried out by providers of NHS-funded services that aims to enable patients to give quick feedback on the quality of care they receive. It asks, 'How likely are you to recommend to friends and family if they needed similar care or treatment?' It is a quick and anonymous way to give your views after receiving care or treatment across the NHS. Since its launch in 2013, more than 25 million pieces of patient feedback have been submitted.

Patients can also give feedback via a third party, such as online feedback platforms such as Patient Opinion (2014), iWantGreatCare (2014), the NHS Choices website (NHS Choices, 2014b), and the local Healthwatch (2014). With the continued growth in digital communication, patients are increasingly turning to social media sites as a forum for giving feedback. Although proactive organizations engage with these sites, there is no formal responsibility to use or respond to information posted on them. Patient stories provide a descriptive narrative of an individual's treatment or care and their journey as a patient through a care pathway or organization. They can be used to encourage discussion in team or board meetings, particularly about patient safety issues EBCD is an approach where individual patients tell the story of their experience of care; then patients and staff together identify areas for improvement and form co-design groups that work to implement changes to services. Patients and staff monitor and oversee changes and improvements as they happen throughout this time.

Patients can play an individual role in reporting patient safety incidents through the National Reporting and Learning System. Patient reports are analysed to help identify common hazards and to understand why things go wrong and how to stop them happening again. Two new patient safety measures – the patient measure of safety and the patient incident reporting tool – are being developed with the aim of better use of patient input to improve the safety of care (Ward et al., 2011). Not acting on feedback given by patients can have a damaging impact. The Mid Staffordshire NHS Foundation Trust Inquiry noted:

"A poor complaints system has a negative impact on the patients and others who seek to use it. Inadequate responses cause distress and may exacerbate bereavement" (Francis 2010, para 60, p. 20).

The current study seeks to answer the question of what constitutes customer experience. The issue of what are the components that constitute the patient experience remains puzzling (Raleigh, 1998).

2.6 Related theories, models, and frameworks

Initial seminal theories on marketing and consumer behaviour were developed and communicated, specifically in the work of Philip Kotler (1967) and John Howard and Jagdish Sheth (1969). The earlier review of the multi-definitions of CE showed definitions that included elements of other concepts, e.g. service quality and customer satisfaction. Similarly, Palmer (2010) states:

> "a number of widely service constructs either run parallel to or are major contributors to the construct of customer experience. In addition to the concept […], discussion of service quality may provide a baseline for experience" (p. 197).

Hence, for the researcher to truly understand and appreciate the renewed focus on customer experience, the researcher needs to understand its historical relationship with concepts such as service quality, customer behaviour, customer satisfaction, customer centricity, customer engagement, customer relationship management, service encounters, and customer co-creation – and to identify and recognize the contributions of these established research areas to customer experience. The researcher can then identify important subsequent developments in how these concepts are interlinked with CE and their contributions to CE research in relation to healthcare study:

- *Customer Buying Behaviour Process Models* – Understanding CE and customer decision-making as a process (1960s–1970s)

- *Customer Satisfaction and Loyalty* – Assessing and evaluating customer perceptions and attitudes about an experience (1970s)

- *Service Quality and Perceived Service Quality* – Identifying the specific context and elements of the CE and mapping the customer journey (1980s)

- *Relationship Marketing* – Broadening the scope of customer responses considered in the customer experience (1990s)

- *Customer Relationship Management* – Linkage models to identify how specific elements of the customer experience influence each other and business outcomes (2000s)

- *Customer Centricity and Customer Focus* – Focusing on the interdisciplinary and organizational challenges associated with successfully designing and managing CE (2000s–2010s)

- *Customer Engagement* – Recognizing the customer's role in the experience (2010s)

- *Customer Co-creation* – co-creation involves customer engagement in the creation of superior customer experiences through ideation, design and development (2015s)

The in-depth discussion on the link to or relationships with CE of the above constructs is outlined in the following sections:

2.6.1 Customer buying behaviour

Initial theories in marketing began in the 1960s, focusing on customer decision-making processes and the experience of buying products. Integrated models showing this buying process, in which customers move from need recognition to purchase to evaluation of the purchased product, were developed. The most influential model in this regard is Howard and Sheth's (1969) model. Also, in this stage, models were developed to explain how advertising works, including the still-used attention–interest–desire–action (AIDA) model and adaptations thereof (Lavidge and Steiner, 1961). These broad, encompassing theories are still very influential and have gained a strong foothold in multichannel research and path-to-purchase modelling, and provide a foundation for research in customer experience (Lemon and Verhoef, 2016). For example, in their conceptual model of multichannel customer management, Neslin et al. (2006) build on Howard and Sheth's (1969) model by suggesting a process from problem recognition to search, to purchase, and to after-sales service using

multiple channels. Pucinelli et al. (2009) and Verhoef et al. (2009) also give strong consideration to the purchase journey in their treatment of CE.

Schmitt (2003) builds upon this process approach, noting that "the key objective of tracking the experience at customer touch points is to develop an understanding of how an experience can be enriched for the customer throughout what marketers call the 'customer decision-making process'" (Schmitt 2003, p. 68). Within path-to-purchase models and CE management, the so-called purchase or marketing funnel (which is strongly linked to the AIDA model) has become extremely popular (e.g. Court et al., 2009; De Haan et al., 2016; Li and Kannan, 2014). Overall, the influence of these early consumer decision-making process models on CE research is evident. Specifically, these models provide the foundation for thinking holistically of the customer experience – as a process consumers go through – what researchers now refer to as the service encounter.

2.6.2 Customer satisfaction and loyalty

The service marketing literature on performance outcome measures, such as customer satisfaction and loyalty, is well-established. Although extant literature indicates a strong connection between customer experience and customer satisfaction, empirical linkages between experience and performance measures have not been robustly established. One key element in understanding and managing the customer experience is the ability to measure and monitor customer reactions to firm offerings, especially by assessing and evaluating customer attitudes and perceptions (Verhoef et al., 2015). One such assessment focused on customer or patient satisfaction. Most of the literature regarding satisfaction has focused on service cognition (Oliver, 1980; Parasuraman et al., 1985; Spreng et al., 1996). The conceptualization of customer satisfaction began in the 1970s. Rowley (1999) considered total experience an absolute concept, a function of customer satisfaction derived at different points in the transaction. However, Chen, Chang, and Fan (2008) found that actual experience and expectations were significant predictors of satisfaction. They remarked on the gap between expectation and actual experience that leads to satisfaction/dissatisfaction. For instance, a customer with positive/negative perceptions would evaluate satisfaction as positive/negative.

Researchers have sought to understand how customers perceive service quality and how their experiences lead to satisfaction. This conversation has led to the articulation of expectancy

theory, which maintains that decision makers pursue specific behaviours because of what they expect to result from their choices (Oliver, 1974). Implicit in this reasoning is that customer experiences that exceed expectations deliver satisfaction (Oliver, 1980; Edvardsson et al., 2005). Experiences that fail to meet expectations lead to dissatisfaction. Expectancy theory further implies that satisfaction emerges through customer experience, which moulds future expectations and choices (Gilmore and Pine, 2002).

Figure 2.4 shows the transactional view of how customer experience influences satisfaction, suggesting that customers possess a priori expectations regarding their needs and possible fulfilment options (Tybout et al., 1981; Stayman et al., 1992). These expectations are phenomenological; that is, they are built from individual experience or the way a person has experienced things in the past (Wallendorf and Brucks, 1993). Memory of previous experiences also shapes how decision makers perceive the current experience, influencing the level of satisfaction with it (Tybout et al., 1981; Edvardsson et al., 2005). Memory of previous experiences also influences expectations regarding future experiences. The affective aspect of expectation formation is more instinctual. It is an emotional reaction to stimulation arising from a customer experience (Zajonc, 1980). Importantly, customer emotions arise quickly, fashioning and being fashioned by the cognitive process associated with the customer experience (Lerner and Keltner, 2000). As a result, customers come into an experience with preconceived expectations (Frow and Payne, 2007) that may not be apparent but are real and influence the way customers (1) process various aspects of the experience and (2) form opinions regarding their satisfaction with the experience.

Customer satisfaction and other approaches to assessing customers' perceptions of their experience serve as additional critical building blocks for our overall understanding of the customer experience and provide the basis for its measurement (Verhoef et al., 2015).

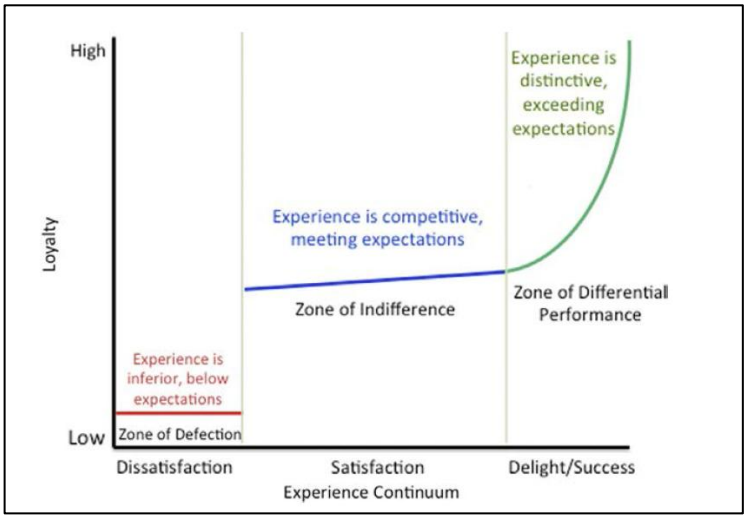


Figure 2.4: A model of customer satisfaction drivers of CE

Source: Adapted from Fawcett et al. (2012)

In the customer experience approach, patient experience is easily conflated with patient satisfaction. There is a substantial and interesting literature on the differences between patient experience and patient satisfaction; however, it suffices to note the dangers that arise from confounding them. The first danger is that patient satisfaction ratings can be misleading. There is a complex relationship between patient knowledge, patient expectations of care, patient experiences of care, patient assessments of care, and objective measures of patient benefit (Williams, 1994; Stanniswewka and Ahmed, 1999; Black and Jenkinson, 2009; Edwards et al., 2004). In some circumstances, high levels of patient satisfaction supply evidence of high-quality medical care, whereas in others, they supply evidence of low expectations or unnecessary treatments (Greaves et al., 2012; Fenton et al., 2012). Unless it is well-designed, a satisfaction-rating instrument cannot tell you what to do when patients are dissatisfied. You may not know what you have done wrong. Service improvement activity requires specific data about what happened, not just data on whether patients were satisfied with what happened (Berwick et al., 2003)

2.6.3 Service quality

Service marketing developed as a separate discipline in the 1980s. With the special characteristics of service offerings (e.g. intangibility, personal interactions), firms began recognizing that marketing service was significantly different from marketing goods (Rathmell, 1966; Rust and Chung, 2006; Zeithaml et al., 2006). One of the major concepts

within service marketing that has garnered significant attention is service quality (Kunz and Hogreve, 2011). Since the development of the SERVQUAL model and measurement scales by Parasuraman, Zeithaml, and Berry (1988), many studies have tried to validate and improve that scale (e.g. Cronin and Taylor 1992, 1994), and many applications in specific contexts (i.e. E-service quality) have been advanced (e.g. Parasuraman, Zeithaml, and Malhotra, 2005; Wolfinbarger and Gilly, 2003).

The SERVQUAL model, in particular, is one of the marketing theories that has had a major influence in practice (Roberts, Kayandé, and Stremersch, 2014). In the area of service marketing, the researcher also observes the development of service blueprinting as an initial attempt to map the customer journey (Bitner, Ostrom, and Morgan, 2008), early recognition of the importance of so-called moments-of-truth or critical incidents in service delivery, and incorporation of atmospherics and the environment as influences on the customer experience (e.g. Bitner 1990, 1992). Taken together, the researcher sees that the service quality literature stream brings to customer experience the focus on the context in which experiences arise, as well as on the journey mapping and measurement/assessment aspects of customer experience.

Service quality is considered the most important factor in relation to customer experience (Conway & Willcocks, 1997). It is described as the comparison between customers' expectations and their perceptions about service performance (Parasuraman, Zeithmal, & Berry, 1985, 1988, 1994). In this context, Gunawardane (2011) suggested that customers' perceptions of the quality of a service encounter depend on the customer's pre-service expectations and post-service perceptions.

2.6.4 Relationship marketing

The 1990s witnessed a focus on developing strong relationships with customers. Relationship marketing mainly developed in business-to-business (B2B) and marketing channels research (e.g. Dwyer, Schurr, and Oh, 1987; Geyskens, Steenkamp, and Kumar, 1998; Morgan and Hunt, 1994). However, it also gained a strong position within consumer markets (Berry, 1995; Sheth and Parvatiyar, 1995), and relationship marketing theories have extensively been tested in business-to-consumer (B2C) settings as well (e.g. Burnham et al., 2003; De Wulf et al., 2001; Verhoef 2003). Major constructs considered include trust, commitment (in its multiple dimensions), switching costs, and relationship quality (as an

overarching construct). Specifically, in the B2B and channel contexts, transaction cost theory-based constructs, such as relationship-specific investments and opportunism, have been treated as antecedents of relationship quality (Palmatier et al., 2006). Encouraged by a stronger attention in economics and marketing and consumer research (e.g. Bagozzi et al., 1999; Frey and Stutzer, 2002), researchers also have recently suggested the need for more attention on emotional aspects of customer relationships (Verhoef and Lemon, 2015) and have begun measuring constructs such as passion and intimacy (Bügel et al., 2011; Yim et al., 2008). In summary, relationship marketing theory has significantly enriched the understanding of various theoretical facets of the customer relationship, extending the focus of customer experience to include emotions and perceptions associated with it.

2.6.5 Customer relationship management

The 2000s brought a stronger focus on extracting value from the customer relationship. Whereas in relationship marketing, the focus was mainly on building strong long-term relationships with customers, customer relationship management and customer value management centred more on the optimization of customer profitability and customer lifetime value (CLV) (e.g. Kumar and Reinartz, 2006; Reinartz et al.,2004). For example, in their definition of customer relationship management, Payne and Frow (2005) call for forming appropriate relationships with customers, implying that a long-term and strong relationship is no longer the ultimate objective. Research has also shown that long-term relationships are not necessarily more profitable and that there is strong revenue and cost heterogeneity between customers (Reinartz and Kumar, 2000; Shah, Kumar, and Kim, 2014; Shah et al., 2012). Following this theme, multiple studies have considered how firms can optimize customer acquisition, customer retention, and development strategies in such a way as to optimize the extracted CLV, which can result in shareholder value creation (e.g. Kumar and Shan, 2009; Lewis, 2006; Reinartz et al.,2005; Shah et al., 2014; Venkatesan and Kumar, 2004). However, researchers might dispute whether these strategies place sufficient emphasis on the value delivered to customers. To address this limitation, the customer equity framework, introduced by Rust, Zeithaml, and Lemon (2000), with its key concepts of value equity, brand equity, and relationship equity as drivers of customer equity, links investments in quality, brands, and relationships to CLV (see also Rust et al., 2004; Verhoef, 2003). Recently, Ou et al. (2014) and Ou, Verhoef, and Wiesel (2016) provided additional support for this framework. The customer relationship management literature's contribution to

customer experience focuses on how specific elements of the customer experience relate to one another and to business outcomes.

2.6.6 Customer centricity or customer focus

The notion of customer centricity as a valuable strategic approach has been proposed, implemented, and debated since the 2000s. Sheth et al., (2000) focus on customer-centric marketing, an approach that centres on understanding and delivering value to individual customers rather than mass or target markets. Though encouraged for several decades, this focus on individual customers has really come to fruition with the ubiquitous availability of individual-level customer data. More broadly, there has also been a movement towards customer focus and customer centricity at the overall firm level, most notably put forth by Gulati and Oldroyd (2005), who identify a four-stage path to a customer-focused culture: (1) communal collaboration: collation of all customer information; (2) serial coordination: gaining insights into customers from past behaviour and all information; (3) symbiotic coordination: developing an understanding of likely future customer behaviour; and (4) integral coordination: real-time response to customer needs (Gulati and Oldroyd, 2005, p. 97). More recently, Fader (2012, p. 9) brought these two approaches together, focusing on customer centricity as a strategy that aligns a company's products and services with the needs of its most valuable customers to maximize the long-term financial value of those customers. Further, James (2013) described an engaged patient as one who is emotionally involved, or affectively committed, to their health and well-being. Thus, patient engagement as a strategy for a healthcare organization should be focused again on the patient's cognitive and affective processes and states (La Vela and Gallan, 2014). This shift has enabled organizations to be more ready for the interdisciplinary and cross-functional coordination required to design, understand, and manage customer experience.

Several managerial tools have been developed to facilitate the shift to customer centricity. The first tool is buyer (or customer) personas. A persona is "a semi-fictional representation of your ideal customer based on market research and real data about your existing customers" (Kusinitz, 2015). Personas have traditionally been used in user-centred design (Pruitt and Adlin, 2006) but have increasingly been incorporated into brand management and customer experience design (Herskovitz and Crystal, 2010). They focus on a specific customer segment, identifying key aspects of that segment's typical customers' needs and experiences.

A second tool is the "jobs-to-be-done" perspective proposed by Christensen and colleagues (Christensen et al., 2007; Christensen, Cook, and Hall, 2005; Nobel, 2011). Christensen's approach focuses on examining and understanding the circumstances in customers' lives that may lead them to purchase a product, thereby viewing the process from the customer's perspective. Taken together, the above discussion showcases how customer centricity has set the stage for a renewed focus on the customer experience.

2.6.7 Customer engagement (Patient engagement)

In the current decade, the major movement in customer management has been on customer and brand engagement. Several definitions have been put forth for customer or patient engagement – focusing on attitudes, behaviours, and value extraction. Overall, customer engagement attempts to distinguish customer attitudes and behaviours that go beyond purchase. Focusing on an attitudinal perspective, Brodie et al. (2011) define customer engagement as "a psychological state that occurs by virtue of interactive, co-creative customer experiences with a focal agent/object (e.g. a brand) in focal service relationships" (p. 260).

This approach suggests that engagement is a motivational state that leads customers to participate with firms. Building upon this, Vivek, Beatty, and Morgan (2012) provide an extensive review of the engagement literature and define customer engagement as "the intensity of an individual's participation in and connection with an organization's offerings or organizational activities, which either the customer or the organization initiates" (p. 133). This view is consistent with VanDoorn et al. (2010), who focus on the non-transactional nature of customer engagement by putting forth the concept of customer engagement behaviour, defined as "the customer's behavioural manifestation towards a brand or firm, beyond purchase, resulting from motivational drivers" (p. 253). This approach has been extended, especially as the digital and social media revolution has strengthened the importance of customer engagement behaviour, as customers become active co-producers of value or destroyers of value for firms (Beckers, Risselada, and Verhoef, 2014; Leeflang et al., 2014; Van Doorn et al., 2010; Verhoef, Reinartz, and Krafft, 2010). Such developments have empowered customers to engage more with firms, either positively or negatively. This "beyond purchase" behavioural dimension of customer engagement includes manifestations such as co-creation, social influence through WOM, and customer referrals (e.g. Hoyer et al., 2010; Libai et al., 2010).

Recent studies have also attempted to measure customer engagement (e.g. Brodie et al., 2013; Isaac, Calder, and Malthouse, 2016; Hollebeek, Glynn, and Brodie, 2014), and to examine how firms can benefit from customer engagement (Kumar and Pansari, 2016). These customer engagement behaviours also have consequences for value extraction. Kumar et al. (2010), for example, identify four components of customer engagement value: customer purchasing behaviour, customer referral behaviour, customer influencer behaviour, and customer knowledge behaviour. Further research has refined and begun to measure these aspects of engagement value, such as customer referral value and customer influence value (e.g. Kumar, Petersen, and Leone, 2010; Kumar et al., 2013).

2.6.8 Customer co-creation

Academics and practitioners increasingly recognize the importance of engaging customers in the creation of new products and services through co-creation (Payne et al., 2008; Prahalad and Ramaswamy, 2003). In recent years, online tools and communities facilitated co-creation in ideation (e.g. customers generating new ideas in companies' virtual environments), design (e.g. customers designing their own offerings with the help of companies' self-design tools), and development (e.g. user communities testing offerings for defects) (Nambisan, 2002). Therefore, co-creation involves customer engagement in the creation of offerings through ideation, design and development (Bolton and Saxena-Iyer, 2009; Mustak et al., 2013; Vargo and Lusch, 2008).

Despite its acknowledged importance, empirical work about the outcomes of co-creation is rather limited (Carbonell et al., 2009). Extant studies – which have largely been limited to conceptual and qualitative studies – associate co-creation with efficiency gains for firms, such as minimization of new product and service development costs (O'Hern and Rindfleisch, 2008), reduced failure risk (Hoyer et al., 2010), and faster speed to market (Alam, 2002). Additionally, co-creation is related to effectiveness gains for firms, such as a closer fit with customer needs (Fang et al., 2008) and better market reach and acceptance (O'Hern and Rindfleisch, 2008). Empirical studies, however, paid scant attention to the impact of co-creation on the customer experience, although generating better customer experiences is a key rationale for firms to opt for co-creation (Klaus and Maklan, 2012; Payne et al., 2008; Pine and Gilmore, 1999).

This section addresses the customer experience in co-creation situations and its determinants. In line with the customer experience literature (Gentile et al., 2007; Holbrook and Hirschman, 1982; Verhoef et al., 2009), we discuss individual determinants (characteristics of co-creating customers) and environmental determinants (characteristics of co-creation environments). Figure 2.5 visualizes our theoretical framework.

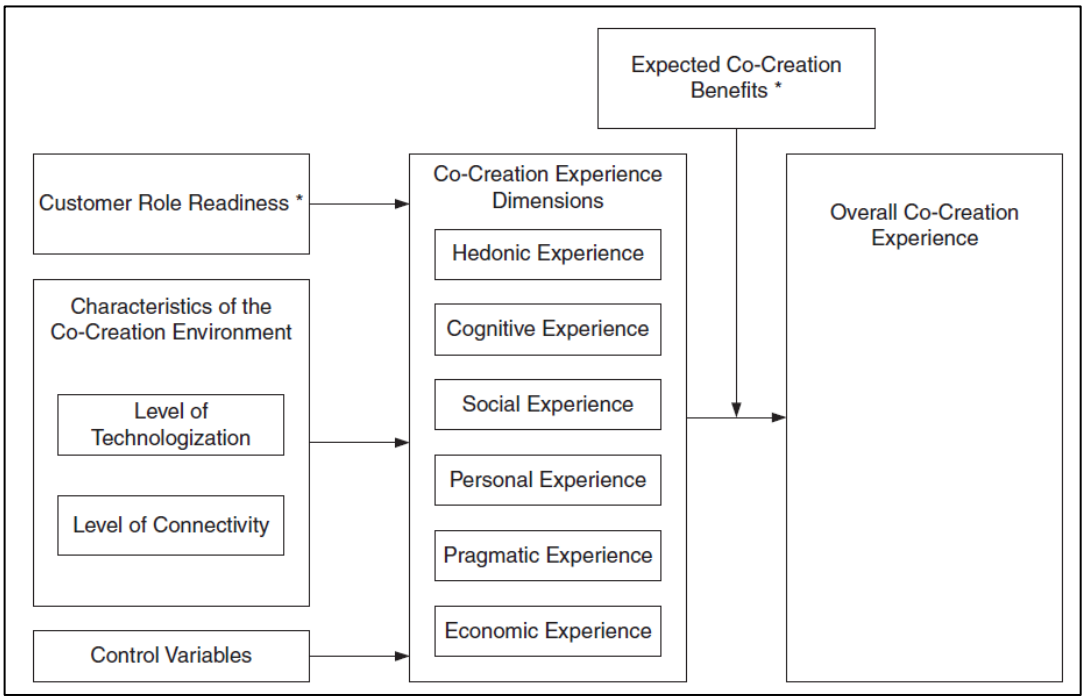


Figure 2.5: Co-creation experience theoretical framework

Source: Adapted from Verleye (2014)

Building on the gaps model that underlines the importance of balancing customer perceptions with expectations to deliver service quality (Zeithaml et al., 1990), Verleye (2014) argued that the co-creation experience depends on the degree to which expected co-creation benefits are met. Hence, he argued that the overall co-creation experience is driven by six co-creation experience dimensions

Customer experience and earlier theories

In conclusion, an important issue is how customer experience relates to the major theories discussed above and specific customer-focused constructs. The researcher synthesized the major contributions of each of the discussed streams and how they infuse the understanding of customer experience as well as the management of customer experience (see Table 2.7). Looking across the decades of research, the researcher broadly categorized the research

themes into three research areas: (1) research focused on process, behaviour, and resulting value: the early consumer buying behaviour process models, customer relationship management, and customer engagement; (2) research focused on process outcomes: satisfaction, service quality, and relationship marketing; and (3) customer-centricity research focused on the internal organizational aspects of customer experience. This clearly shows that, although CE is interlinked with these theories, it remains a distinct construct. The researcher discusses, in the following section, how customer experience can be considered distinct from other constructs in marketing.

Time Frame (Decade)	Historical/Original service constructs	Representative Articles	Modified service constructs - prefixed with "patient"	Contribution of historical constructs to Customer Experience
1960s–1970s	Customer Buying Behaviour: Process Models	Howard and Sheth (1969); Lavidge and Steiner (1961)		Encompassed path to purchase Broad, experiential focus Conceptual linkage models Considered CE and customer decision-making as a process
1970s	Customer Satisfaction and Loyalty	Oliver (1980); Bolton and Drew (1991); Gupta and Zeithaml (2006)	Patient satisfaction	Identified key metrics to begin to assess overall CE Empirical linkage models to identify key drivers Assessed and evaluated customer perceptions and attitudes about an experience
1980s	Service Quality (healthcare service quality)	Bitner (1990, 1992); Parasuraman, Zeithaml, and Berry (1988); Rust and Chung (2006); Bitner et al. (2008) Lemke et al. (2011)	Patient total quality of service	Incorporated atmospherics and environment Early journey mapping through blueprinting Linked marketing and operations – focus on quality Identified the specific context and elements of the CE
1990s	Relationship marketing	Dwyer, Schurr, and Oh (1987); Morgan and Hunt (1994); Berry (1995)	Patient relationship marketing	Expanded to B2B contexts Identified key attitudinal drivers Broadened the scope of customer responses considered in the customer experience
2000s	Customer Relationship Management (patient relationship management)	Reinartz and Kumar (2000); Verhoef (2003); Reinartz, Krafft, and Hoyer (2004); Bolton, Lemon, and Verhoef (2004); Rust, Lemon, and Zeithaml (2004); Payne and Frow (2005); Kumar and Reinartz (2006); Neslin et al. (2006); Kumar and Shah (2009)	Patient relationship management	Enabled return-on-investment assessment Identification of key touch points and drivers Data-driven Incorporated multichannel aspects Identified how specific elements of the customer experience influence each other and business outcomes
2000–2010s	Customer Centricity and Customer Focus	Sheth et al. (2000); Gulati and Oldroyd (2005); Shah et al. (2006)	Patient centric or patient-centred	Customer perspective throughout organization Embedded the customer and customer data deeper into the organization Focused on redesigning CE from customer perspective
2010s	Customer Engagement)	Van Doorn et al. (2010); Libai et al. (2010); Brodie et al. (2011); Kumar et al. (2010); Kumar et al. (2013); Hollebeek et al. (2014)	Patient engagement	Recognized value of nonpurchase interactions Incorporated positive and negative attitudes, emotions, and behaviours Conceptual platform to incorporate social media More clearly recognized the customer's role in the experience

Table 2.7: Historical Perspective: Contributions to Customer Experience

Source: Modified from Verhoef et al., (2016)

2.7 Customer experience as a distinct construct

In conclusion, the current literature states that CE is a multidimensional construct encompassing a customer's cognitive, emotional, behavioural, sensorial, and social responses to a firm's offerings throughout the customer's purchase journey. For a further understanding of the CE construct, it was useful to attempt to differentiate it from other customer-focused constructs - customer satisfaction, service quality, consumer behaviour, customer relationship management, customer focus or centricity, and customer engagement. CE is a relatively broad construct. Customer satisfaction could be one component of CE, focusing on the customer's cognitive evaluation of the experience. One could even argue that CE is broadening the concept of customer satisfaction, leading to a richer view. Service quality (and its constituent elements) would be considered an antecedent of CE, and in line with earlier research (e.g. Mittal, Kumar, and Tsiros, 1999), CE is related to the emerging construct of customer engagement. As noted above, CE is a multidimensional construct that captures the customer's overall responses to the firm's offerings across the entire customer journey. Customer engagement focuses on the extent to which the customer reaches out to and initiates contact with the firm, whether attitudinally or behaviourally. As such, "reaching out" (or engagement) constitutes touchpoints along the customer journey and elicits cognitive, emotional, behavioural, sensorial, and social responses from the customer. Customer engagement then becomes part of the overall customer experience and, in its specific manifestations, constitutes touchpoints along the customer journey. To date, studies have neglected this connectedness (see Malthouse and Calder, 2011, for a call for such research), but given that many channels and touch points are highly interactive and provide multiple opportunities for customers to engage with the firm, it is important to consider customer engagement in the development of CE theory. Thus, the researcher views customer engagement as a component of CE through specific interactional touchpoints, such as social communities and interactions with service employees or other customers. So far, there is no research that clearly shows the nomological network of CE and how this construct relates to other customer-focused constructs. This is a critical issue for future research; however, it is beyond the scope of this thesis.

2.8 Related theoretical models and frameworks

Researchers (Mascarenhas et al., 2006; Garg et al., 2011) have suggested that although different authors have proposed and validated models that reflect either dimensions or

attributes of CE, the variables across these models are sector-specific. It is also recognized that despite the importance of CE and the positive attention this concept has received during the last few years, the explanations of CE have remained vague and lack a thorough theoretical foundation (Tynan and McKechnie, 2009; Gentile *et al.*, 2007; Maklan and Klaus, 2011). There have been few attempts to define the concept of CE and to identify its dimensions, attributes, and outcomes across diverse contexts, including healthcare services (Lemke et al., 2011; Garg et al., 2011). There is no consensus on the number of dimensions and attributes that constitute the construct of CE in the existing literature. Studies represent different points of view about the CE construct. However, it is agreed that the conceptualization of experience comprises "multi-aspects" (Holbrook and Hirschman, 1982; Mascarenhas et al., 2006; Gentile et al., 2007; Garg et al., 2011; Chahal and Dutta, 2016; Maklan and Klaus, 2011; Lemke et al., 2011). These authors argue that experiences are customer-dependent and context-specific. Holistically, Gentile et al. (2007) viewed the CE construct from a different angle. They conceptualized CE as a multidimensional structure, and its components are sensorial, emotional, cognitive, pragmatic, lifestyle, and relational.

As above, there is a diversity of constitution to CE constructions. The fragmentation of constitutions has led some scholars to develop integrated models that incorporate a number of theoretical underpinnings. Four attempts to integrate various streams were made in the context of banking services (Maklan and Klaus, 2011), services in general (Lemke at el., 2011), and conceptual (Garg et al., 2011;Chahal and Dutta, 2014). These authors' CE models comprise primary dimensions and sub-dimensions, which are further divided into attributes. Hence, the CE models or frameworks of Maklan and Klaus (2011), Lemke et al. (2011), Garg et al. (2011), and Chahal and Dutta (2014) are suitable as the departure points or initial working frameworks for a study in the context of UK NHS hospitals, because they have the benefit of integrating holistically all dimensions and attributes and take into account not just the outcomes of CE, but also factors that significantly influence the positive and negative CEs. As noted in the literature review, there is no CE conceptual framework that has been adapted from one context and tested in a different one or industry. It is recognized that adapting, for example, Maklan and Klaus's (2011) model for a UK bank context and testing it in UK NHS hospitals would not be appropriate because the experiences are customer-dependent and context-specific. As a result, this research will not test other authors' CE conceptual frameworks but instead propose a working framework for the UK NHS hospital context, which will be further developed with the final research findings. The above-mentioned models are each synthesized further in this section.

Maklan and Klaus's (2011) customer experience model

Maklan and Klaus (2011) developed a model for CE comprising their identified dimensions and attributes that explains its most important marketing outcomes: loyalty (defined as mortgage repurchase), WOM recommendations (Samson, 2006), and satisfaction. Maklan and Klaus's (2011) CE model of dimensions, attributes, and exogenous (outcomes) variables in the UK bank context is presented below in Figure 2.6. Their model comprises four main dimensions: Peace of mind, Outcome focus, Moments of truth, and Product/service experience. Each of these primary dimensions is further divided into a number of attributes. Maklan and Klaus's (2011) CE model is considered suitable as the departure point or framework because it is the only study that consistently used the terms of components of CE in relation to this study's focus, "attributes, dimensions" and outcomes (positive and negative factors of CE), as opposed to the others, which generalized attributes as items or components of dimensions.

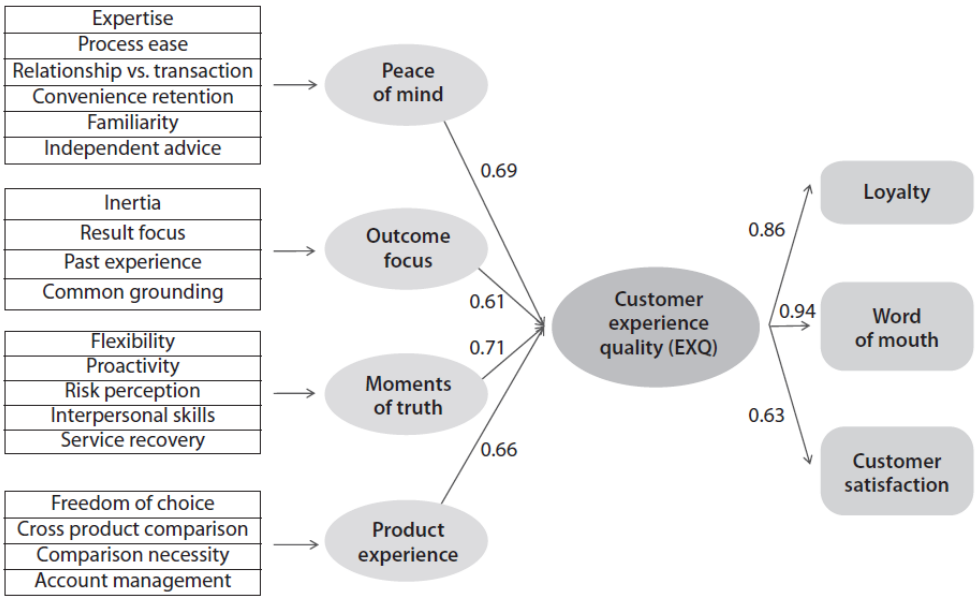


Figure 2.6: Customer experience model: dimensions, attributes, and exogenous variables

Source: Adapted from Maklan and Klaus (2011)

Their resulting model comprises four primary dimensions (Peace of mind, Outcome focus, Moments of truth and Product experience) with 19 corresponding attributes, which were labelled as in the figure above.

Traditionally, customer satisfaction is modelled as a mediator between service quality and behavioural intention (Cronin Jr & Taylor, 1992). Research indicates that service quality also plays a mediating role between service attributes and behavioural intentions, with its attributes being more strongly related to overall service quality than to behavioural intentions (Dagger *et al.*, 2007). This demonstrates significantly stronger relationships between customer experience, as defined in this study, and loyalty than between customer satisfaction and loyalty. Compared with the relationship between customer satisfaction and WOM, Maklan and Klaus (2011) also established a more direct link between customer experience and WOM. Therefore, while there is a body of literature offering customer satisfaction as a mediator between service quality and loyalty and WOM (Seiders *et al*. 2005), Maklan and Klaus's (2011) research advocates that customer experience could be an even better predictor of loyalty and WOM. Maklan and Klaus's (2011) study finds that the four POMP dimensions of customer experience explain most of the variance in bank loyalty, WOM, and customer satisfaction. The findings indicate that customers evaluate the customer experience at an overall, dimensional, and attribute level, and that each level drives perception at the level above.

These findings support conceptual papers which suggest that the customer experience is broadly based (Berry *et al.*, 2006; Schembri, 2006), yet not as broad as suggested by some (Gentile *et al.*, 2007; Meyer & Schwager 2007; Verhoef *et al.*, 2009). Dimensions arising from the literature and even from the qualitative stage, such as social interactions (Bagozzi, 2000), brand (Brodie, 2006), and price (Baker *et al.*, 2002), are not significant. One possible explanation for this counterintuitive finding is that the sample comprises repeat customers. Based on the attributes and dimensions of service experience, the researcher believes his findings are particularly relevant to other high-involvement, high-contact professional services.

Experience is far broader and less bounded than the concept of product or service quality it replaces; hence, its measurement is far more complex. However, experience is not all-encompassing, and it is incumbent on the researcher to uncover what attributes and dimensions are in or out, and which ones matter most. In so doing, marketing investments can be directed more effectively to maximize drivers of financial performance, namely loyalty, satisfaction, and share-of-wallet. Researchers should not over-compensate for the limitations of the traditional conceptualization of product or service quality. It is likely that practising researchers will need to model customer experience for their unique context; current generic conceptualizations of experience may be too broad to be actionable and relevant in any one context.

There is a growing focus on the importance of attending to 'patient experience' in the delivery of health services (Shale, 2015; Staniszewska and Churchill, 2014). Over the last decade, policy has emphasized the importance of positive patient/customer experience as a cornerstone of high-quality health and social care in the NHS England hospitals, with many initiatives attempting to develop patient-centred practice.

Chahal and Dutta's (2014) generic customer experience model

Consistent with this study, Chahal and Dutta (2014) reviewed the extant literature on key components of customer experience – concept, dimensions, attributes and factors, and outcomes (both positive and negative), and developed their framework, as illustrated below in Figure 2.7. However, they posit that their study paves the way for researchers and practitioners as a departure point for developing CE contextual models. Their model is based on Schmitt's (1998) five dimensions: sensory experience (sense); affective experience (feel);

creative cognitive experience (think); physical experience, behaviours, and lifestyles (act); and social identity experience (relate). Chahal and Dutta (2014) posit that all five dimensions contribute significantly to the creation of CE. Similarly, for this study, among the varied experiences discussed in the literature, Gentile et al.'s (2007) and Schmitt's (2000) dimensions are found to be quite holistic and formative, addressing this study's research questions. Building on Schmitt's (1988) earlier dimensions, Gentile et al. (2007) distinguished between six experiences that marketers can create for customers: 1) sensory experiences (sensing); 2) emotional experiences (feeling); 3) creative cognitive experiences (thinking); 4) pragmatic experiences (acting); 5) lifestyle experiences that result in and; 6) relational (social). Additionally, in this context, Pine and Gilmore (1998b) suggested that the more senses an experience engages, the more effective and memorable it can be. Schmitt believes that the goal of experiential marketing is to create holistic experiences that integrate all these individual types of experience into one holistic experience (total customer experience), which enhances the level of satisfaction.

Chahal and Dutta (2014) took a different approach and grouped the various attributes of CE under four categories:

1) *core servi*ce characteristics, which include service quality;
2) *supportive service* characteristics, which include five factors: access, choice, information, redress, and representation;
3) *contextual* characteristics, which include past experience, level of perceived risk, distress, preference, and personality;
4) *socio-economic* status and associated groups such as relatives, friends, and acquaintances.

Further to the literature review, service quality is conceptualized in terms of the gap between expectations and performance in reference to five dimensions: tangibility, reliability, responsiveness, assurance, and empathy (Parasuraman et al., 1985, 1988, 1994). Studies such as those by Conway and Willcocks (1997), Lemke et al. (2011), and Maklan and Klaus (2011) have advocated a significant relationship between service quality and customer experience. The authors, as well as Chahal and Dutta (2014), posit that service quality affects CE; that is, higher service quality contributes to a favourable experience.

Conway and Willcocks (1997) discussed the role of supportive, social, and contextual factors affecting CE. The five supportive characteristics, access, choice, information, redress, and

representation, are required for a better understanding of the CE creation. For instance, the experience would be quite satisfactory when a customer has easy access to services and information. They remarked that the delivery of the required information, both before and after service consumption, can enhance the value of the CE. Similarly, redress, which refers to remedial action for service failure across a service delivery system, also contributes to CE. Beyond the supportive factor, social and contextual factors are equally important in creating the customer experience. The contextual determinants, including past experience, perceived risk, distress, preferences, and personality, also significantly contribute to CE. This is also supported by Rashid and Jusoff (2009). The individual/contextual influencing factors include risk, preference, personality and socio-economic status, and social factors include relatives, friends, and acquaintances, as well as other important parties. Socio-economic status and associated groups, such as relatives, friends, and acquaintances, significantly influence CE.

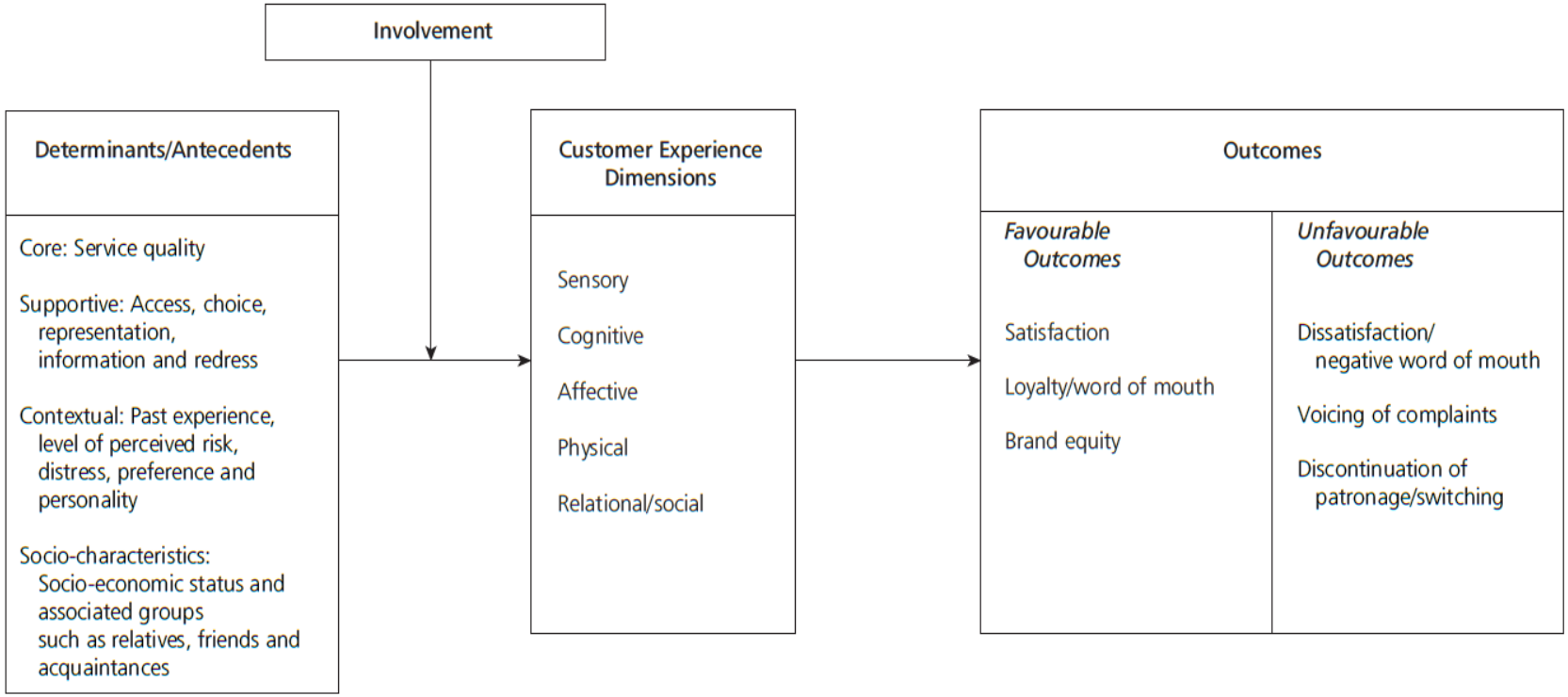


Figure 2.7: Customer experience generic research model

Source: Adapted from Chahal and Dutta, (2014).

Consistent with earlier reviews of the relationship between CE and customer satisfaction, Chahal and Dutta (2014) argue that a positive and significant relationship exists between favourable CE and satisfaction, and a negative and significant relationship exists between unfavourable customer experience and dissatisfaction. Similarly, Maklan and Klaus (2011) linked CE to customer experience outcomes. Additionally, Kumar et al. (2007), while discussing favourable CE, noted that positive expectations, along with positive experiences, lead to a high satisfaction score, whereas negative expectations and positive experiences of a service yield the highest satisfaction score. They further suggested that negative expectations and negative experiences, together, generally yield low satisfaction scores, whereas positive expectations of a service, along with negative experiences, yield the lowest satisfaction scores. Kim et al. (2008) and Shankar et al. (2003) opined that, overall, the more favourable the prior experience is, the higher the level of satisfaction. Galetzka, Verhoef, and Pruyn (2006), while discussing satisfaction, observed that service validity and service reliability are two significant and necessary conditions that must be met for customer satisfaction to occur. They further remarked that customers are dissatisfied with an experiential service when either service reliability or service validity is insufficient. In other words, a highly reliable but invalid service or a highly valid but unreliable service will make a customer dissatisfied.

Consistent with the researcher's review of the literature (refer to Section 2.6.1) on the relationship between CE and customer satisfaction and loyalty, Chahal and Dutta's (2014) model posits that customer satisfaction influences customer loyalty, and that customer dissatisfaction significantly influences negative WOM, complaint voicing, and discontinuation of patronage. Similarly, Maklan and Klaus's (2011) model makes this connection between satisfaction and loyalty. Additionally, Kim et al. (2008) observed that when product or service performance exceeds customer expectations, the repurchase rate increases. In other words, customers who trust or have confidence in a company will continue to buy the products or services that satisfy them. In addition to a direct, positive relationship between satisfaction and loyalty, Oliva et al. (1992) also discussed a nonlinear relationship between these two constructs. They pointed out that when satisfaction increases above a certain level, customer loyalty increases rapidly. On the other hand, Mittal, Ross, and Baldasare (1998) contemplated that a high level of dissatisfaction might have a large and deleterious impact on retention. Moreover, Arnold et al. (2005) noted that a customer who has endured terrible experiences may use negative WOM, voice his complaint by sending emails, writing letters, etc., or discontinue his patronage and switch to a competitor.

Based on the satisfaction and WOM discussion above, Chahal and Dutta's (2014) model further proposed that favourable CE outcomes positively influence brand equity, whereas unfavourable ones negatively influence it. Similarly, Keller (1993) established that one characteristic of brands with strong brand equity is greater brand loyalty, which is a function of variables such as satisfaction and WOM. He believed that a brand possesses positive customer-based brand equity when a customer reacts more favourably to a product and possesses negative customer-based brand equity when a customer reacts less favourably to the marketing activities associated with a brand. Additionally, Kim et al. (2008) investigated the relationship between loyalty and equity and found that brand loyalty did not positively influence brand equity.

Lemke et al.'s (2011) customer experience quality model

Lemke et al. (2011) developed a holistic conceptual model of customer experience quality based on 40 consumer interviews (Fig. 2.8). While the framework is positioned as generic and universally applicable, their data strongly suggest that the dimensions of customer experience differ across B2B and B2C contexts. They identify 119 sub-categories that describe customer experience quality in a generic way and categorize them into 17 experience dimensions that are specific to the service context (see Appendix). These categories are grouped according to Payne et al.'s (2008) generic conceptual model of the customer experience. The framework comprises three broad categories of customer interactions referred to as "communication encounters" (i.e. interactions aimed at creating connections and enacting a dialogue with customers), "service encounters" (i.e. interactions with staff and facilities in service provision), and "usage encounters" (i.e. interactions related to the use of a product or service and to the support of that usage).

Lemke et al.'s (2011) service encounter dimension includes several attributes familiar from the service quality literature, as do Chahal and Dutta's (2014) core service characteristics, which include service quality as an attribute. They further posit that service quality significantly influences customer experience. Eight of Lemke et al.'s (2011) service encounter attributes closely relate to SERVQUAL (Parasuraman et al., 1988) and its variants "Caring – Attitudes", "Caring – Procedures", and "Reliability" are close to the SERVQUAL dimensions Empathy, Assurance, and Reliability, respectively, while "Accessibility" is close to the Access category of Parasuraman et al.'s (1998) original qualitative study, and to several items from SERVQUAL. "Value for Time" relates to Responsiveness;

"Atmosphere", or the extent to which the company enables a pleasant relaxing environment, relates to Tangibles; and "Personalization" – dealing with customers in a personal way and adapting the offer to meet needs – and "Application of Knowledge" are close to the Competency category within Parasuraman et al.'s (1998) original qualitative study. This is consistent with the earlier models of and review discussions on how service quality is interlinked with CE and that they are distinct constructs.

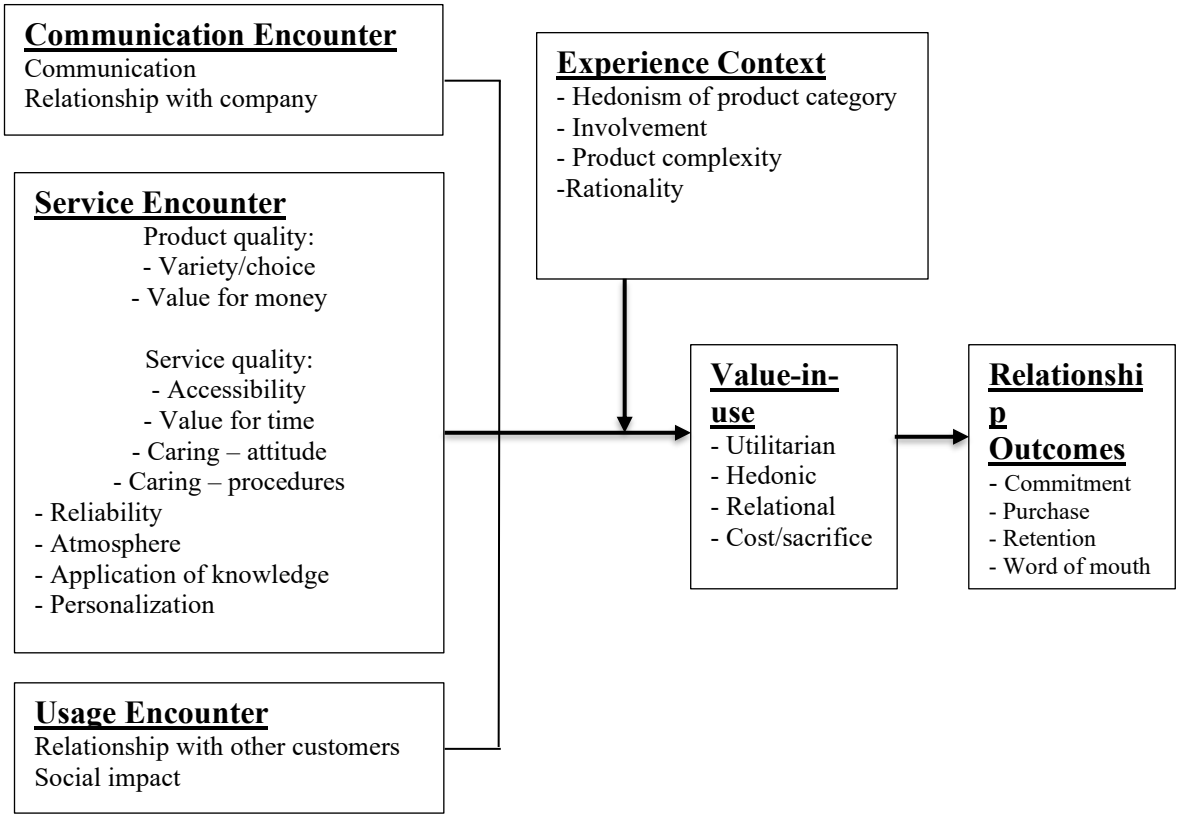


Figure 2.8: Conceptual model of customer experience quality

Source: Adapted from Lemke et al., (2011)

As the model (Fig. 2 .8) shows, this construction includes such commonly identified categories of patient experience and service quality as "Value for Time" (close to Parasuraman et al.'s (1988) timeliness), a "Caring Attitude" (close to the empathy dimension), and "Reliability". CE is a distinct construct, broad, and goes beyond the notion of service quality; however, it spans Payne et al.'s (2008) delineation of the communication encounter (e.g. the "Communication" category), the service encounter (e.g. "Application of Knowledge", "Caring – Procedures and Processes"), and the consumption encounter (e.g. "Social Impact", "Relationship with Other Customers"), which Lemke et al. (2011) incorporated in their definition of customer experience.

This suggests that customers do indeed assess their CE holistically, consistent with previous conjectures (Payne et al., 2008; Verhoef et al., 2009). Lemke et al.'s (2011) full list of CE dimensions and attributes is displayed in Appendix A. Some constructs were mentioned only in the B2B or B2C context. For the purpose of this study, the researcher's synthesis of Lemke et al.'s (2011) model selected only B2C attributes, as this research focuses on identifying the CE dimensions and attributes from customers' perspectives. Lemke et al. (2011) identified attributes and dimensions that outline the reference framework of this research.

Garg et al.'s (2011) customer experience generic model

In line with this study's focus, Garg et al. (2011) identified the attributes, dimensions, and consequences of CE and proposed a generic research model for CE, shown in Figure 2.9. Similar to Chahal and Dutta's (2014) model, Garg et al.'s (2011) model highlights diverse dimensions of CE, which they also grouped under the common classifications of "Sensory" (Schmitt, 1999), "Affective" (Gentile et al., 2007), "Cognitive" (Gentile et al., 2007), "Behavioural" (Schmitt, 1999; Gentile et al., 2007), and "Relational" (Schmitt, 1999). The CE attributes examined by Garg et al. (2011) comprise several components that are also common in Maklan and Klaus (2011), Chahal and Dutta (2014), and Lemke et al. (2011), such as "core service, presence of others, employees, servicescape, speed, customization and convenience". Additionally, Garg et al. (2011) classified these attributes into three major groups of factors, following Constantinides (2004), namely functionality factors, psychological factors, and content factors. They further divided these groups into two sub-groups, i.e. offline and online. Nowadays, most companies have websites, and customers are gaining experiences from both online and offline channels (Gar et al., 2011). Constantinides (2004) argues that organisations cannot ignore customers' online experiences.

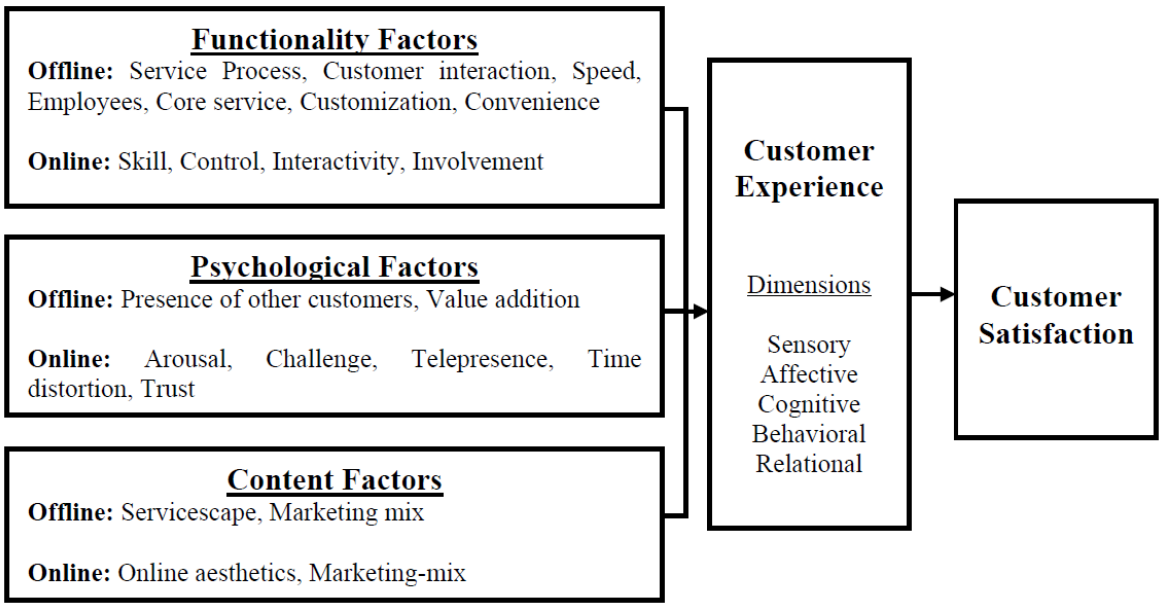


Figure 2.9: Generic conceptual framework of customer experience

Source: Adapted from Garg et al. (2011)

Garg et al.'s (2011) study identified various factors in the form of consequences (outcomes) of CE, such as "customer satisfaction, loyalty, behaviour, aroused feeling, brand attitude, profitability, memories, WOM, intention to recommend, patronage and repurchase intention" and a few of these (WOM, loyalty, customer satisfaction, patronage) are consistent with Chahal and Dutta (2014), Maklan and Klaus (2011), and Lemke et al. (2011). Surprisingly, Garg et al. (2011) considered only customer satisfaction as the main outcome of CE, as it appears most frequently in their literature review.

To sum up, different authors, including Garg et al. (2011), Lemke et al. (2011), and Chahal and Dutta (2014), have proposed and validated models that reflect on the attributes, dimensions, and outcomes of CE, but the components of these models are sector-specific. At the dimension, attribute, and outcome levels, there is significant consistency among Chahal and Dutta's (2014) framework, the generic model of customer experience quality (Lemke et al., 2011), and Garg et al.'s (2011) generic model of CE. These studies include the categories (dimensions/attributes) of "personalization", "atmosphere", "competence", "attitudes and behaviours", "communication", "procedures and processes", "timeliness", "reliability", "relationship with other customers", "choice", "communication", "social impact", "involvement", and "relationship with staff". In addition, in all four studies (Garg et al., 2011; Maklan and Klaus, 2011; Lemke et al., 2011; Chahal and Dutta, 2014) there is also significant consistency in CE outcomes – these include "WOM", "loyalty", and

"satisfaction". Notably, Garg et al.'s (2011) and Chahal and Dutta's (2014) generic models adopt the Gentile et al. (2007) and Schmitt (1989) CE dimensions of "Sensory", "Affective", Cognitive, "Behavioural", "Relational/social", and "Physical". These commonalities suggest that a similar set of CE experience issues broadly exists at a high level of abstraction. According to Garg et al. (2011), Lemke et al. (2011), Chahal and Dutta (2014), and Maklan and Klaus (2011), their identified CE dimensions, attributes, and outcomes and presented models can act as a base for many future research studies, which will in turn be very helpful for the management of the various organizations. In this context, the four discussed models and some components were adopted for the development of the initial research framework for CE in the NHS hospitals context, and this is discussed in the following section.

2.9 Synthesis of theoretical perspectives – initial research model

The literature review critically evaluates theories and models from various disciplines relevant to the study. The research has extended the models developed by Maklan and Klaus (2011), Chahal and Dutta (2015), Garg et al. (2013), and Lemke et al. (2011), which were derived from a literature review of the dimensions and attributes of CE in general. Thus, adaptations and extensions were required in relation to identifying critical dimensions and attributes of CE and the significant factors that influence positive and negative CE in the NHS hospitals context. This resulted in an initial framework that melds and extends distinct conceptual elements from separate theories. The initial model consists of three key components of CE: dimensions, attributes, and outcomes. A further component illustrates areas for potential customer engagement/involvement or co-creation.

From the literature review and the discussed CE models, it can be assumed that CE is an important, multi-aspect concept, complex, holistic, and contextual. Despite its importance in other sectors, including healthcare, there remains no consensus on which components constitute its construct. Thus, the research gaps are addressed by the following research questions:

RQ1 – What are the critical dimensions and attributes that constitute the construct of CE in the NHS England hospitals context?

RQ2 – What are the significant factors that influence the positive CE in the NHS hospitals context?

RQ3 – What are the significant factors that influence the negative CE in the NHS hospitals context?

An initial conceptual model was developed that synthesizes the results from the literature and concludes the chapter. Based on the initial research model (Figure 2.10), the author will elaborate on three strands of theory, which is a novel approach in academia. By elaborating on the elements of these models – main dimensions (Chahal and Dutta, 2014; Garg et al., 2011; Gentile et al., 2007; Schmitt, 1998), sub-dimensions (Lemke et al., 2011), and outcomes of CE (Maklan and Klaus, 2011; Chahal and Dutta, 2014; Garg et al., 2011), the author will reflect on how these elements can be incorporated and synthesized in a revised framework. In following Fink's seven-step approach (2009), the initial research model adapts and extends the model developed by Chahal and Dutta (2014). This initial model (Figure 2.10) illustrates the critical dimensions, attributes, and significant factors or outcomes that must be considered in the study of CE in NHS hospitals. It consists of four key components: primary dimensions, secondary dimensions, attributes, and outcomes, i.e. positive and negative experiences (of CE). A further component illustrates areas for a possible application of the involvement or co-creation. The initial research model and the following research questions guide the research. It is important to note that qualitative research findings should be used here to gain understanding and provide directional insights. As such, the following illustration should be seen for its heuristic value.

These findings support conceptual papers which suggest that the customer experience is broadly based (Berry et al., 2006; Schembri, 2006), yet not as broad as suggested by some (Gentile et al., 2007; Meyer and Schwager, 2007; Verhoef et al., 2009). Klaus and Maklan (2011) stated that they were not proposing a generalized model, but rather presenting a single, context-specific example to illustrate how academics and practitioners can depart from theirs.

The researcher melded and incorporated some components of the four theoretical models (Garg et al., 2011; Lemke et al., 2011; Maklan and Klaus, 2011; Chahal and Dutta, 2014) in relation to the literature findings made so far. As a result, a generic theoretical initial model of customer experience was developed, Figure 2.10, which will be adapted further during analysis and results for the NHS Hospitals context. As mentioned earlier, the CE concept is assumed to be context-dependent because the ways in which customers judge their experiences in different environments vary (Zomerdijk and Voss, 2010). Healthcare is a

relevant context for studying experience quality because, as with other professional services, the quality of the medical act and outcome (i.e. the "curing") is more difficult to assess than the quality of the service process (i.e. the "caring") (Wisniewski and Wisniewski, 2005). Therefore, the dimensions and attributes, attitudes and behaviours, customization, communication, competence, availability, efficiency, reliability, employees, other customers, servicescape, atmosphere, caring attitude, etc., need to be considered by the theoretical working model of patient experience dimensions and attributes in NHS hospitals. Hence, this study focuses on patients' or customers' views.

Figure 2.10 displays a generic theoretical initial model, which will be adapted further during the analysis and results sections. It could be argued that a thematic review could have been used to discuss the service quality work of Parasuraman et al. (1985) and to assess the current state of research considering their work. This possibility was considered but rejected for the following reason: the focus of the present research is to identify critical dimensions and attributes of the customer or patient experience in the context of NHS England hospitals. A thematic review based on the theoretical working model of service quality dimensions and attributes would set a wrong focus and shift too much weight on the service quality model and, in turn, affect the quality of the review.

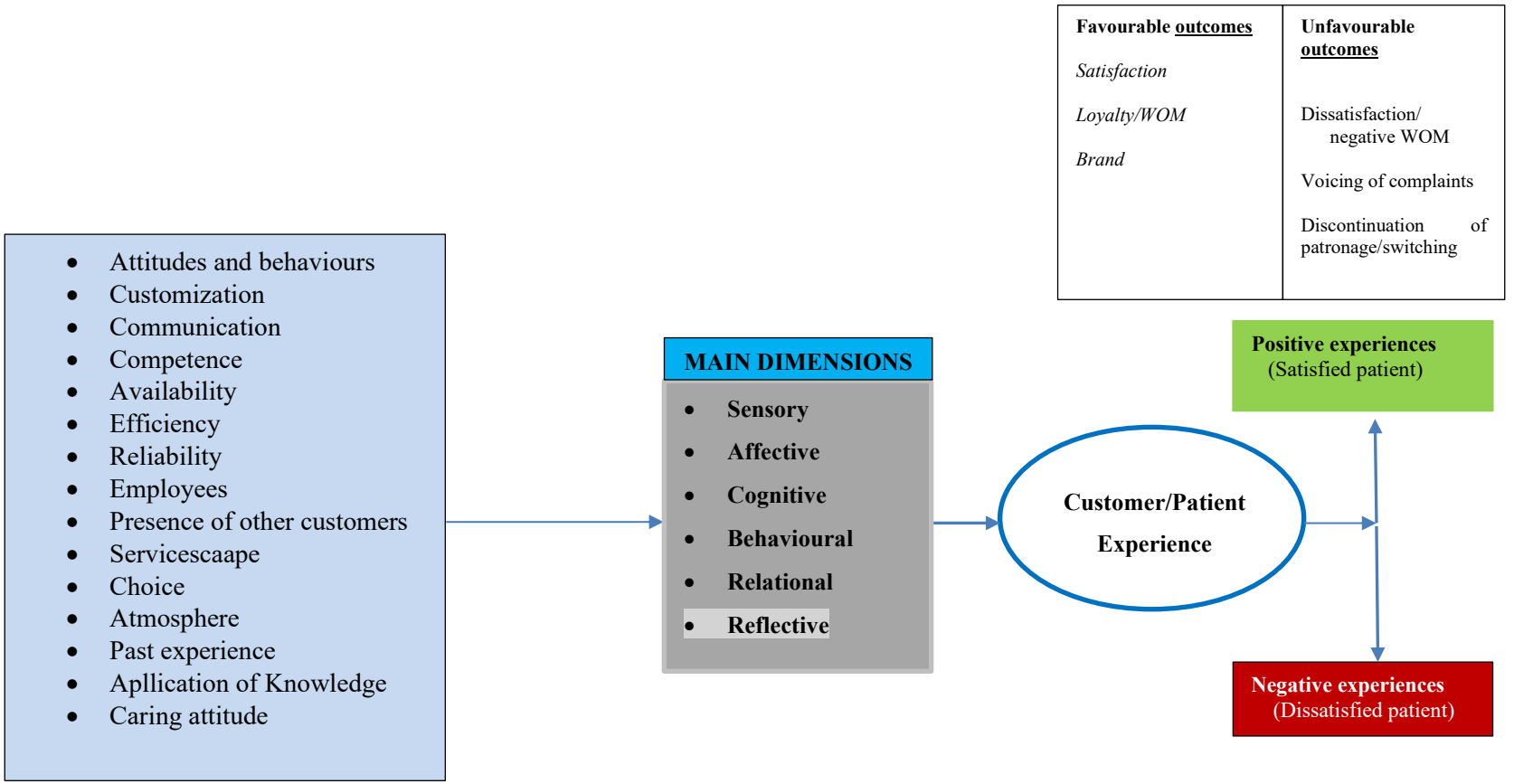


Figure 2.10: Initial research model (based on Lemke et al., 2011; Chahal and Dutta, 2015; Garg et al., 2013, and Ponsignon et al., 2015)

Finally, Fottler et al. (2006) suggest a mismatch between patients' expectations and providers' priorities in healthcare. For instance, O'Connor et al. (2000) argue that organizations often focus on the tangible aspects of the experience (e.g. beds or technical equipment), while patients value reliability, responsiveness, and staff empathy. Fottler et al. (2006) note that existing survey instruments may overlook the quality dimensions that truly matter to patients. This suggests the need for an inductive exploration of CE in healthcare. Since experience perceptions are subjective and personal (Lemke et al., 2011), a conceptualization of CE must be developed from the perspective of the recipient of the service. Healthcare services are often experienced by both patients and carers (i.e. friends and family), who may be referred to as a "collective customer". This suggests that the perceptions and evaluations of experience from the collective customer are therefore necessary to inform a comprehensive understanding of the phenomenon. This ensures that CE dimensions and attributes emerge only when they are important in patients' and carers' mental construction. A qualitative, customer-centric approach allows for the development of deep insights into what constitutes CE, consistent with the statement of Verhoef et al. (2009), Gentile et al. (2007), and Maklan and Klaus (2011) that scholars should seek to develop a richer conceptualization of the customer experience.

To summarize, this chapter has highlighted that CE is context-dependent. This provides a strong rationale for exploring this concept in the specific context of NHS England hospitals. Furthermore, it has been suggested that current service marketing concepts/models are interlinked with CE, whereas CE is a distinct construct. The customer experience is a holistic concept that goes beyond the "service encounter". Empirical evidence suggests that the CE concept has more dimensions than service quality. Finally, it is important to consider the judgment of both patients and carers (i.e. the collective customer) about the quality of the healthcare experience.

2.10 Gaps in the extant customer experience literature

After a thorough review of the extant literature on customer experience, several significant research gaps are evident. Although scholars have begun to recognize customer experience as an important topic worthy of research, the 'newness' of the construct leaves several areas unexplored. Specifically, a review of the pertinent literature on customer experience reveals several theoretical and methodological gaps.

2.10.1 Theoretical research gaps

Scant investigations on customer experience 'direct and indirect interactions':

The existing work on customer experience identifies that customers form evaluations of their experience at different interactions with the firm. Prior studies have identified different types of stimuli that influence customer experience at different direct and indirect interactions. Up to the present time, there have been no attempts to identify, categorize, and define the components of dimensions and attributes that make up direct and indirect interactions.

- *Limited holistic models of customer experience that take into account the critical attributes and dimensions of customer experience:*

While various studies have explored the attributes and dimensions of customer experience, the distinction between the two terminologies poses a challenge, as in some research, the terms attributes and dimensions have been used interchangeably. For example, some studies consider the attributes or dimensions of customer experience, but do not examine consumers or factors that could influence positive and negative customer experience evaluations (e.g. Grewal, Levy, and Kumar, 2009; Rose et al., 2012). Of the existing work in the customer experience literature, very few studies (Garg et. al, 2011; Maklan and Klaus, 2011; Lemke et al., 2011; Chahal and Dutta, 2014) have proposed a holistic theoretical model that 'pieces together' the relationship between attributes, and dimensions and factors that significantly influence positive and negative CE and the other service marketing constructs, such as service quality, customer satisfaction, involvement, and co-creation.

2.10.2 Methodological research gaps: scant assessments of customer experience on online customer reviews

A review of the pertinent empirical literature on customer experience reveals that interviews, surveys, and a focus-group evaluation approach are the dominant methods. However, to gain a true insight into consumers' 'lived' experiences, customer experience evaluations should be conducted through unsolicited customer reviews posted on online customer review platforms. No studies to date have investigated the holistic nature of CE's dimensions and attributes from the customer or patient perspective within the context of NHS hospitals.

To advance the body of knowledge on customer experience, the researcher intends to explore identified gaps to make a substantial theoretical and methodological contribution to the customer experience discipline in the healthcare context, as well as to the broader marketing literature.

2.11 Summary

A great customer experience provided by firms is assumed to create a competitive advantage in the marketplace as well as a positive impact on the organization or brand. Chapter 2 showed a clear view of the notion of customer experience and showed that the concept is poorly defined. Research and theories on experience have remained vague, and there is a need for further research to address our limited understanding of customer experience. Although Pine and Gilmore (1999) introduced and developed 'experience realms', a practical and conceptual framework for understanding the nature of customer experience in general, their framework lacks a detailed analysis of these dimensions and their measurements. There is insufficient research to measure these concepts.

Chapter 2 also highlighted the relationships between CE and various service marketing constructs and how CE is a distinct construct. This chapter reviewed these attempts because experience and service marketing constructs and emotions are inextricably linked to CE. The chapter also sheds light on the concept of patient experience and the different theories that explain patient motivations. The chapter moved on to discuss related theories of CE. Finally, the last section of this chapter built the initial working model of CE.

CHAPTER 3: RESEARCH STRATEGY AND METHODOLOGY

> "…a tension will quickly be revealed between contrasting modes of thought. But this does not mean that one is absolutely right and the other totally wrong. It is possible that they are both partly right and partly wrong. And as the argument evolves, the best of both arguments will often crystallize"
>
> Gaarder (1995, p. 304).

This chapter presents the research paradigm, specifically the research design and the research methodology. The chosen research methodology addresses the research questions and objectives discussed in Chapter 1. In this chapter, alternative research philosophies and methodologies are also summarized, and justifications are given for the chosen research philosophy and methodology.

3.1 Research paradigm

Research paradigms address the philosophical dimensions of social sciences. According to TerreBlanche and Durrheim (1999), the research process has three major dimensions: ontology, epistemology, and methodology. According to them, a research paradigm is an all-encompassing system of interrelated practice and thinking that defines the nature of enquiry along these three dimensions. It is a set of fundamental assumptions and beliefs as to how the world is perceived, which then serves as a thinking framework that guides the behaviour of the researcher (Jonker and Pennink, 2010).

The term paradigm originated from the Greek word 'paradeigma', meaning pattern, and was first used by Thomas Kuhn (1962) to denote a conceptual framework shared by a community of scientists that provided them with a convenient model for examining problems and finding solutions. Kuhn defines a paradigm as "an integrated cluster of substantive concepts, variables and problems attached with corresponding methodological approaches and tools…". According to him, the term paradigm refers to a research culture with a set of beliefs, values, and assumptions that a community of researchers shares regarding the nature and conduct of research (Kuhn, 1977). A paradigm, hence, implies a pattern, structure, and framework, or system, of scientific and academic ideas, values, and assumptions (Olsen et al., 1992, p. 16).

Although philosophical backgrounds are usually implicit in most research, they affect research practice. Some writers (e.g. Berry and Otley, 2004; Creswell, 2009; Saunders et al., 2009; Neuman, 2011) emphasize that it is important to initially question the research paradigm to be applied in conducting research because it substantially influences how one undertakes a social study in the way of framing and understanding social phenomena. Following this suggestion, various research paradigms are discussed below to justify the theoretical assumptions and fundamental beliefs underpinning social research.

3.2 Philosophical perspectives

This study aligns with an interpretivist paradigm's ontology and epistemology assumptions and reality of knowledge (Berger and Luckman, 1967). In order to select the most appropriate methodology with which to carry out the objectives, it is crucial that this researcher firstly understands the philosophical perspective of the study (Holden and Lynch, 2004). The two main philosophical dimensions to distinguish existing research paradigms are ontology and epistemology (Laughlin 1995; Kalof et al., 2008; Saunders et al., 2009). They relate to the nature of knowledge and the development of that knowledge, respectively. Ontology is the view of how one perceives a reality (Wahyuni, 2012). Ontological and epistemological aspects concern what is commonly referred to as a person's worldview, which has significant influence on the perceived relative importance of the aspects of reality.

According to Lather (1986a, p. 259), research paradigms inherently reflect our beliefs about the world we live in and want to live in. In social research, ontologically, one can perceive that reality exists externally and independently of social actors and their interpretations, which is termed objectivist (Saunders, Lewis, and Thornhill, 2009) or realist (Neuman, 2011). On the other hand, subjectivist or nominalist adopter theory believes that reality is dependent on social actors and assumes that individuals contribute to social phenomena.

The second paradigm, epistemology, comprises the beliefs about how to generate, understand, and use knowledge that are deemed acceptable and valid. In addition to these two fundamental philosophies, two basic beliefs that shape how we investigate reality are *axiology* and *methodology*. The former is concerned with ethics, encompassing the role of values in research and the researcher's stance toward the subject studied. The latter refers to a model for conducting research within a particular paradigm. Paradigms can be based on

the tripartite linkage of ontological, epistemological, and methodical questions (Morgan, 2007), which are shown in Table 3.1.

Ontological question	Epistemological question	Methodological question
What is the form and nature of reality and, there, what is there that can be known about it?"	"What is the nature of the relationship between the knower or would-be knower and what can be known?"	"How can the inquirer (would-be knower) go about finding out whatever he or she believes can be known?"

Table 3.1: Ontological, epistemological, and methodical questions

Adapted from Guba and Lincoln (1994, p. 108)

It is clear from the research methodology literature that various researchers have defined different paradigms. For example, Creswell (2009, p. 6) discussed postpositivism, constructivism, advocacy/participatory, and pragmatism as different worldviews. Building on the work of Saunders et al. (2009), Guba and Lincoln (2005), and Hallebone and Priest (2009), Wahyuni (2009) also defined four research paradigms: positivism, postpositivism, interpretivism, and pragmatism. Table 3.2 shows the main distinguishing elements of the four paradigms, as identified by Wahyuni (2009).

	Research Paradigms			
Fundamental Beliefs	***Positivism*** (Naïve Realism	***Postpositivism*** (Critical Realism)	***Interpretivism*** (Constructivism)	***Pragmatism***
Ontology: the position on the nature of reality	External, objective, and independent of social actors	Objective. Exists independently of human thoughts and beliefs of knowledge of the existence, but is interpreted through social conditioning (critical realist)	Socially constructed, subjective, may change, multiple	External, multiple, view chosen to best achieve an answer to the research question
Epistemology: the view on what constitutes acceptable knowledge	Only observable phenomena can provide credible data, facts. Focus on causality and law-like generalizations, reducing phenomena to simplest elements	Only observable phenomena can provide credible data, facts. Focus on explaining within a context of contexts	Subjective meanings and social phenomena. Focus upon the details of the situation, the reality behind these details, subjective meanings, and motivating actions	Either observable phenomena or subjective meanings can provide acceptable knowledge dependent upon the research question. Focus on practical applied research, integrating different perspectives to help the data
Axiology: the role of values in research and the researcher's stance	Value-free and etic Research is undertaken in a value-free way, the researcher is independent of the data and maintains an objective stance	Value-laden and etic Research is value-laden; the researcher is biased by world views, cultural experiences, and upbringing	Value-bond and emic Research is value-bond; the researcher is part of what is being researched, cannot be separated and so will be subjective	Value-bond and etic-emic Values play a large role in interpreting the results, the researcher adopting both objective and subjective points of view
Research methodology: *The model behind the research process*	Quantitative	Quantitative or qualitative	Qualitative	Quantitative and qualitative (mixed or multi-method design)
Based on Saunders et al. (2009, p. 119), Guba and Lincoln (2005), and Hallebone and Priest (2009)				

Table 3.2: Fundamentals beliefs of research paradigms in social sciences

Source: Adapted from Wahyuni (2012)

3.2.1 Interpretivism

This research was performed within the interpretivism paradigm. Interpretivism, at the far extreme of postpositivism, subscribes to constructivism. Creswell (2012) defined the characteristics of the interpretivist/social constructivist paradigm as follows:

> "In this interpretative framework, qualitative researchers seek understanding of the world in which they live and work. They develop subjective meaning of their experiences – meanings directed toward certain objects and things. These meanings are varied and multiple, leading the researcher to look for complexity of views rather than narrow the meaning into a few categories or ideas. The goal of this research, then, is to rely as much as possible on the participants' views of the situation" (p. 301).

Accordingly, interpretivists recognize the impact of their own background and experience on the research. Within the constructivism paradigm, it is assumed that it is not possible to observe the real world (Guba & Lincoln, 1994, p. 110) but "our understanding of this world is inevitably our construction, rather than a purely objective perception of reality, and no such construction can claim the absolute truth" (Maxwell, 2012). Constructivists are open to new views of the world (Guba & Lincoln, 1994, p. 113), and this is reflected in their use of comprehensive, open-ended questions (Creswell, 2009, p. 8). This is in line with the approach of this research, which used the NHS Choices website's questions, e.g. "What you LIKED?", "What you DISLIKED?", and "What ADVICE?". According to Creswell (2009, p. 8), interpretivists assume that people want to understand the world they are part of. This researcher wanted to understand hospital customers' experiences from patients' perspectives through their online posts. It was part of the research design for this thesis to get involved with the world and to make sense of it; hence, an interpretivist paradigm was well-suited to this purpose (Crotty, 1998, p. 7). This research began with a theory from a narrative review (Creswell, 2003, p. 9) and a pattern of meanings generated or inductively developed during the research data collection process (Guba & Lincoln, 1994, p. 111). This approach is well aligned with a constructivist stance to research. This contextualised research was conducted within a constructivist paradigm, as it was assumed that a pluralistic, interpretative "perspective toward reality" (Creswell & Miller, 2000, pp. 125-126) would best suit the research topic.

To understand the social world from the experiences and subjective meanings that people attach to it, interpretivist researchers favour interaction and having a dialogue with the studied participants. They also prefer to work with qualitative data, which provides rich descriptions of social constructs.

Walsham (1993) argues that in the interpretive tradition, there are no 'correct' or 'incorrect' theories. Instead, they should be judged according to how 'interesting' they are to the researcher as well as those involved in the same areas. Myers (2009) argues that the premise

of interpretive researchers is that access to reality (whether given or socially constructed) is only through social constructions such as language, consciousness, and shared meanings (online). The interpretive paradigm is underpinned by observation and interpretation; thus, to observe is to collect information about events, while to interpret is to make meaning of that information by drawing inferences or by judging the match between the information and some abstract pattern (Aikenhead, 1997). It attempts to understand phenomena through the meanings that people assign to them (Deetz, 1996).

Reeves and Hedberg (2003, p. 32) note that the "interpretivist" paradigm stresses the need to put analysis in context. The interpretive paradigm is concerned with understanding the world as it is from the subjective experiences of individuals. The interest of interpretivists is not the generation of a new theory, but to judge or evaluate, and refine interpretive theories. Walsham (1995b) presents three different uses of theory in interpretive case studies: theory guiding the design and collection of data; theory as an iterative process of data collection and analysis; and theory as an outcome of a case study. The use of theory as an iterative process between data collection and analysis has been applied in this research study. This study is situated in the interpretivist paradigm.

Table 3.3 displays the characteristics of interpretivism, as used in this study, categorized into the purpose of the research, the nature of reality (ontology), the nature of knowledge and the relationship between the inquirer and the inquired-into (epistemology), and the methodology used (Cantrell, 2001).

Feature	Description
Purpose of Research	To examine and identify the critical dimensions and attributes of customer experience construct in the UK NHS hospitals context, using archive data of customers' or patients' hospital experience reviews posted on the NHS Choices website.
Ontology	• There are multiple realities. • Reality can be explored, and constructed through human interactions, and meaningful actions. • Discover how people make sense of their social worlds in the natural setting by means of daily routines, conversations, and writings while interacting with others around them. These writings could be text and visual pictures. • Many social realities exist due to varying human experience, including people's knowledge, views, interpretations, and experiences.
Epistemology	• Events are understood through the mental processes of interpretation that is influenced by interaction with social contexts. Those active in the research process socially construct knowledge by experiencing the real-life or natural settings. • The inquirer and the inquired-into are interlocked in an interactive process of talking and listening, reading and writing. • More personal, interactive mode of data collection.
Methodology	• Processes of data collected by text messages, interviews, and reflective sessions. • Research is a product of the values of the researcher.

Table 3.3: Characteristics of interpretivism

Source: Adopted from Cantrell (2001)

The key words pertaining to this methodology are participants, collaboration, and engagement (Henning, van Renburg, and Sit, 2004). In the interpretive approach, the researcher does not stand above or outside but is a participant observer (Carr and Kemmis, 1996, p. 88) who engages in the activities and in discerning the meanings of actions as they are expressed within the specific social context.

3.3 Basic assumptions underlying the interpretive research

The ontological and epistemological assumptions underlying the interpretive research tradition differ from those of the positivist tradition. The development of the interpretive research tradition is often traced back to ideas from Weber (1947, 1964) that were subsequently developed further by phenomenological sociologists such as Schutz (1945, 1953), Berger and Luckmann (1966), Giddens (1984, 1993), and Bourdieu (1990). However, the roots of the interpretive research tradition are many, and it is not a single unified approach. The more influential approaches are various forms of social constructionism (Berger & Luckmann, 1966; Bourdieu, 1990; Giddens, 1984, 1993), critical theory

(Alvesson & Deetz, 2000; Habermas, 1972), ethnomethodology (Atkinson, 1988; Garfinkel, 1967; Heritage, 1984; Silverman, 1998), interpretive ethnography (Denzin, 1997; Geertz, 1973; Van Maanen, 1995), symbolic interactionism (Blumer, 1969; Mead, 1934; Prasad, 1993), discourse analysis.

Despite the great variety of approaches, what unifies them is their phenomenological base, which stipulates that person and world are inextricably related through the lived experience of the world (Berger & Luckmann, 1966; Gadamer, 1960, 1994). Hence, within interpretive approaches, the human world is never a world in itself; it is always an experienced world, that is, a world related to a conscious subject. Thus, the ontological and epistemological assumptions underlying the interpretive research tradition reject the existence of an objective knowable reality beyond the human mind. Instead, they stipulate that knowledge is constituted through the lived experience of reality. Therefore, it would be inconsistent to justify knowledge produced within this tradition using criteria based on an objectivist ontology and epistemology. The idea of the life-world expresses that the person and the world are inextricably related through the person's lived experience of the world.

As Bengtsson (1989) argued:

> "Even if the life-world is objective both in the sense that it is a shared world and in the sense that it transcends (exceeds) the subject, that is, its qualities are not qualities within the subject, it is likewise inseparable from a subject, namely, the subject who experiences it, lives and acts in it. The world is always there in the first person from the perspective of my space and time here and now" (p. 72).

Bengtsson points out that the lifeworld is the subject's experience of reality at the same time as it is objective in the sense that it is an intersubjective world. We share it with other subjects through our experience of it, and we are constantly involved in negotiations with other subjects about reality in terms of our intersubjective sense-making of it. Consequently, the agreed meaning constitutes the objective, intersubjectively.

Interpretivism is both a philosophy and a method (LeVasseur, 2003; McPhail, 1995; Wojnar & Swanson, 2007). It combines interpretivist and phenomenology views, which are concerned with the art and theory of interpretation, with phenomenology, the study of describing phenomena (Van Manen, 1990). In contrast to positivism, interpretivism rejects objectivity, abstraction, fixed reality, and generalizability in favour of subjectivity, interpretive meaning, experience, and understanding (Szarycz, 2009). The goal in

interpretivism is to understand the nature and meaning of human experience, to discover the heart and depth of a person's lived experience. The method seeks to discover the essence of events, relationships, thoughts, feelings, values, and beliefs (Casterline, 2009). By bringing to the fore the experience as articulated by the experiencer, interpretivists can generate new meanings that challenge conventional wisdom and structural and normative assumptions (Lester, 1999).

Interpretivism is particularly useful for exploring subjective lived experiences (Andriotis, 2009; Lopez & Willis, 2004b; McPhail, 1995; Wojnar & Swanson, 2007). Interpretivists attempt to provide an in-depth understanding of the internal meanings or essence of a person's experience in the lived world by careful interpretation of that experience, striving to understand experience rather than provide a causal explanation. "...phenomenology is concerned with 'what it is like', or 'how it seems', and not with the workings of an 'external world'. The study of 'lived experience'...is not an assessment of an objective reality but rather, it is a description of reality as it is articulated by the respondent…It is a question of 'perceptions' and 'meanings', not measurements and causes" (Szarycz, 2009, p. 49). Interpretive research relies heavily on self-report: researchers consult and trust participants to tell them their stories. Researchers in this genre should not, therefore, make any claims about objectivity or about extrapolating from a specific participant's lived experience to an external reality.

The interpretivist researcher derives data through techniques such as first-person accounts of participants in interviews, action research, participant observation, analysis of personal texts (personal diaries, notes, journals, and online message boards), and focus group discussions. After data generation, the next stage is immersion in the data to discern underlying themes and meanings. Interpretive methods can be applied to single cases or to judgment samples. In multiple participant research, inferences can be drawn from recurring themes in the data, though these are only tentative (Lester, 1999).

Throughout the interpretive research process, the researcher engages in introspection, self-dialogue, and self-discovery, and acquires a passionate engagement with the phenomenon, which encourages disclosure from participants (Casterline, 2009). To facilitate self-reflection, the researcher might record thoughts, feelings, or ideas emerging through intuition, reading, observation, and living the research experience in a personal journal. These processes help the researcher to clarify the research question(s). Thus,

hermeneutic phenomenology is an explicitly reflexive methodology. As such, the researcher makes no pretence of seeking objective truth.

3.4 Research design

The research design can be thought of as the *logic* or *master* plan of a research project that outlines how the study is to be conducted. The research design is similar to an architectural outline. The research design can be seen as actualization of logic in a set of procedures that optimize the validity of data for a given research problem. According to Mouton (1996, p. 175), the research design aims to "plan, structure and execute" the research to maximize the "validity of the findings". It provides a framework from the underlying philosophical assumptions to research design and data collection. Yin (2003) adds further that "colloquially a research design is an action plan for getting from *here* to *there*, where 'here' may be defined as the initial set of questions to be answered and 'there' is some set of (conclusions) answers" (p. 19). Figure 3.1 provides an overview of the research design choices for this thesis.

Firstly, to identify the research approach this thesis will adopt, the researcher began to highlight the nature of the research objectives. This study aims to explain the significance, importance, and dimensions and attributes of the customer experience from the consumer's point of view. The study also aims to explain the factors that significantly influence positive and negative customer experiences and their outcomes. Those factors have been derived from extant literature and theories in the respective fields of study (i.e., service quality, customer satisfaction, consumer behaviour, customer engagement, service encounter, customer relationship management, customer co-creation, and service marketing). Hence, the research problem of this thesis is grounded in what is already known from previous studies, and, consequently, a theoretical framework is developed as a starting point for the current study. This framework presents variables of attributes and dimensions that are claimed to be important in generating positive or negative customer experiences in the service context, and it additionally presents outcomes. In seeking to achieve the research objectives, the researcher takes into consideration the fact that when choosing the research method, it is important to base it on the purpose and the research questions. Consequently, the following paragraphs will attempt to illustrate and justify the research methods used in this study.

In general, researchers approach the building and testing of theory in one of two ways: deductively or inductively. From a philosophical perspective, Blaikie (2000) identified four possible research strategies: inductive, deductive, retroductive, and abductive. Table 3.4 illustrates how the four research strategies typically relate to this study's research and questions. As the main research question in this study was "what" the underlying critical dimensions and attributes of customer experience are, an inductive research strategy based on interpretivism was considered most suitable. Therefore, this necessitated the use of inductive strategies for exploration and description.

Objective	Inductive Research Strategy	Deductive Research Strategy	Retroductive Research Strategy	Abductive Research Strategy	Type of Research Question
Exploration	***			***	What?
Description	***			***	What?
Explanation	*	***	***		Why?
Understanding				***	Why?
Change		*	**	**	How?
Evaluation	**	**	**	**	What and Why
Assess Impacts	**	**	**	**	What and Why?

Table 3.4: Research strategies, objectives and questions (Blaikie, 2000)

In practice, most researchers use both approaches at various points of their studies. The current research, therefore, employs an inductive approach. A deductive approach implies that research is built on theories that already exist in the domain that is being researched (Bryman and Bell, 2007). An inductive approach will be employed because important factors may have been identified beyond those derived from the existing literature. Crotty (1998) suggested that in designing a research proposal, we should consider four questions:

> **RQ1.** What epistemology (theory of knowledge embedded in the theoretical perspective) informs the research, e.g. objectivism, subjectivism?
>
> **RQ2.** What theoretical perspective (philosophical stance) lies behind the methodology in question, e.g. positivism and postpositivism, interpretivism, and critical theory?

RQ3. What methodology (strategy or plan of action that links methods to outcomes) governs our choice and use of methods, e.g. experimental research, survey research, ethnography?

RQ4. What methods (techniques and procedures) do we propose to use, e.g. questionnaire, interview, focus group?

Based on Crotty's model, Creswell (2003) addressed three elements of inquiry (i.e. knowledge claim, strategies of inquiry, and methods) pertaining to the design of the research. With respect to the current study, the researcher will follow the Creswell model to illustrate the research design, given its systematic nature, which is ideal for understanding or exploring complex phenomena such as CE. Figure 3.1 shows how these elements merge together to outline the approach of the research and, in turn, translate into processes in the design of the research.

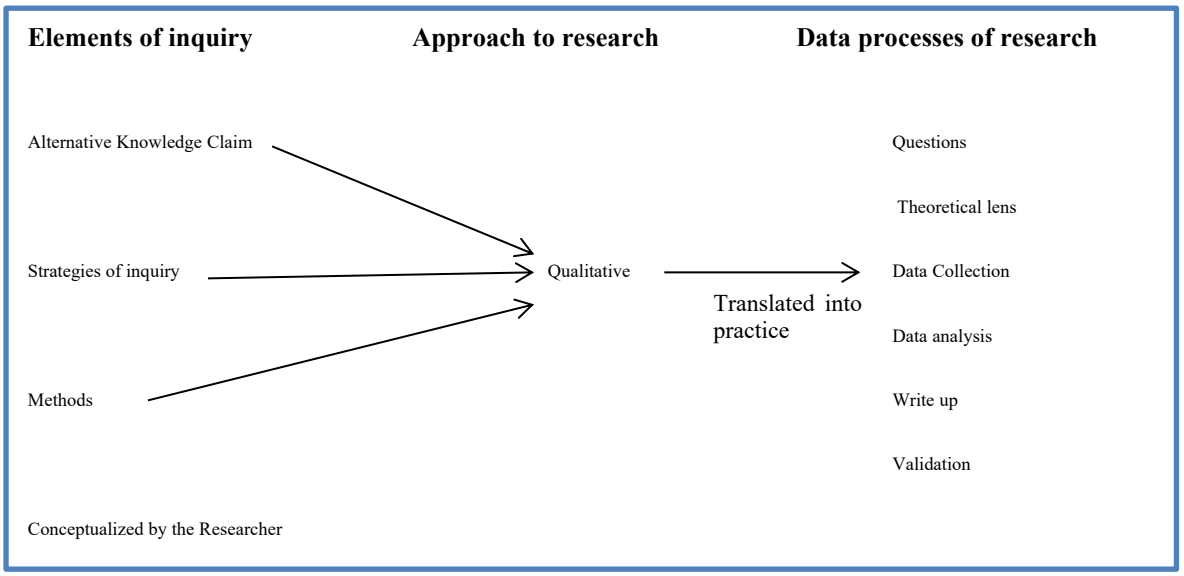


Figure 3.1: Knowledge claims, strategies of inquiry, methods leading to approaches, and the design process

Source: Adopted from Creswell (2003, p. 5)

According to Creswell (2003), the first step to design a research project is to evaluate the knowledge claims brought to the study.

Knowledge claims are assumptions that researchers start a project with about how they will learn and what they will learn during their enquiry. These claims might be called paradigms (Lincoln and Guba, 2000; Mertens, 1998); philosophical assumptions, epistemologies, and

ontologies (Crotty, 1998); or broadly conceived research methodologies (Neuman, 2000). Philosophically, researchers make claims about what is knowledge (ontology), how we know it (epistemology), what values go into it (axiology), how we write about it (rhetoric), and the process for studying it (methodology) (Creswell, 1994, 2003, p. 6).

There are four sets of assumptions concerning knowledge claims: postpositivism, constructivism, advocacy/participatory, and pragmatism (Creswell, 2003). However, most ongoing social research is based on two major approaches, positivism and interpretivism. Positivism is the oldest and most widely used approach. It is broadly defined as the approach of natural sciences. In contrast to positivism, interpretive researchers see that the goal of social research is to develop an understanding of social life and discover how people construct meaning in natural settings (Neuman, 2003). They argue that ordinary people use common sense to guide their daily lives. Therefore, one must first grasp common sense (Neuman, 2003). The current study employs a qualitative approach to understand the problem because it is more suitable when the goal is to unfold what surrounds a phenomenon (Carson et al., 2001). In the context of this study, the merit of this method is that qualitative research will excel at telling the story, help in the understanding of complex social phenomena, and assist the researcher in developing themes from the participants' points of view. Furthermore, the study uses the netnography research method (which is explained in greater detail in the next section).

The overall research design is depicted in Figure 3.2. According to Lincoln and Guba (2000), Mertens (1998), and Creswell (2003), solid lines demonstrate direct/strong influence between the research elements, whereas dotted lines demonstrate indirect/weak influence between the research elements.

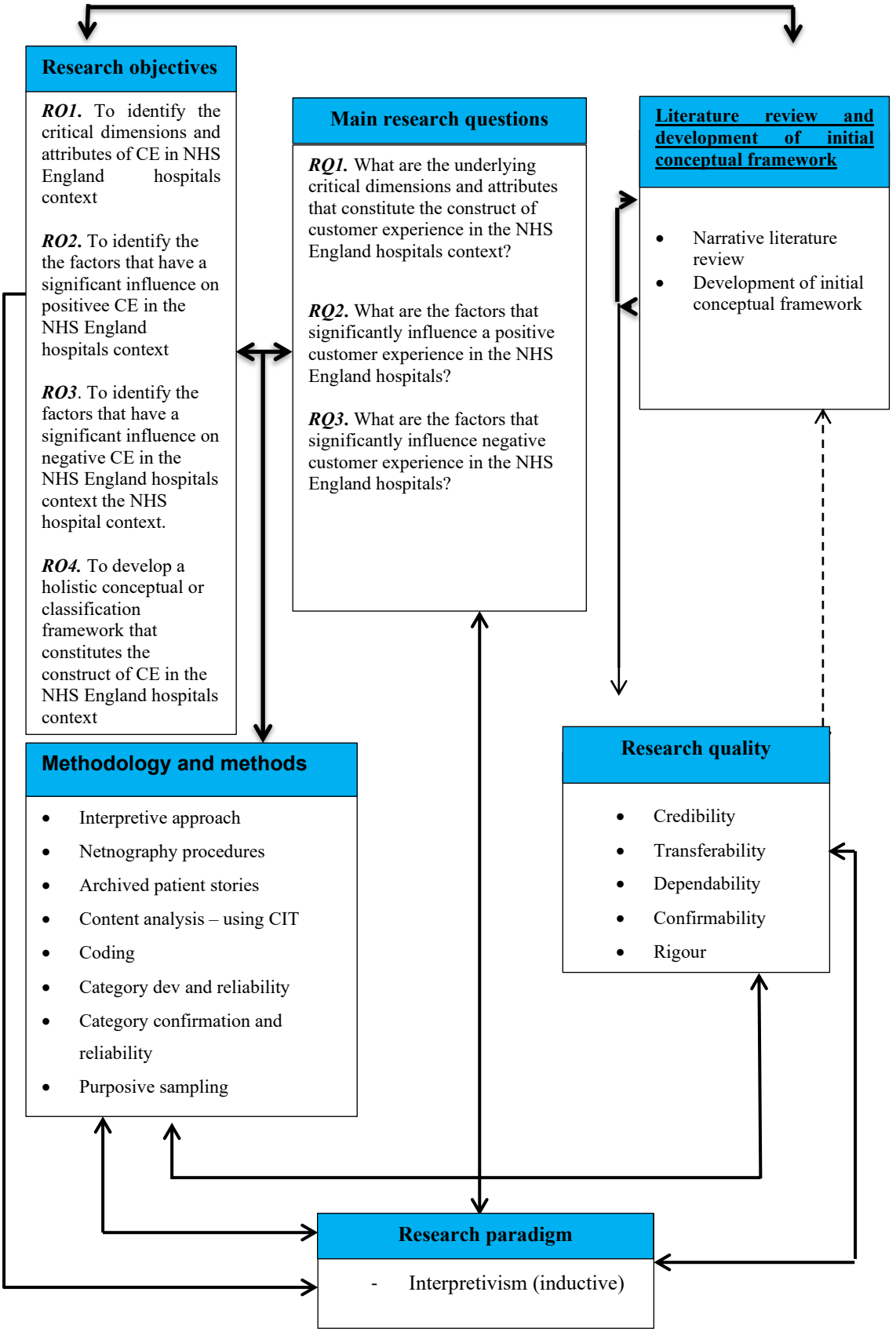


Figure 3.2: The overall research design

Source: Author's own

3.5 Justification for using a qualitative approach

Qualitative research is more likely to be used for theory generation and exploring new topics, although it can also be used for theory verification (Punch, 2005, p. 16). This research focused on understanding CE, a complex phenomenon that is a conceptually under-researched topic (please refer to Section 2.13.1) (Alaranta and Jarvenpaa, 2010), and therefore, this study was conducted using a qualitative exploratory research design. This is aligned with Creswell's (2009) understanding of when a qualitative research design should be selected:

> "If a concept or phenomenon needs to be understood because little research has been done on it, then it merits a qualitative approach" (p. 18).

Many scholars (e.g. Domegan and Fleming, 2007; Denzin and Lincoln, 2003; Richardson, 1995) argue that human learning is best researched by using qualitative data. Maxwell (2005, p. 22) remarked that developing understanding inductively is one of the key strengths of qualitative research. "Many qualitative studies are descriptive and exploratory: They build rich descriptions of complex circumstances that are unexplored in the literature" (Marshall and Rossman, 2010, p. 68).

In selecting a research methodology, Guba (1981, p. 76) suggests that "it is proper to select that paradigm whose assumptions are best met by the phenomenon being investigated". This study examines customer experience and identifies its critical dimensions and attributes from the patient's perspective in the context of NHS hospitals. It is also generally recognized that qualitative researchers are concerned with a deeper understanding rather than simply the results. When trying to understand phenomena through the perception of those in that event, and the description of their understanding of the event that characterizes it, qualitative approaches are more appropriate than quantitative designs to provide the deep insight necessary to understand the participants' role in the event, and their individual perceptions of the lived experience. Qualitative approaches are becoming more widely used as analysis methods improve and people seek better ways to gather data about a problem (Price, 2002).

Guba and Lincoln (1994) responded to the belief that only quantitative methods result in scientifically valuable outcomes. They argued that quantitative research ignores meaning and purpose. In contrast to quantitative research, qualitative research is able to "provide rich insight into human behaviour" (Guba and Lincoln, 1994). Developing understanding

inductively is one of the key strengths of qualitative research (Maxwell, 2005, p. 22). Although qualitative data collection is challenging, many studies which focus on management research rely on this type of study (Edmondson and McManus, 2007, p. 1155). Edmondson and McManus (2007) argued about methodological fit that:

"When little or no prior work related to research questions exists, researchers face problems when they seek to collect purely quantitative data. First, it is almost certain that the quantitative measures will have an ambiguous relationship to the phenomena under study. The measures may capture preliminary ideas about emergent constructs, and the analysis, which are certain to the measures rather than to the phenomena themselves, do not aid the researcher in truly learning from the field setting…Similarly, a hybrid approach also suffers from the uncertain status of (quantitative) measures that are employed before sufficient exploration of a new area has pinned down factors to measure" (p.1171).

This researcher follows the line of argumentation of Edmondson and McManus (2007), who advised that, when new research questions need to be answered, researchers should pursue a qualitative approach by conducting interviews or observations, and that they should follow "qualitative data opportunistically" (p. 1172). The focus of the study was on participants' multiple perceptions and meanings of events, and on the researcher's understandings of these. Due to the typical processes used, qualitative approaches can better account for the complexity of group behaviours and reveal interrelationships among multifaceted dimensions of different patients' stories during their direct and indirect interactions with NHS hospital services.

The essential processes in this study included observing, investigating, and documenting, in detail, the unique hospital service experiences of individuals within the complexity of a real online feedback platform. The processes that influenced these experiences and the analysis of the resulting descriptive data were all undertaken by the researcher as a non-participant in the study. This approach allowed for 'thick narrative descriptions' of the phenomena under study and gave the researcher the opportunity to understand the views of the participants. The researcher found a qualitative description of their experiences and an inductive analysis of data as most appropriate for the purpose of this research because all these procedures enhanced the possibility for some kind of subjectivity, which would have been lost if quantitative strategies were applied. Further, constructed knowledge is not *truth* that remains stable and generalizable across all possible contexts; rather, it exists within specific contexts

and perspectives – knowledge that may profess to be truth for one context may not be truth for other contexts (Guba and Lincoln, 1994). Therefore, experimental designs in social science research using quantitative data may not be the most appropriate approach to studying customer experience. However, it must be noted that the resulting outcomes do not support extensive generalizations; rather, they present contextual findings that help develop knowledge and understanding in the NHS hospitals context.

More specifically, the qualitative focus of this thesis is grounded in interpretivist paradigms of reality and knowledge, which have gradually become more popular for conducting research in customer experience studies. The methodology has been deployed variously by management and social sciences researchers to describe and understand the experience of customers, competitors, service suppliers, and other stakeholders (Alvesson and Sköldberg, 1999; Prasad and Prasad, 2002; Zald, 1996; Atkinson, Coffey, and Delamont, 2003; Denzin and Lincoln, 1994, 2000; Flick, 2002; Lincoln and Denzin, 2003; Schwandt, 1994).

3.6 Personal reflection and reflexivity

Reflexivity is a phenomenon that emerges out of discussions about the objectivity - subjectivity contention in research (Ateljevic et al., 2005; Feighery, 2006; Handler & Saxton, 1988; Lancaster, 1996; Rogers, Malancharuvil-Berkes, Mosley, Hui, and Joseph, 2005; Walby, 2010; Westwood, Morgan, and Pritchard, 2006). The debate centres on the researcher's role in shaping the research outcome. According to Feighery (2006, p. 271), reflexivity refers to the capacity of researchers to reflect upon their actions and values during research, whether in producing data or writing accounts.

It insists on “modest claims”. Thus, proponents of the reflexive turn argue that researchers should make their claims with a degree of reservation; that they must self-critique. In practice, reflexivity manifests in two forms: positional reflexivity, in which the analyst examines place, biography, self, and other to understand how they influence the analysis, and textual reflexivity, which entails the researcher analysing the very exercise of textual representation (Feighery, 2006). In qualitative research, the researcher is the research instrument and thus actively engages with his/her personal background, culture, and frame of reference in co-creating and interpreting data with the participant (Golafshani, 2003). Feighery (2006, p. 270) asserts that, regarding the importance of reflexivity, all research endeavours are influenced by actions, interactions, and interventions in the life-world of the

researcher before and during the research process, thereby reflecting the subjective nature of knowledge. Researchers, like all humans, are members of a social world. However, traditionally, researchers have not readily acknowledged the relationship between the knower and the known.

Feighery observes that with the reflexive turn, there is increasing acknowledgement of the reflexive influence of the epistemic subject on the constructed knowledge. As such, Caton and Santos (2007) suggest that data generation should begin with a process of personal reflection, the goal of which is to bring the researcher's personal experiences, reflections, and insights to the fore of the project. This suggestion is also consistent with the interpretive phenomenological notion of embedding the researcher's background and preconceptions into the inquiry and seeing this as a positive and necessary process (Laverty, 2003; Lopez & Willis, 2004a; Pernecky & Jamal, 2010). According to Feighery (2006), reflexivity applies to the researcher-self as well as to personal experiences of the research process, to cognitive aspects of the construction process in research, to the language of understanding, to authorship, to theoretical perspectives, and to voice. The author's attempts to highlight, throughout this thesis, his own subjective perspectives and background, in addition to using the active voice, are all efforts to be reflexive. The author emphasizes that the knowledge created in this study is only a "tale of the field", rather than a fixed reality which is not subject to contestation (Muzonda, 2012). By constantly engaging with varying scholarly standpoints on CE and adding his own interpretation, the researcher seeks to provide a pluralist analysis of CE, which underlines its multifaceted, complex nature, contestable on multiple levels.

3.7 Research Methods

In this section, first, justifications are provided for combining two qualitative methods – netnography and the Critical Incident Technique (CIT)- in the thesis. This is done to identify, from a customer/patient's perspective, underlying critical dimensions and attributes of the CE construct and factors that significantly influence positive and negative CE within the NHS England hospitals context. Hence, the researcher employed inductive methods. Next, the justification of the qualitative research approaches is briefly evaluated.

Market and customer research has been understood as a term encompassing various activities that allow the market researcher to "listen to" the "voice" of the market and customers, in

terms of consumer opinions and behaviour, as well as understanding customer emotions such as shared anger, happiness, fear, and annoyance. There are several market research methods, and each method contains both strengths and weaknesses. Traditionally, researchers in the business field use standard market research methods such as focus groups, interviews, and surveys. Today, in the age of the Internet and technology, more researchers and firms have utilized the online market research methods, e.g. focus group, online interview, online survey, CIT, online ethnography, and netnography to conduct their market research projects. Among online market research methods, netnography is the most useful and beneficial for marketers, as it directly provides consumers' insights from large online resources. Many organizations and academic market researchers have recently applied netnography to generate deep insights into consumers' perceptions on different subjects. Netnography is utilized for various business purposes, such as to gain an understanding of consumers' experiences with firms or products/services, to study culture, and to look for new product ideas. Therefore, applying netnography in understanding customer experiences has become a phenomenon.

To gain in-depth knowledge of patients' experiences on an online platform focused on specific health problems, netnography was used for data collection, and CIT content analytical techniques were used for analysis and interpretation. Thus, no healthcare studies have applied a multi-method approach – netnography and CIT- in a single study. In this vein, this thesis adopts a netnographic and CIT study approach to investigate and analyze how patients express their feelings about NHS hospital experiences on www.nhs.uk. According to Hartley (2004), a single-case study is suited to research that "explores new and emerging processes of behaviour" and allows researchers greater opportunity to explore a subject in more depth (Keeling, Khan & Newholm, 2013).

3.7.1 Justification of netnography approach

The challenge of making contact with participants

A key challenge of pursuing in-depth research with healthcare patients is how to access them, or how to ituate us strategically and unobtrusively in a 'contact zone' where there can be meaningful and at least somewhat sustained encounters with patients. Experience is something singular that happens to an individual and which researchers cannot directly access (Carù and Cova, 2008). Therefore, researchers interpret only what their subjects have expressed orally, in writing, or through their behaviour. Experience has become more and more important to marketing services, but the methodologies typically used to research experiences, such as interviews and focus groups, have a number of drawbacks, such as respondent inhibition (Elliott and Jankel-Elliot, 2003). If you want to know what it is like being a patient in a hospital in England in the 21st century, the best thing to do, as Harvard psychologist Daniel Gilbert puts it, is to listen to patients.

> "If we want to know how a person feels, we must begin by acknowledging the fact that there is one and only one observer stationed at the critical point of view…she is the only person who has even the slightest chance of describing 'the view from in here', which is why her claims serve as the gold standard against which all other measures are measured". (Gilbert, 2006)

Hospitals, as working environments and settings for care, are in a constant state of flux. As mentioned earlier, patients' and families' stories about what happens to them in hospital at any one time illuminate current realities and provide valuable insights into the 'behind the scenes' forces that shape the experience. Patients' experiences of the hospital are inherently difficult to grasp. It is richly textured and complex. By definition subjective, the experience is such that no one else can know how it works from one moment to the next, how the different aspects of the experience (the process of care, the manner in which it is delivered, the environment in which it occurs, the physical sense of the place) come together, or what they mean for this particular person at this particular moment in their life. Patients do not naturally differentiate between aspects of care or rank them in order of importance. Everything about the process is a manifestation of the greater whole. Equally, patients' judgements about the quality of the whole are informed by the care they witness others receiving. This is not because they see themselves as the same as other patients. It is because when they witness something happen to another patient, good or bad, they immediately know that the same could happen to them. All these presented challenges for the author, in the first

instance, because of the strict patient data confidentiality policies in the NHS. To circumvent that, the researcher adopted a multi-method – the netnography, a systematic research method for collecting participants' reviews or stories online, and CIT qualitative content analytical techniques for data analysis. Both procedures and techniques are outlined, and a detailed description of all steps will follow in the subsequent sections. However, verbatim accounts are argued to be important to understanding the private nature of the experience to be studied (Carù and Cova, 2008).

3.7.2 Netnography approach

This section introduces the netnography method in various forms, drawing on existing theories and research. The section is divided into four parts. The first and second parts define and describe the uses of netnography, covering the fundamental knowledge and applications of the netnography research method. The third part explains the steps of conducting netnography, and the method for performing each step. Additionally, the final part presents the evaluation of the netnography method along with the rationale for using CIT qualitative content analytical procedures in this thesis's data analysis and interpretation.

Netnography, as a research approach, is linked to the nature and development of customer reviews on online platforms, social media, and in Internet-archived data (La Rocca, Mandelli, & Snehota, 2014, p. 691). According to Rageh, Melewar, & Woodside (2013), "experience is something singular that happens to an individual, and which researchers cannot directly access" (p. 131). Therefore, researchers only interpret what their subjects have expressed orally, in writing, or through their behaviour. It is argued that netnography is the best method for examining experience because individuals usually write their reviews after their stay ends, so their experience is not affected by observation (Kozinets, 2002; Rageh, Melewar, & Woodside, 2013, p. 131). This study indicates that research on netnography has increased. Researchers have begun analysing the method and its benefits. The analysis of publications over time clearly shows that authors have increasingly studied and used netnography in the last few years. Particularly since 2005, with the rise of social media, Facebook, YouTube, and Twitter and the availability of numerous online discussion boards and forums, the number of publications has increased considerably. By 2009, more than 175 million consumers had registered on Facebook. In the same year, 600 minutes of user-generated content were added to YouTube per minute. Moreover, the fact that already in 2008 three-quarters of Internet visitors used social media made it an important trend and

led to the increased interest of academics and researchers alike regarding the analysis of its content (Kapplan and Haenlein, 2010).

3.7.3 Definitions and core elements of netnography

In the late 1990s, Kozinets developed 'netnography' as an online marketing research technique to provide consumer insights. It is an adaptation and expansion of ethnographic methods to online formats, broadly based on the reflexive narratives people publish online (Kozinets, 1997, 1998, 2001, 2002). Netnography is a contemporary qualitative research methodology (Kozinets, 1997, 1998, 1999, 2002; O'Reilly et al., 2007) that has been applied across many fields as an appropriate method for assessing and understanding online communities. Kozinets (2002) has defined netnography in terms of both product and process. According to Kozinets (2002, p. 62), netnography, taken from "inter[net] and eth[nography], is a new qualitative research methodology that adapts research techniques of ethnography to study cultures and communities through computer-mediated communication. Additionally, computer-mediated communication (CMC) is any communication that occurs through a computer or network. CMC includes forums, postings, instant messages, emails, chat rooms, and mobile text messaging (Kozinets 2010a, p. 189). Those CMCs are sources for researchers collecting their ethnographic data to arrive at an understanding and representation of a cultural or communal phenomenon. In summary, netnography is participant-observational research (adapted from ethnography) conducted through online fieldwork (CMC or Internet-based sources).

Another school of thought terms netnography as digital ethnography or virtual ethnography, which "is essentially the application of ethnography to a computer-mediated environment with the epistemological remit largely unchanged" (Xun & Reynolds 2010, p. 18). It means that netnography is a qualitative research method which offers greater insight and understanding of the virtual world to discover and explain the consumer's experiences, needs, ideas, choices, symbolic meanings, and so on. Netnography, by definition, is a term that acknowledges the use of online resources or a computer. In the meantime, the ethnography of consumption has, in just a few years, become a major qualitative research strategy, given the limitations of questionnaire-driven verbatim accounts and other kinds of interviews (Mariampolski, 1999, 2005), when it comes to understanding the deep feelings and emotions lived by consumers (Carù and Cova, 2008). Pettigrew et al. (2013) underscore that netnography, as a form of online data collection, blends ethnography, content analysis,

and discourse analysis. The salient features of netnography are that it is realistic, unsolicited, unobtrusive, less intrusive, less time-consuming, and more inexpensive than ethnography (Kozinets, 2002; Kozinets, 2006; O'Reilly et al., 2012).

The core value of netnography is listening to consumers rather than asking them questions, understanding consumers' attitudes and behaviours rather than measuring their opinions. Experience is something singular that happens to an individual and which researchers cannot directly access (Carù and Cova, 2008). Therefore, researchers only interpret what their subjects have expressed orally, in writing, or through their behaviour. Experience has become more and more important to marketing services, but the methodologies typically used to research experiences, such as interviews and focus groups, have a number of drawbacks, such as respondent inhibition (Elliott and Jankel-Elliot, 2003). Instead, verbatims are argued to be important to understanding the private nature of the experience to be studied (Carù and Cova, 2008). Hence, netnography is considered a new market research method, which provides deep insight and understanding within a natural, multidimensional, and highly technological research environment. It is outside the scope of this thesis to debate the extent to which netnography is similar to ethnography, and there are clear differences in the time taken to obtain data, the degree of immersion of the researcher in the ‘‘field site", and the nature of researcher participation in the online group or community under study. This thesis employs Kozinets' (2010) method, as it provides a clearly defined, articulated approach to conducting online ethnography that carefully considers the ethics of online research.[2] Kozinets (1998) argues that netnography is a particularly suitable methodology for studying "those cultures and communities which do not exist in real life, but are manifest exclusively through computer - mediated communication"[3] (p. 367). The methodology of the current study can be referred to as "pure netnography", as it consists entirely of studies of online data collection from an online community (Kozinets, 2010).

[2] Ethical considerations will subsequently be discussed in Section .

[3] Computer-mediated communication is generally considered to be any act of communication occurring through the use of two or more networked computers (e.g. instant messages, emails, chat rooms) (McQuail, 2005).

Characteristic	*Ethnography*	*Netnography*
Research focus	Human society with all its groups	Online communities
Communication focus	All forms of human communication including body language, tone, etc.	Online content: primarily textual communication with some multimedia elements
Method	Obtrusive – the researcher participates in the group that is the object of research	As a general rule unobtrusive – based on anonymous observation
Data collection	Real-life observation and primary data collection	Data access supported by computer-based information retrieval methods and secondary data collection
Efficiency	Long in duration, high in costs, slow in speed	Relatively short in duration, relatively low in costs, fast inspeed
Retroactivity	No	Yes

Source: Derived from Kozinets (2002, pp.63, 70) and Kozinets (2006a, pp.281–282)

Table 3.5: The main differences between ethnography and netnography

As Internet access has become more widely available, people have come to adopt it as yet another medium with which they can chronicle their lives, with the added dimension that they now have an audience. Hence, the massive escalation in personal storytelling has arisen alongside the emergence of blogs and social media

3.7.4 Uses of netnography in different perspectives

Netnography is a relatively novel research technique originally developed for studying consumer behaviours and culture by Robert Kozinets in the 1990s (Beaven and Laws, 2007; Dwivedi, 2009; Janta and Ladkin, 2009; Kozinets, 2006; Morgan, 2008). To be more accurate, netnography is a multi-method, that is, a combination of various methods and techniques that can include content analysis, historical analysis, semiotics, hermeneutics, narrative analysis, and thematic analysis, among others (O'Reilly, Rahinel, Foster, and Patterson, 2007). In this study, the author conducted a thematic analysis to glean patterns of meaning from online reviews by hospital patients and customers, because the main challenge of pursuing in-depth research with healthcare patients is how to access them unobtrusively within the constraints of strict patients' data confidentiality policies in NHS studies. Netnography provides a means of accessing and interpreting computer-mediated textual discourse among anonymous or pseudonymous participants on public forums (Kozinets, 1997, 1998, 1999, 2002).

Nowadays, more companies are outsourcing their market research to gain deeper customer insights and identify new opportunities to expand their markets. Researchers believe in the netnography method and have been applying it to market research. For example, pharmaceutical companies have contracted Consulting for Pharma – a market research agency – to conduct various Netnography Insights projects, including one on schizophrenia drugs for Janssen Pharma, one on Alzheimer Caregivers for Merz Pharmaceuticals, and one on Vaccination for Sanofi Pasteur. Consulting for Pharma analysed how online communities' patients communicate their experiences with specific drugs, opinions, and feedback on all kinds of drugs, resulting in solid, drug-universal insights (Bastian, 2014). Also, for example, Danone contracted HYVE – a market research agency – to conduct a Netnography Insights project for them on drinks and beverages. HYVE analysed consumers' statements, opinions, and feedback on all types of beverages (excluding alcoholic drinks), resulting in solid, beverage-universal insights. Additionally, in the field of sports, Adidas successfully developed a new model of basketball shoes using netnography (HYVE – Netnography Insights, cases and references, 2013).

3.7.5 Netnography step-by-step procedures

Kozinets (2010) provides strategies for adapting these guidelines to the online context. The procedure of conducting netnography is divided into four stages and follows six steps: research planning, entrée, data collection, interpretation, ensuring ethical standards, and research representation. The current study employed the procedure recommended by Kozinets (2002, pp. 61, 63) for netnographic research (which he has adapted from traditional ethnographic research). Kozinets (2010) provides strategies for adapting these guidelines to the online context. These guidelines are discussed below. Figure 3.3 offers a diagrammatic flowchart.

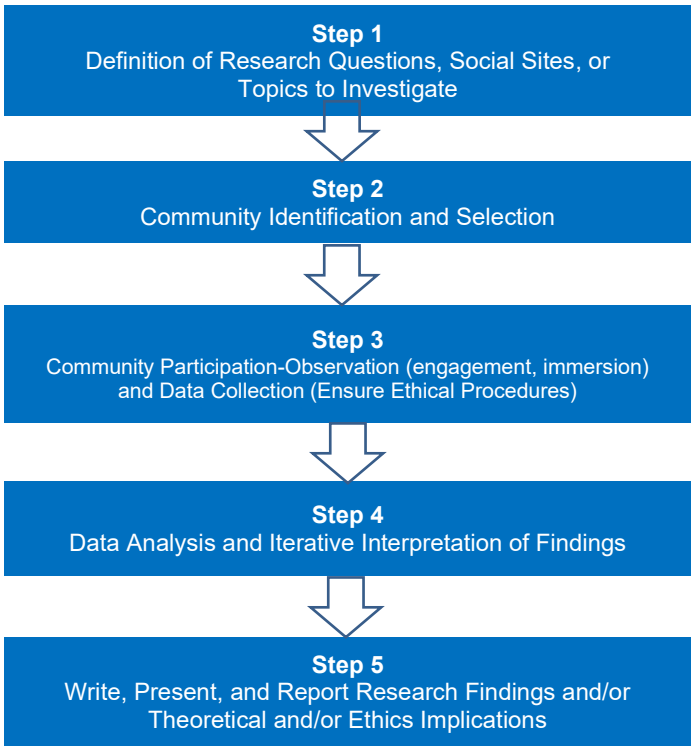


Figure 3.3: Simplified flowchart of a netnography research project

Source: Adapted from Kozinets (2010)

The definition and application of each step will be presented in the following sections.

The presentation is not in a step-by-step format. The steps will be analysed along with the stages of conducting netnography research. The steps of a netnographic research project outlined in Figure 3.4 will be used to organize the chapter. The following sections will explain how the present thesis applied the four steps required in a netnographic study in this thesis. Step 1 will detail the entrée steps taken in the present thesis; step 2 will detail the data collection performed across each of the three studies in turn; step 3 will detail the analytic steps taken across each of the other three studies in turn; and step 4 will discuss the ethical considerations considered throughout the thesis.

3.7.5.1 Reflexivity and reflections

Before describing step 1 (entrée), it is essential to comment on reflexivity as an important element of ethnographical research (Mukono, 2014; Kozinets, 2015). Generally, reflexivity in ethnography requires researchers to undertake a constant analytical and evaluative process of their own actions and beliefs (Abercrombie, Hill, & Turner, 2000). In other words, it is "a process of self-reference" (Davies, 1999, p. 4). Reflexivity allows a researcher to

acknowledge that her opinions and preconceptions will affect her perceptions of the culture under study, as she must always interpret the data (Young, n.d.). The researcher is an integral part of the research process and plays a role in the construction of meaning, co-constructing the data (Davies, 1999; Young, n.d.). A researcher must be reflexive about their personal characteristics to locate themselves within the research. Identifying differences between the researcher's personal characteristics and those of study participants was essential to take steps to minimise potential differences or misconceptions between us in the research process.

In terms of the epistemological stance of the current thesis, weak social constructionism recognizes that language has a constructive nature and does not simply mirror reality. The narratives and texts created in this thesis are representations of experiences by patients who have utilized language to produce these texts in conjunction with me as the researcher. In this sense, my involvement in the research process contributes to the construction of meaning. Reflexivity, then, allows me to explore how my involvement with this research both acts upon and informs the research. My subsequent narrative will acknowledge any preconceived notions that I have about customer/patient experiences during the data collection and analysis process.

This means that reflexivity is a way of attending to the institutional location of historical and personal aspects of the research relationship (Parker, 2005, p. 25). This position of the researcher then makes subjectivity a crucial resource in the research process and something that can be made visible to the reader, so that it is also useful to them if they want to take the work forward (Parker, 2005, p. 26). As Kozinets (2010, p. 169) explains, “one meaning of reflexivity is that the scientific investigator is part of the setting, context, and culture she is trying to understand and portray…Reflexivity is thus the extent to which the netnogaphic text acknowledges the role of the researcher and is open to alternative interpretations”.

3.7.5.2 Step 1: Planning and entrée

Planning and entrée are the ***first stage*** of conducting netnography research, including two initial steps that help market researchers prepare themselves carefully for the process. Firstly, researchers need to determine the research focus and research questions and identify the main topics that they want to investigate (Kozinets, 2002, p. 63). In terms of research design, Creswell (2009, p. 129) suggests that qualitative researchers should create broad questions to ask for “an exploration of the central phenomenon or concept in a study”. In netnographic

research, it is useful to apply this principle when determining research questions, since netnography collects information from the entire online community rather than relying on personal opinions. Hence, the netnographer can start with a set of research questions regarding the main research topic. During the investigation, the original questions may change, and new, appropriate, and focused questions may emerge.

In the ***second stage*** of planning and entrée, netnographic researchers need to find appropriate online fields for collecting data and familiarize themselves with the online communities (Kozinets, 2010a, 79). Thus, there is a need to identify appropriate online forums for the study most relevant to a researcher's particular research interest, and to learn as much as possible about the communities identified. According to Kozinets (2010a), bulletin boards and forums are among the oldest and richest forms of online communities. They are text-based information that provides opinions on particular orientations or consumer topics. These days, forums also comprise new online communities such as Facebook, Instagram, Tumblr, Pinterest, Snapchat, Twitter, blogs, wikis, audio/visual sites, social content aggregators, and social networking sites. Online customer review platforms and interaction among these web pages create huge opportunities for researchers to collect relevant data. For example, the web page www.epinions.com provides an online community for studying consumer-to-consumer/business exchanges (Kozinets 2002, p. 63), such as the www.tripadvisor.co.uk. Researchers need to choose sites with the highest traffic to obtain thick, in-depth data. Certain groups are preferred that have:

> "(1) are more focused to research question, relevant segment, topic, or group; (2) higher 'traffic' of postings; (3) larger numbers of discrete message posters; (4) more detailed or descriptively rich data; and (5) more … between member interactions of the type required by the research questions" (Kozinets, 2002, p. 63).

In his volume on the principles of research design, John Creswell (2009, pp. 129-30) advises qualitative researchers to choose broad questions that ask for "an exploration of phenomenon or concept in a study". He asserts that the intent of qualitative researchers should be to explore a complex set of factors surrounding a central phenomenon and then to present the varied perspectives on the meanings held by participants experiencing this phenomenon. According to Kozinets (2010), this perspective aligns with a netnographic approach and implicitly suggests a more open, exploratory approach that suits the novel context of Internet cultures and communities. He went on to argue that netnographies are appropriate for gathering more than personal perspectives or meanings. Furthermore, netnographies do not

necessarily have to start with a brand-new phenomenon, offering a tabula rasa or open slate approach to theory development. They can also hone in, narrow, and focus on relationships or previously identified constructs to provide us with a deeper or more detailed understanding.

Björk and Kauppinen-Räisänen (2011) reiterate that netnographers must, before entering the field, determine the role they will assume (active or passive) and the level of notification they will use (overt or covert), as illustrated in Fig. 3.4.

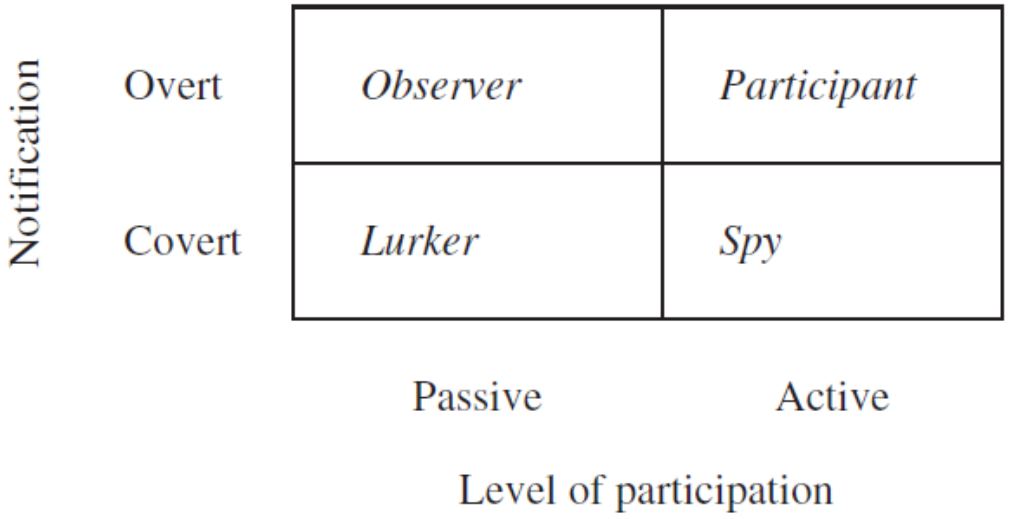


Figure 3.4: Researcher's position in netnographic studies

Source: Adpted from Björk and Kauppinen-Räisänen (2011)

The observer informs online customers of their presence in the community and asks for permission to conduct research. He or she takes on a passive role, that of an outsider, and does not interfere in the ongoing discussion. The lurker takes on a passive role, too, but does not reveal his or her identity to the bloggers. The spy is more active than the lurker. The spy immerses himself or herself in the discussion but participates incognito. A participant is active in the ongoing discussions and explicitly announces his or her dual role as a researcher and participant.

The researcher used a passive, covert approach in this study, i.e. he did not interfere with the ongoing discussions and "influence the study subject" (Arsal, Woosnam, Baldwin, & Backman, 2010, p. 405). This research position was also practised by Langer and Beckman (2005), who studied patients' experiences of cosmetic surgery. The researcher did not consider the decision not to seek consent or to communicate his research interests critical,

since the patient stories are anonymous, may have been posted months ago, and are publicly available on the Web. No login details are required to access the platform and review or download archived patient stories. Björk and Kauppinen-Räisänen (2011) argue that the choice of entry, that is, how a researcher presents themselves, the research project, its aims, and expected outcome, is not an issue in netnographic studies where the researcher is a lurker**.**

Netnography, in the form of lurker or non-participant observation, is used in this study, based on unsolicited customer/patient reviews published on the Internet that provide detailed information about their experiences in NHS hospitals. The reason for choosing the non-participant observation is the undesirable influence of the outsider on the group (Elliott and Jankel-Elliott, 2003). Also, the study was conducted completely unobtrusively because netnography can be conducted in an entirely unobtrusive manner (Kozinets, 2002).

The researcher reviewed the most prominent websites that offer online consumer/patient reviews of their experiences (positive or negative) with NHS hospitals in England, taking into consideration the criteria recommended by Kozinets (2002). The growth of the Internet and the vast number of websites pose obstacles for netnographers in finding suitable research sites. How can they locate a specific community for data collection among millions of webpages? The answer is to use search engines in the early stages of searching and data collection. Major search engines like Google.com, Yahoo!, and MSN are the best friends of nascent netnographers (Kozinets, 2010a, 88). Google.com is the best source of community information; however, researchers should also use Yahoo! because results may differ between the two search engines. Besides, using Google Groups (https://groups.google.com/) or Yahoo! Groups (http://groups.yahoo.com/) provides researchers with access to the main newsgroups through web-based readers and interfaces.

Basically, Google Groups or Yahoo! Groups filter websites, newsgroups, or forums by chosen keywords, allowing researchers to access discussions or ideas on a specific subject. Thus, Google Groups or Yahoo! Groups offer more relevant results than pure Google or Yahoo! search engines. In order to maximize the results of using search engines, it is necessary and important to combine the use of various search engines. For example, researchers can combine general search engines (e.g., Google Search) with community search engines (e.g., Yahoo! Groups) and search specific social sites. The search for convenient websites for this study was conducted on Google using combinations of the

following keywords: “NHS hospitals”, “patient experience reviews”, and “patient experience feedback”. As part of the digital health phenomenon, several online platforms have been developed to encourage patients and their caregivers to share their experiences with one another and contribute to a massive database. Several online feedback platforms for patients and carers are emerging, particularly in developed countries such as the USA, the UK, and Australia (Greaves et al., 2013). These platforms include CarePages (2013), PatientsLikeMe (2013), Health Unlocked (2013), CureTogether (2013), Smart Patients (2013), Treato (2013), Patient Opinion (2013), and NHS Choices (2013). Many of these websites have attracted large numbers of regular users. The developers of NHS Choices, for example, claim that it is the most widely used patient-support site in the UK, receiving over 40 million visits a month, while Patient Opinion asserts that it receives over a million visits a month. The discourses of these sites focus on patient support and the democratic sharing of information, allowing contributors to benefit from others’ knowledge and experience with their hospital experiences and hospital responses. Sites such as NHS Choices and Patient Opinion focus more narrowly on eliciting patients’ experiences of NHS health services with the aim of directly informing service providers of the positive and negative experiences that patients have so that services may be improved: “We pass your stories to the right people to make a difference”.

As a result, two websites were found to be more relevant to this studyhttp://www.nhs.uk and www.patientopinion.co.uk). Customer feedback is commonly used to evaluate a provider's performance from the customer's perspective. Feedback provided through dedicated websites allows customers to voice their opinions about the quality of their service experiences. The number of people using these platforms to describe or rate their healthcare experiences is continuously increasing (Greaves and Millett, 2012). Lupton (2014) terms this phenomenon “the digital patient experience economy”. These novel sources of rich data can therefore help gain a better understanding of health services from the perspectives of patients and carers (Greaves et al., 2013).

Part of the ethic of sharing expressed on many of the websites is users’ agreement to make this data increasingly available (in aggregated or anonymized form) to healthcare researchers, policymakers, and providers. As shown in the words quoted from NHS Choices, it is argued that such “sharing’ is part of the project of ‘making the NHS hospitals patients’ experiences better”. As part of a general rhetoric of democratization and participatory cultures (Beer, 2009; Beer and Burrows, 2010), it is suggested that individuals become good

citizens by participating in these technologies and contributing their experiences so that they may be aggregated for the greater good (Adams 2011, 2012; Harris et al., 2012; Wyatt et al., 2013). Being a digitally engaged patient, therefore, involves considering the benefits offered by one's participation to others as well as to oneself.

An overview of the NHS Choices website

The website was selected because it is more relevant than other sites, such as Patient Opinion, and because it focuses on the research question and objectives of this study. Also, there is higher traffic in posts and more detailed, richer data. In a similar study, Yang and Fang (2004) used the same procedures to analyse consumer complaints and compliments with securities brokerage services. The NHS Choices website is the UK's leading independent feedback platform for health services, with over 14 million stories published since 2007. In 2015, the NHS Choices website recorded 583 million visits, that is, 80 million more than in 2014, and currently enjoys over two million unique visitors per day (NHS Choices, 2016)

All types of patients and carers can willingly respond to three simple, open-ended questions: "What did you like?" "What did you dislike?", and "What advice can you give?" NHS Choices aims to elicit responses about the positive and negative aspects of healthcare, direct, indirect, and unexpected interactions or encounters, so that this information can be used to improve service delivery (see example Figure 3.5). The contribution of NHS Choices patient feedback in the improvement of the quality of care was recently recognized in a prominent government-sponsored report (Francis, 2013). The researcher presented the research goals and methods to the Director of Patient Experience at NHS Choices, who provided him with links to access the archived, unrestricted, entire database of patients' stories and reviews since 2007. The links allow the public to download full extracts of past and the latest published patients' stories data in csv format. The data files are updated daily and are made available by NHS Choices under the Open Government Licence (see example Figure 3.6). Next is the data generation phase, which involves copying text directly from the selected NHS Choices platform example screenshot below with patient comments (Figure 3.5).

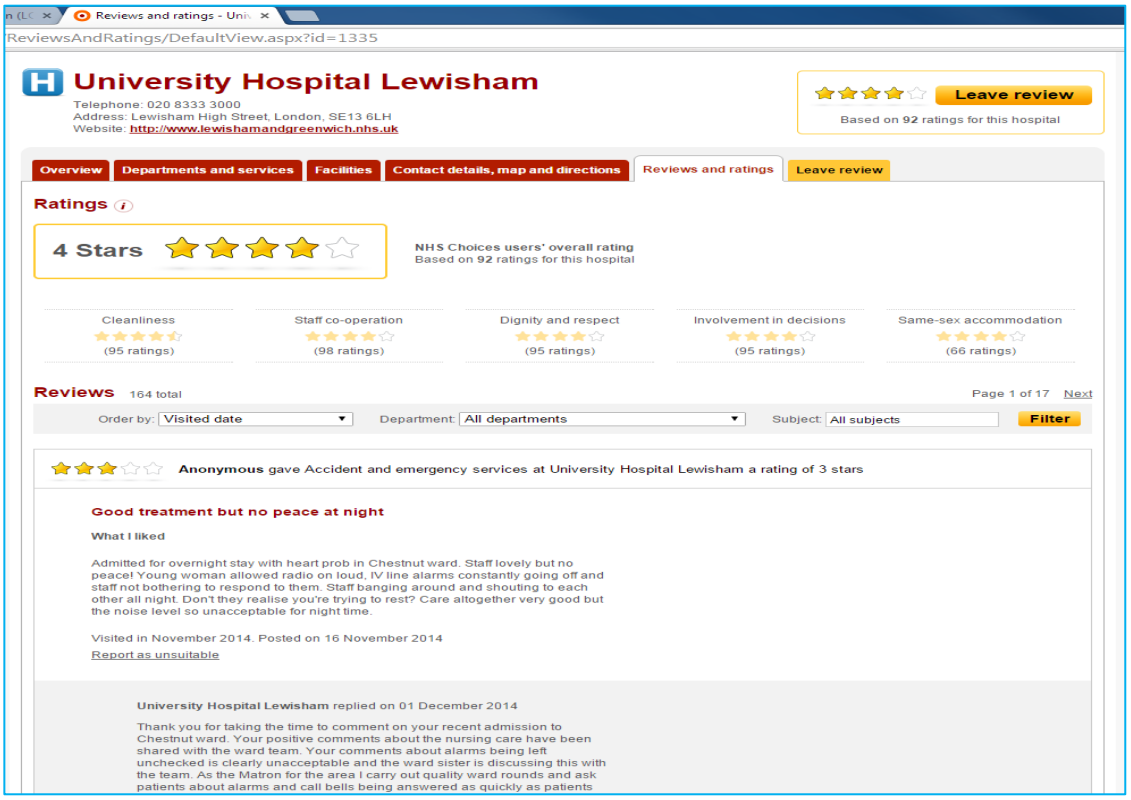


Figure 3.5: Example NHS Choices patient experience reviews site

Source: (http://www.nhs.uk)

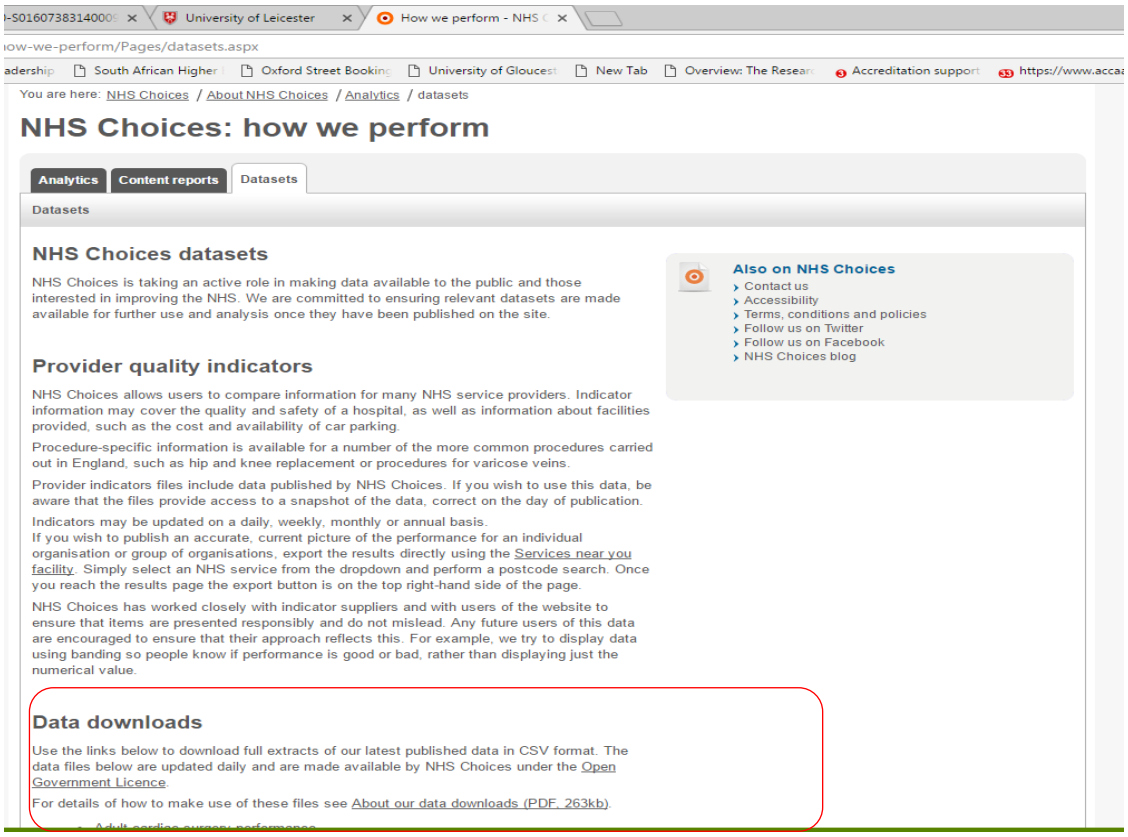


Figure 3.6: Example NHS Choices public access to archived patient stories

Source: (http://www.nhs.uk/datasets)

3.7.5.3 Rationale for using stories as empirical material

Stories provide the opportunity to explore how people describe and evaluate their healthcare experiences. They enable the identification of quality dimensions from the collective customer's perspective. Assessing the quality of health services using fixed multiple-choice questions is commonplace. However, it may be inappropriate to use pre-determined questionnaires to measure the healthcare experience as this would suggest that the dimensions of experience are already known (Tsianakas et al., 2012). Bate and Robert (2007) argue that an experience "can never be observed or accessed directly, but only indirectly through the words and languages people use to describe it when they look back at it". Drawing on Greenhalgh et al. (2005), they suggest that stories "contain almost everything […] required for a deep appreciative understanding of the strengths and weaknesses of a present service". Given the open-ended nature of the questions, NHS Choices patient stories provide a significant opportunity for the development of a rich, detailed understanding of patient hospital experiences. Moreover, stories are created unobtrusively and independently from the research. Patients and carers freely and willingly decide what information they want

to provide based on what matters to them. The important dimensions of experience quality emerge from the data as they appear in the respondent's construction. Finally, Burns et al. (2000) show that respondents disclose rich and deep accounts of their experiences of service contexts characterized by high levels of customer involvement, such as healthcare (Berry and Bendapudi, 2007).

3.7.5.4 Sample selection

Sampling in netnography is purposive, as the researcher carefully selects online threads that are relevant, active, interactive, substantial, heterogeneous, and data-rich (Janta, Lugosi, Brown, and Ladkin, 2012; Kozinets, 2002). This study focused on the threads on the NHS Choices website in which both patients and their relatives discussed their hospital experiences and reflected, either directly or indirectly, on their positive and negative experiences. They are a good proxy for holistic CEs as they involve numerous discrete interactions between patients and providers (Tsianakas et al., 2012). Moreover, Dagger et al. (2007) report difficulties in validating generic models of healthcare service quality, perhaps due to the high variety in conditions studied (e.g. minor/major or short-term/long-term), which can influence the type and relative importance of quality dimensions. This study's sample selection allows sufficient homogeneity to derive common customer/patient experience dimensions and attributes. Medical treatments and outcomes improve continuously, but organizations are increasingly expected to provide the right experience to both patients and carers.

This study identified the totality of patients', their friends', and carers' stories archived on NHS Choices (820), which was downloaded and imported into a data file. The researcher applied a strict protocol comprising three criteria to select a sample from this set. A story had to describe clear perceptions and evaluations of positive or negative experiences, describe a healthcare experience (i.e., two or more interactions), and include sufficient and precise details about the experience to allow identification of experience dimensions or attributes. The selected stories were formatted as individual case files, each assigned a unique case identifier (1-470), and imported into NVivo 11 qualitative data analysis software (see Appendix).

Characteristics of the sample frame

The researcher analysed 820 stories. However, according to a report from the Royal College of Nursing in the UK (RCN, 2013), 200 patient stories are deemed an appropriate sample size for generating the key themes associated with a particular topic.

The average length of each story was 180 words. The sample had good regional representation, with no single region accounting for more than 10 per cent of the sample (as shown in Table 3.10). The stories were published between August 2013 and December 2013. In addition to geographic (see Figure 3.7) and time representations, inpatients and outpatients were covered. The types of conditions were unspecified in the stories. Almost three-quarters of the total stories were written by patients, and the remaining quarter by their carers or families. Figure 3.8 shows the geographical regional distribution of these hospitals by NHS England Strategic Authority – for the purpose of this study, NHS Scotland, NHS Wales, and NHS Northern Ireland were not included. Using the sample frame (see Figure 3.9) will help narrow down the data and make it more manageable, resulting in over 600 reviews for the study. Essentially, provides a national geographical representation and therefore enhances the generalizability of the findings of this research.

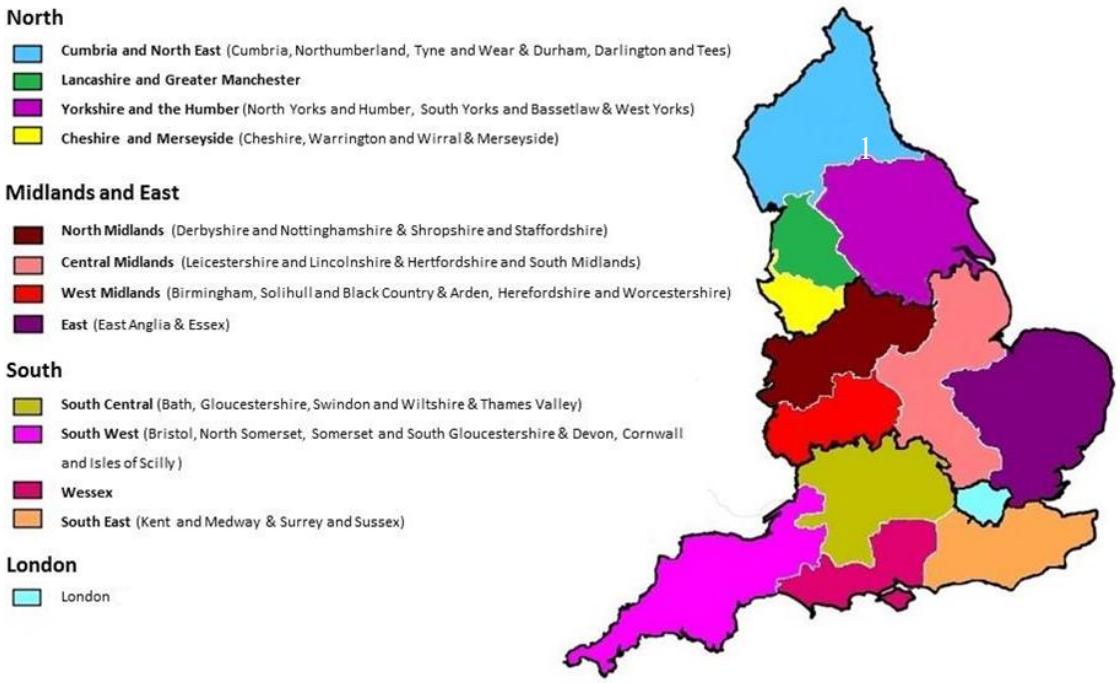


Figure 3.7: Regional participants' distribution by NHS England Strategic Authority

Source: NHS England, DOH (2015)

Using the sample frame (see Figure 3.8) will help narrow down the data and make it more manageable, resulting in over 600 reviews for the study. Essentially, provides a national geographical representation and therefore enhances the generalizability of the findings of this research.

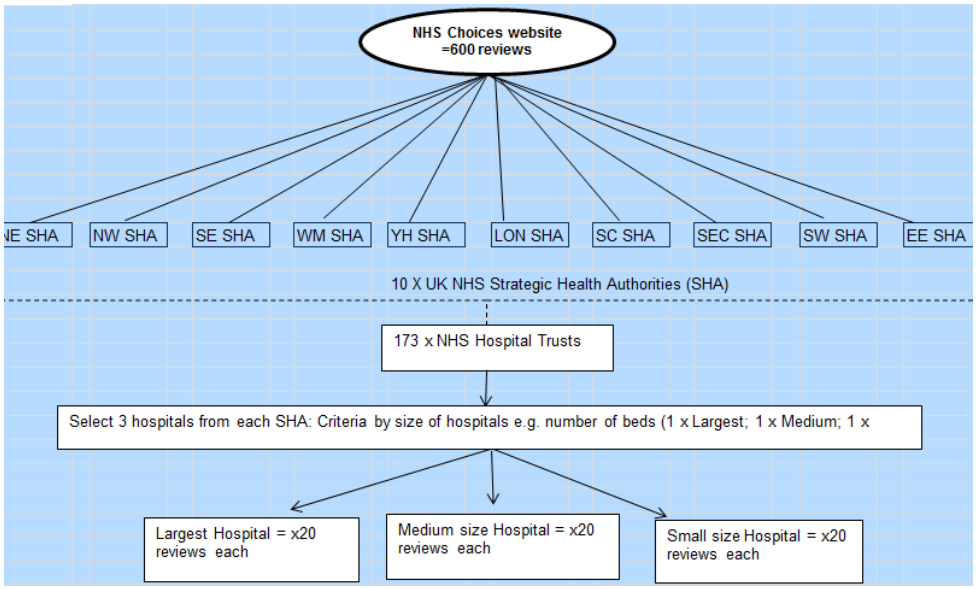


Figure 3.8: Sample frame by hospital trust size and NHS Strategic Health Authority

Source: Author's own

3.7.5.5 Step 3 – Data collection procedure

The third step of Kozinets' framework involves data collection. Kozinets (2002) stated that there are two types of data collection when conducting netnography: "(1) the data that the researcher directly copies from the computer-mediated communications of virtual community members, and (2) the data that the researcher inscribes regarding his/her observations of the community, its members, interactions and meanings" (p. 7). In this study, a direct copy from the archived CMCs of online community members was adopted. Netnographers can choose whether to use manual data collection or a qualitative data analysis software program to assist with coding and organising the data. Manual data collection includes using a pen-and-paper technique or jotting in computer files or a spreadsheet, e.g., Microsoft Excel. Besides the manual method, for this study, the researcher used NVivo 11 to manage all the collected data (Kozinets 2010a, p. 99). Some aspects were considered when choosing the customer messages. For example, the texts that are experiential in nature and provide a full description of the experience were selected. Secondly, overwhelming amounts of data were anticipated; therefore, all messages were

examined, and any responses deemed to be posted by staff were discarded. Thirdly, an attempt was made to identify diverse (both positive and negative) journal postings of experiences, with the intention of following a sampling strategy that did not aim for representativeness or transferability but rather focused on analysing the topic in depth (see Brown et al., 2003).

The selection process resulted in 820 reviews (see Figure 3.9) below. The collected messages were posted between August 2013 and December 2013. This period was chosen because it is the busiest on the NHS calendar, making it an ideal time to evaluate CE. Although the website was national in scope, postings were primarily in English. The researcher accessed customer/patient reviews on the NHS Choices website from 1st August 2013 to the middle of December 2013 to secure a sufficient volume of reviews about a predetermined sample of NHS hospitals in England. The researcher immersed himself in downloaded spreadsheets while monitoring customer reviews and communications for three months. As a result, this facilitated the review selection process.

Kozinets (2002) stated that "the uniquely mutable, dynamic, and multiple online landscape mediates social representation and renders problematic the issue of informant identity" (p. 64). In an online environment, community members might be more likely to reveal identities that differ significantly from their 'real' identities, which could undermine the trustworthiness of the data collected (Sandlin, 2007). A general response to this argument is that researchers should consider speech acts or communication as the unit of analysis, rather than the individual (Kozinets, 2002). Kozinets (2002) also argued that blatant misrepresentation is frowned upon by most online communities, where 'codes of etiquette' discourage this sort of behaviour through 'flaming, ostracism, and banishment' (Kozinets, 2002, p. 65). To ensure the most trustworthy data possible, Kozinets (2002) urges researchers to immerse themselves in the community's culture through long-term engagement (cited in Sandlin, 2007).

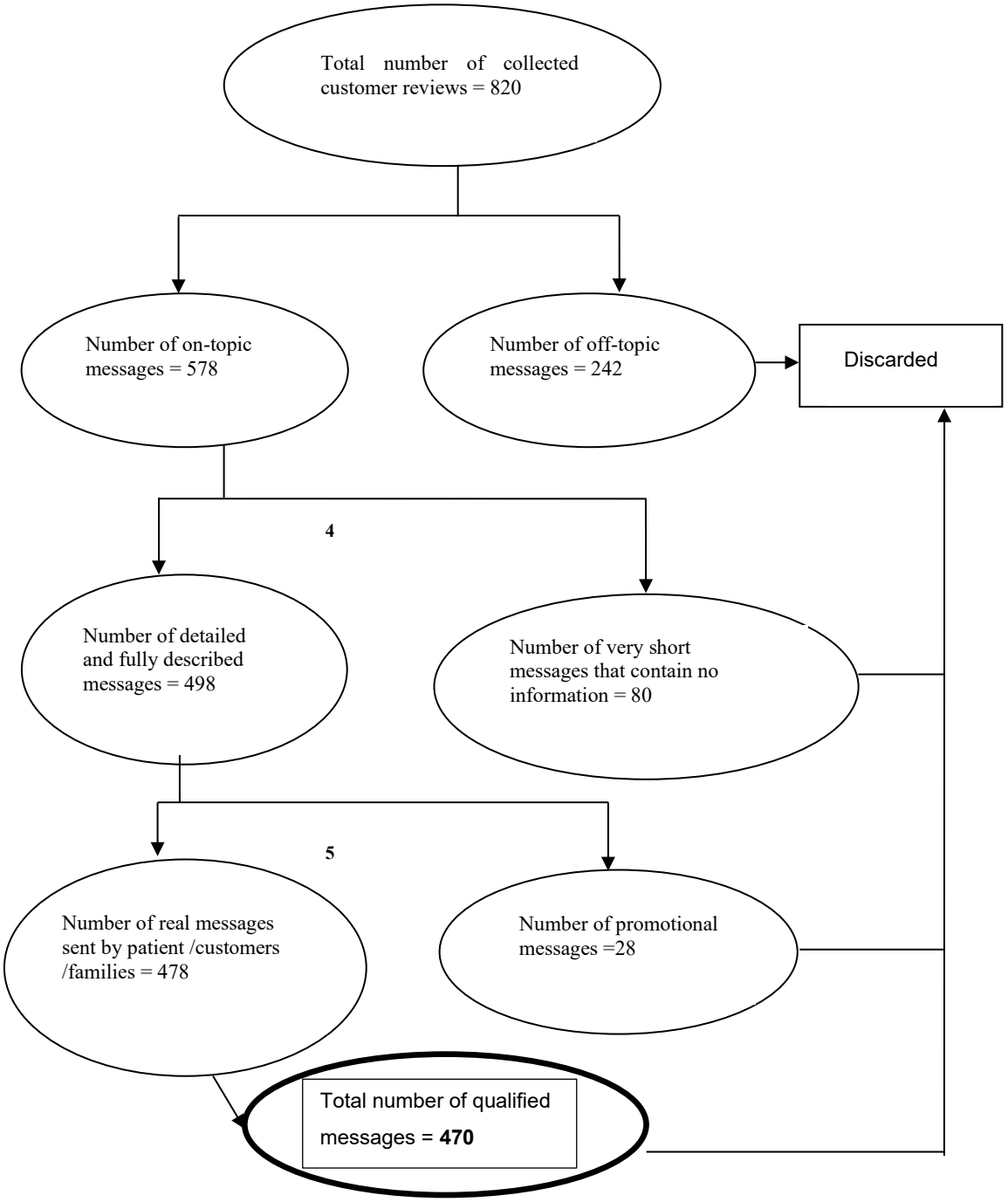


Figure 3.9: Customers' reviews selection process

Source: Author's own

[4] The functional messages are those primarily concerned with the evaluations of different services provided by the hospital without mentioning any kind of emotions provoked or telling any stories about the experience.

[5] Promotional messages are believed to be sent by the organization to promote the hospital among the online community members.

Throughout the process, the researcher needs to be aware of relevant ethical requirements. Kozinets (2002) recommends that the researcher should disclose his or her presence and intentions to the members of the relevant online community. However, as noted above, in more recent years, researchers have argued that this is no longer necessary when data are extracted from public communication media (Langer & Beckman, 2005), as NHS Choices data are already in the public domain. It is inconsequential and almost absurd to request permission to access content that is public anyway. Consent and member checks are required in studies involving non-public forums. As was the case with this study, the researcher is a passive observer of patients' online reviews; hence, the requirement for individual, informed consent falls away. The University's Ethics committee, which approved the study, also took this approach.

For the present study, a total of 470 online reviews downloaded from NHS Choices were analysed. Table 3.6 provides a summary of the number of patient reviews drawn from netnography for each NHS hospital across 80 hospitals, i.e., 46 per cent of the total of 172 acute NHS Hospital Trusts in England.

NHS hospital	Number of patient reviews
1. Addenbrooke's	8
2. Aintree University Hospital	9
3. Airedale General Hospital	6
4. Alexandra Hospital	4
5. Ashford & St Peter's Hospitals	3
6. Basildon and Thurrock University Hospitals	7
7. Basingstoke and North Hampshire Hospital	3
8. Birmingham Women's NHS Foundation Trust	5
9. Blackpool Victoria Hospital	4
10. Brighton General Hospital	5
11. Central Middlesex Hospital	5
12. Colchester General Hospital	8
13. Croydon University Hospital	8
14. Darent Valley Hospital	5
15. Ealing Hospital	4
16. Frimley Park Hospital	5
17. George Eliot Hospital – Acute Services	9
18. Gloucestershire Royal Hospital	6
19. Good Hope Hospital	3
20. Guy's Hospital	6
21. Hammersmith Hospital	8
22. Harefield Hospital	7
23. Homerton University Hospital	7
24. Hull Royal Infirmary	4
25. James Paget University Hospital	6
26. Kent and Canterbury Hospital	6
27. Kettering General Hospital	4
28. King's College Hospital (Denmark Hill)	7
29. Leeds General Infirmary	4
30. Leicester General Hospital	4
31. Liverpool Women's NHS Foundation Trust	7
32. Luton and Dunstable University Hospital	6
33. Milton Keynes University Hospital	4
34. Norfolk and Norwich University Hospital	2
35. North Manchester General Hospital	5
36. North Tyneside General Hospital	4
37. Northampton General Hospital (Acute)	3
38. Northwick Park Hospital	7
39. Nottingham University Hospitals NHS Trust – City Campus	4
40. Papworth Hospital	6
41. Peterborough City Hospital	4
42. Princess Alexandra Hospital	6
43. Queen Alexandra Hospital	8
44. Queen Elizabeth Hospital	7
45. Royal Berkshire Hospital	3
46. Royal Bolton Hospital	4
47. Royal Bournemouth and Christchurch Hospitals	5
48. Royal Brompton Hospital	3

NHS hospital	Number of patient reviews
49. Royal Free Hospital	8
50. Royal Shrewsbury Hospital	4
51. Salford Royal	5
52. Salisbury District Hospital	4
53. Solihull Hospital	4
54. Southampton General Hospital	5
55. Southend University Hospital	6
56. St George's Hospital (London)	6
57. St Helens Hospital	4
58. St James's University Hospital	3
59. St Peter's Hospital	3
60. St Thomas Hospitals'	7
61. County Hospital, Stafford	8
62. Sunderland Royal Hospital	4
63. Tameside General Hospital	8
64. The Ipswich Hospital	4
65. The James Cook University Hospital	3
66. The Princess Royal University Hospital	5
67. The Queen Elizabeth Hospital	4
68. The Royal Liverpool University Hospital	4
69. The Royal London Hospital	3
70. The Whittington Hospital	6
71. York Teaching Hospital	3
72. Trafford General Hospital	6
73. University College Hospital	9
74. University Hospital (Coventry)	4
75. University Hospital Lewisham	6
76. University Hospital of Hartlepool	6
77. Warrington and Halton Hospitals	4
78. Warwick Hospital	7
79. West Middlesex University Hospital	3
80. Yeovil District Hospital	4
Total patient reviews analysed	**470**

Table 3.6 3.10: NHS Choices patient stories by NHS EnglandHospital Trusts

Source: Author's own

3.8 Step 4 - Data analysis

Data analysis involves the examination, interpretation, and inference from collected data on netnographic participation and observation (Kozinets, 2010a). According to Miles and Huberman (1994), there are many common qualitative data analysis processes, some of which are adapted in analysing netnographic data. These methods in netnographic analysis include coding, noting, abstracting and comparing, checking and refinement, generalizing,

and theorizing (Kozinets, 2010). Thus, since its introduction in 1997, netnography has steadily gained interest among researchers, and Bartl et al.'s (2016) recent literature review on netnography adds evidence that netnographic research is progressing on several fronts. On the one hand, companies adopt netnography as a market research method; on the other hand, scholars use it as a scientific research and data collection method (Bartl et al., 2016). Nevertheless, netnography remains an emerging field of research.

This growing body of netnography literature has, in turn, stimulated interest among scholars, who have begun to apply this method as a scientific research and data collection technique (Bartl et al., 2016; Mukono, 2014). They argue that if scientific and academic interest in netnography continues to increase and the method is adopted more widely in practice, progress must be made in research data analysis. Additionally, there is a need for greater research diversity in this area.

3.8.1 Netnography data analysis procedures and processes drawbacks:

Mukono and Markwell's (2014) further observation from their review of publications using netnography is that it is used as part of a triangulated or mixed-methodology. For example, Janta et al. (2011) triangulated netnography with interviews and online data, which is a multi-method approach with CIT. Mukono and Markwell (2014) went on to state, "Netnography cannot (and need not) provide exhaustive insights about any one topic. There is always the opportunity to gain further understanding via other techniques" (2014, p. 290). However, this is not to suggest that netnography may not be used on its own as a methodology. Rather, depending on research questions and goals, researchers decide whether triangulation or mixed methods are appropriate. There were very few theses included in the researcher's sampling of netnographic publications. Mukono and Markwell argued that due to its relative infancy, netnography is not yet regarded as a ''standard'' or ''universally'' accepted methodology, making students and supervisors reluctant to adopt it (Mukono and Markwell, 2014). It might also be that many healthcare researchers are not yet convinced of the merits of netnography. Students and supervisors might be concerned that they lack the means to defend the methodology in the event of criticism. Another possible explanation is a general lack of awareness of the methodology among students, and ignorance or a lack of confidence regarding its execution. However, with more publications of netnographic studies in high-profile healthcare and consumer research journals, confidence in and awareness of netnography are likely to increase among healthcare marketing scholars. Also, the more

explicit these publications are about how netnography is applied to healthcare marketing studies, the more likely it is to be widely adopted by other healthcare marketing researchers in the future.

Although there has been an increase in the adoption of netnography among health researchers, the methodology remains underutilized and somewhat outside the mainstream. It is hoped that with the continued expansion of so-called Web 2.0 technologies, which mediate the creation and exchange of text in online community environments, and, as a consequence, as more content related to healthcare is uploaded, healthcare researchers will increasingly consider adopting netnography as a research methodology, either on its own, or as part of triangulated or multi-methodology or mixed-method designs. With the increasing ease of conducting such phenomenological research online, qualitative researchers face gaps in methodological detail (Xun & Reynolds, 2010). In the case of netnographic studies, where the processes and methods unfolding in the technology arena are so diverse, reflective accounts of the research process are crucial to address the underdeveloped methodological details. In addition, as more netnographic articles are published in top-ranking services marketing journals, it is expected that netnography will be increasingly accepted as a rigorous and efficacious methodology for a diverse range of research topics, and that specific methods and techniques around data analysis used in its implementation will become clearer (Mukono and Markwell, 2014). This growing body of netnography literature has, in turn, stimulated interest among scholars, who have begun to apply this method as a scientific research and data collection technique (Bartl et al., 2016; Mukono, 2014).

Netnography data analysis step-by-step processes are vague and ambiguous, so there is a lack of a standard, systematic procedure, particularly for answering this thesis's research questions and for understanding the nature of positive and negative incidents in patient experiences. Hence, the analysis, interpretation, and reporting of the data from this study were conducted using CIT qualitative content analytical techniques, as outlined in the following sections.

This study indicates that research on netnography has increased. Researchers have begun analysing the method and its benefits. The analysis of publications over time clearly shows that authors have increasingly studied and used netnography in the last few years. Particularly, since 2005, with the rise of social media, Facebook, YouTube, and Twitter, and

the availability of numerous online discussion boards and forums, the number of publications has increased considerably.

3.8.2 Justification for CIT qualitative content analytical procedures

Flanagan regarded CIT as a "flexible set of principles which must be modified and adapted to meet the specific situation at hand" (Flanagan, 1954, p. 335). Over the 60 years since its inception, CIT has proved responsive to changing research approaches. Researchers have modified CIT in various ways, extending beyond 'scientific' behavioural analysis to more holistic investigation of aspects of human experience and meaning that people attach to activities. Researchers, including myself, are tending away from previous concerns about objectivity and generalization towards individual perspectives and significance (Chell, 1998; Kain, 2004). CIT qualitative content analytical procedures, an inductive method, are employed to analyse the dimensions and attributes of the CE construct within NHS hospitals and identify the significant factors that influence both positive and negative CEs. The nature of this thesis's research questions makes CIT content analysis an appropriate method when CIT is linked to netnography's fourth-step data analysis procedure, given netnography's vague, ambiguous data analysis procedures described in the above section. Content analysis is a scientific, objective, systematic, and generalizable method for describing communication content (Kassarjian, 1977). The nature of the feedback questions (i.e. "what happened?") provides "factual reports of events" (Hopkinson and Hogarth-Scott, 2001), reflecting individual experiences that are personal and subjective. Bitner et al. (1990) suggested that CIT takes on the stories that people have told and then applies content analysis to the stories in the data analysis stage of the procedure. CIT has been used in a variety of service contexts in recent years to explore service research issues and has been instrumental in advancing our understanding of these issues (Gremler, 2004). Service researchers (Grove and Frisk, 1997; Edvardsson, 19992; Bitner, 1990; Nyquist et al., 1985) have found CIT to be a valuable tool, as the analysis approach suggested by the CIT method often results in useful information that is more rigorously defined than in many other qualitative approaches (Gremler, 2004). It allows researchers to focus on a very specific phenomenon by forcing them to define the "specific aim" of their study and to identify important thematic details, with vivid examples to support their findings.

The CIT and netnography maximizes the positive and minimizes the negative attributes of anecdotes, turning complex experiences into rich data and information. Most people enjoy

telling stories: they like to be listened to and are glad that their experiences are thought important. Especially when data and information are collected anonymously, investigators can gain deep insights into individuals' emotions, feelings, and actions and uncover new meaning. (As you would expect, the technique is therefore especially useful where hazard, security, or privacy confuse a situation.)

Content analysis (CA) has been viewed as both a purely positivist, quantitative methodology (Neuendorf, 2002) and as a qualitative, feminist approach (Leavy, 2000). Qualitative content analysis (QCA) relies heavily on interpretation of text, which is the main reason why it has been criticized as unscientific. However, Krippendorf (2004) argues that "all reading of texts is qualitative, even when certain characteristics of a text are later converted into numbers" (p. 19), emphasizing that qualitative text analysis is necessary to understand deeper meaning. The term CA has come to describe a "family of analytic approaches" ranging from interpretative to systematic analyses (Hsieh & Shannon, 2005, p. 1278). Generally speaking, QCA codes text data into categories, which are then statistically analysed, whereas QCA focuses on the contextual meaning of language in the text (Hsieh & Shannon, 2005). While a comprehensive debate of the qualitative versus quantitative nature of CA is outside the scope of this thesis, it is important to realize that, while CA has previously been viewed as quantitative, it is increasingly being accepted as a qualitative approach (Krippendorf, 2004). In fact, qualitative CA is the most common methodology employed in qualitative descriptive studies (Preece & Ghozati, 2001; Sandelowski, 2000).

Generally speaking, then, QCA aims to summarize the content of verbal or written data. Sandelowski (2000) explains that depending on qualitative content analysis is a "means to an end", where the final aim is to provide "a description of the patterns or regularities in the data that have, in part, been discovered and then confirmed by counting" (p. 338). Weber (1990) explains that QCA moves beyond counting words and examines language to classify large amounts of text into categories that represent similar significance.

The researcher used CIT content analytical procedures to analyse the content of the 470 patient stories and to develop a classification framework for experience quality. This approach was inspired by Ponsignon et al.'s (2015) study of the quality of healthcare experience. CIT studies have identified various aspects of customer attitudes and behaviours across contexts, including healthcare (see Gabbott and Hogg, 1996). CIT studies usually rely on structured interviews to gather information about a customer experience (Gremler, 2004).

The researcher contends that the written stories within his data have advantages over interviews. First, the risk that the respondent does not remember the experience well is minimized. Second, it guards against response bias while maintaining salience in the data. Stories can provide rich information about the variety of interactions that occur throughout the patient care experience.

Data analysis involves the drawing of inferences from raw data. A content analysis of these patient stories was performed using CIT procedures to identify, classify, and validate the critical dimensions and attributes of the customer experience in UK NHS hospitals, from a customer's or a patient's perspectives. The analysis used data gathered through netnography as outlined in Section 3.7.2. CIT has been used in several empirical studies as a method to identify and analyse shortcomings in service quality (Grove and Fisk, 1997; Edvardsson, 1992; Edvardsson, 1988; Bitner, 1990; Nyquist et al., 1985) and the method is especially useful when the purpose is to describe a "real world phenomenon based on thorough understanding" (Grove and Fisk, 1997, p. 67; Olsen, 1992) and also when the goal is to analyse short narratives (Czarniawska, 2004). CIT qualitative methods provide rich description of complex phenomena and identify unique or unexpected events (Yin, 1981; Eisenhardt, 1989). Further, inductive methods allow for illumination of the experience and interpretation of events by actors being studied, which gives voice to those whose views are rarely heard (Bryant and Charmaz, 2010).

Qualitative content analysis was used to identify the characteristics and nature of critical incidents and to extract general categories and subcategories from the data. Qualitative content analysis is a step-by-step process of categorization (Graneheim & Lundman, 2004), and as such, there are general guidelines that the researcher should follow to perform the analysis. For the purposes of this study, the researcher developed and used a four-step approach to analyse the data. The four basic steps involved in the process of qualitative content analysis were as follows: a) the unit of analysis; due to the nature of the data and the purpose of research, each critical incident formed a unit of analysis for this study, b) arranging the raw data; each critical incident was assigned a unique serial number, PI01, PI02, etc., so that no two incidents had the same number, c) coding; critical incidents were coded based on their nature, i.e. *'positive'* or *'negative'* as defined by the patients, and d) category extraction (and sub-categories); categories were based on who the *'actor'* was in the account of the incident, not imposed by the researcher, but as they emerged from the data. It is important to note that the descriptions of critical incidents under each category are

in the patients' language and have not been paraphrased by the researcher. Critical incidents were then grouped into subcategories based on the actor's general action, behaviour, or attitude in the incident. Given the qualitative nature of the study, I decided to create enough categories so that every critical incident could be included, according to content analysts Graneheim & Lundman (2004), and to count incidents with more than one actor category and sub-categories as the same incident to express its full meaning (ibid, 2004).

The CIT (Flanagan, 1954) has been successfully used by service industries for several years to evaluate consumer expectations, and more recently, in health research. Nurse researchers have found that CIT facilitates understanding of both nurses' roles and the interactions among nurses, patients, and other clinicians (Byrne, 2001). CIT has been used effectively in a variety of nursing research studies, including the examination of quality of nursing care (Redfern & Norman, 1999), aged and extended care nursing (Cheek et al., 1997), the practical knowledge held by expert nurses (Conway, 1998), reflective practice in mental health nursing (Minghella & Benson, 1995), and exploring consumer views of nursing care (Cox, Bergen & Norman, 1993).

Subsequent use of the method has broadened the concept of both "critical" and "incident". Byrne (2001) and Norman et al. (1992) assert that some participants construct their accounts of incidents by reducing multiple experiences. These authors argue for acceptance of these reconstructed experiences as critical incidents. Norman et al. (1992) also prefer to use the term "revelatory" instead of "critical," as it indicates to participants that the situation in question should be significant or meaningful rather than dangerous.

Rous and McCormack (2006) advocate the use of the following specific questions to help elicit "*significant events*", critical incidents:

- What preceded and contributed to the event or incident?
- What did the person or people do or not do that had an effect?
- What was the outcome or result?
- What made this action significant or insignificant?
- What could have made the action more significant?

An everyday definition of incident is "any event which is not part of the standard operation of a service, and which causes, or may cause, an interruption to, or a reduction in, the quality

of that service" (Macquarie Dictionary, 2005). This definition aligns with nursing perceptions of the term "incident" because, in the hospital setting, it could encompass a medication error, a patient fall, or a needlestick injury. Therefore, dependent on the aims of the research and the specific events being investigated, the notion of a significant event, rather than a critical incident, may be more appropriately used when interviewing health professionals, as it provides a better description of the types of examples required. Similarly, Norman et al. (1992) found that the most meaningful data were obtained when participants were allowed to recount the important activities surrounding the event, rather than when clearly demarcated incidents with a beginning and end were collected. Changing the term from critical to significant does not change the fundamental process of the procedure as described by Flanagan (1954); rather, it provides the appropriate emphasis for the recollection of events.

Previous knowledge or a background in the profession under investigation also influences the analysis of the events. It becomes impossible not to allow prior experience to inform the analysis of the events, which further enhances the importance of questioning the data and ensuring that accurate representations are derived from the events. Critical discussion with others can also help remove potential bias that may arise when researchers work within their local environment. When used carefully and accurately, prior knowledge can greatly enhance a study's findings and form the basis of informed, grounded research. Self-reflection, both during and after data collection, and careful consideration of all the data obtained, facilitate the development of new insights and knowledge. Conscious self-awareness that is identified and reported enhances rigour and facilitates openness in research.

CIT is a flexible approach that can be easily modified to suit specific settings and researchers and, as shown in this study, makes a valuable contribution to mixed-method studies.

3.8.3 Defining CIT

CIT, a well-proven qualitative research approach that relies on a step-by-step procedure for content analysis and classification of observations of human activities and their significance to the people involved, was introduced to the social sciences by Flanagan (1954) 50 years ago (Gremler, 2004). It is capable of yielding rich, contextualized data that reflects real-life experiences. Its creator, John Flanagan described it thus:

> "[…] The critical incident technique outlines procedures for collecting and analysing observed incidents having special significance and meeting systematically defined criteria". (Flanagan 1954, p. 327)

The value and efficacy of CIT are attested by research studies in a widening range of social science disciplines over 50 years. As its name suggests, the CIT involves the study of *critical incidents* – or significant instances of a specific activity – as experienced or observed by the research participants. Detailed analysis of critical incidents enables researchers to identify similarities, differences, and patterns and to seek insight into how and why people engage in the activity. People assign meanings to their experiences, and when we group collections of such meanings to make sense of the world, we engage in a kind of research, a seeking of understanding. The CIT provides "a systematic means for gathering the significances others attach to events, analysing the emerging patterns, and laying out tentative conclusions for the reader's consideration" (Kain, 2004, p. 85).

CIT findings generally support practical outcomes – often related to healthcare – and provide a knowledge base for further research. Since its introduction, the CIT method has been used in a wide range of disciplines. Specifically, this study employed CIT, which is described by Chell (1998) as follows:

> "The critical incident technique is a qualitative interview procedure which facilitates the investigation of significant occurrences (events, incidents, processes, or issues) identified by the respondent, the way they are managed, and the outcomes in terms of perceived effects. The objective is to gain understanding of the incident from the perspective of the individual, taking into account cognitive, affective, and behavioural elements" (p. 56).

Defining 'critical incidents'

Critical incidents have been used extensively in service quality and management literature. They are defined as interaction incidents, which the customer perceives or remembers as unusually positive or negative when asked about them. Customers recall them and tell them as stories (Flanagan, 1954; Bitner, 1990; Edvardsson, 1988, 1992; Strauss, 1993; Roos, 1999b).

Critical incidents are usually defined as "brief written or spoken depictions of vividly remembered events" that hold special significance for the person who experienced them (Brookfield, 1990, p. 84). Critical incidents can be associated with past or current experiences or observations that occur in everyday life or professional practice and can be positive or negative (and unpleasant) events (Ghaye & Lillyman, 2006; Green Lister & Crisp, 2007). In addition, critical incidents are unplanned, unanticipated, and uncontrolled (Woods, 1993). Green Lister & Crisp (2007, p. 24) argue that critical incidents tend to "mark significant turning points or changes in the life of a person or an institution or in some social phenomenon". For Tripp (1993), however, "critical incidents are not necessarily dramatic or obvious; most critical incidents are straightforward accounts of very commonplace events that occur in routine professional practice but are rendered critical through analysis" (pp. 24-25).

In general usage, 'critical incident' often implies a major crisis or turning point, such as the Mid Staffordshire NHS Foundation Trust incidents. Real-life incidents also serve as the focus of CIT studies. While they are not necessarily dramatic, they still represent aspects of human experience that are significant to the individual concerned. Numerous incidents – instances of a particular activity – are purposefully collected during a CIT research project. According to Flanagan (1954, p. 338), "an incident is critical if it makes a 'significant' contribution, either positively or negatively, to the general aim of the activity, and it should be capable of being critiqued or analysed".

Bitner, Booms, and Tetreault (1990) defined an incident as an observable human activity that is sufficiently complete to allow inferences and predictions about the person performing the act. A critical incident is described as one that makes a significant contribution, either positively or negatively, to an activity or phenomenon (Bitner, Booms, and Tetreault, 1990; Grove and Fisk, 1997). Thus, the objective of this study was to identify the factors that

significantly influence positive and negative customer experiences in NHS hospitals. Significant events or incidents can be gathered in various ways, but in service research, the approach generally asks respondents to tell a story about an experience they have had. For this study, the critical incidents were gathered from the NHS Choices website by applying netnography. (see Section 3.7).

Thus, CIT researchers should be expected to identify precisely what a critical incident is in the given context. Concerned about the emphasis on the word 'critical' in this technique, Norman et al. (1992) suggest 'revelatory', and others suggest 'significant' (New South Wales Nurses Registration Board, 1992) as alternatives that better describe the more everyday incidents that may be the focus of healthcare research. It appears from this discussion that, with a change of name from 'critical' to one such as 'revelatory' or 'significant', this method may be considered even more universally useful (Keatinge, 2002, p. 34).

3.8.4 The role of the CIT method in service research

Despite that, Corbin and Strauss argued that "Qualitative methods, like their quantitative cousins, can be systematically evaluated only if their canons and procedures are made explicit" (1990, p. 4). The amount of service research has exploded in the past three decades, and a variety of methods and techniques have been employed to study marketing and management issues in service contexts. One approach, CIT, has been used frequently in this research in recent years. Amydee et al. (2014) and Ponsignon et al. (2015) used the method to qualitatively explore, identify, and analyse positive and negative CE studies in healthcare. Prior to their research, much of what scholars understood about such evaluations was limited to global assessments of satisfaction or abstract concepts (e.g. service quality). The CIT method enabled the researchers to capture vivid details and to identify important themes that a literature search, quantitative research, or even in-depth interviews would not have illuminated – particularly at a time when scholars knew very little about the CE construct across different healthcare studies.

The CIT method does not consist of a rigid set of principles to follow, but it can be thought of as having a rather flexible set of rules that can be modified to meet the requirements of the topic being studied (Burns et al., 2000; Hopkinson and Hogart-Scott, 2001; Neuhaus, 1996).

> Gremler states that: "as future researchers craft their manuscripts (and reviewers review them), it is time to transition from explaining what the CIT method is and defending its usage to providing more detailed discussions of the operational procedures (e.g., data collection, data analysis) being used in the studies. The method has clearly been accepted as legitimate, so discussions in methodology sections should focus more on operational procedures and less on justifying it as being an appropriate method of enquiry" (2004, p. 77).

3.8.4.1 CIT in practice:

This section outlines the five-step CIT process established by Flanagan (1954). It also presents the author's doctoral study as an example of CIT modified and applied to research.

Selecting CIT

The researcher selected the CIT as the content analytical method for this study because:

- it supports a straightforward qualitative analytical approach that is flexible to a multi-method approach with netnography
- it offers well-proven, clearly defined guidelines for data analysis and allows modifications;
- it focuses on real-life human experiences;
- it enables the development of practical outcomes;
- it is relatively flexible; and
- it has successfully supported other healthcare studies.

However, like other researchers, the author has developed a modified approach to CIT (see Figure 3.11). Since this study is based on a holistic understanding of CE (Gentile et al., 2007), the author broadened the CIT behavioural focus to encompass behavioural, cognitive, affective, emotive, and pragmatic responses, as well as positive and negative influences.

3.8.5 CIT content analytical procedures or process

This step involves an inductive data analysis process that aims to classify *critical incidents* and identify critical dimensions and attributes of CE. These are arranged into a series of well-defined, mutually exclusive categories and sub-categories of decreasing generalizability/increasing specificity. The analysis process recommended by Flanagan is outlined below in Figure 3.10, followed by a description of its practical application to my

study. As a result of conducting the research synthesis, the researcher identified six studies using a content analytical approach that were to be considered "model" CIT studies in terms of how the method is employed and reported: Bitner, Booms, and Mohr (1994); Bitner, Booms, and Tetreault (1990); Edvardsson (1992, 2001); Keaveney (1995); Meuter et al. (2000); Fawcett et al. (2012); Hugh (2007); Kemppainen (2000), and Stauss and Weinlich (1997), and the researcher's additional review of healthcare experience quality by Ponsignon et al. (2015). According to Gremler (2004) and Zainol and Lockwood (2014), such exemplars should be used as a guide for service researchers conducting content-analytic CIT research and reporting their methods and results.

Although it is beyond the scope of this study to provide a complete description of the CIT research process, Table 3.7 includes a list of five phases to consider when employing the CIT method (Gremler, 2004). The five phases, based on Flanagan's (1954) original description of the method, are problem definition, study design, data collection, data interpretation, and report of the results (Gremler, 2004). This is also being supported by Chung and Hoffmann (1998).

Phase 1: Problem definition
Phase 2: Study design
Phase 3: Data collection
Phase 4: Data analysis and interpretation
Phase 5: Results report

Table 3.7: CIT five-step process, Flanagan (1954)

It is accepted that there are three major stages in carrying out CIT analysis: assembly of data, data analysis, interpretation and results reporting (Gilbert and Lockwood, 1999; Gremler, 2004). However, in common with other researchers (Zainol and Lockwood, 2014; Gremler, 2004), researchers have developed a modified approach to CIT, shown in Figure 3.10, and these stages are then broken down into six steps. Figure 3.10 below shows a clearly defined, systematic, and sequential analytical framework concerning the steps involved.

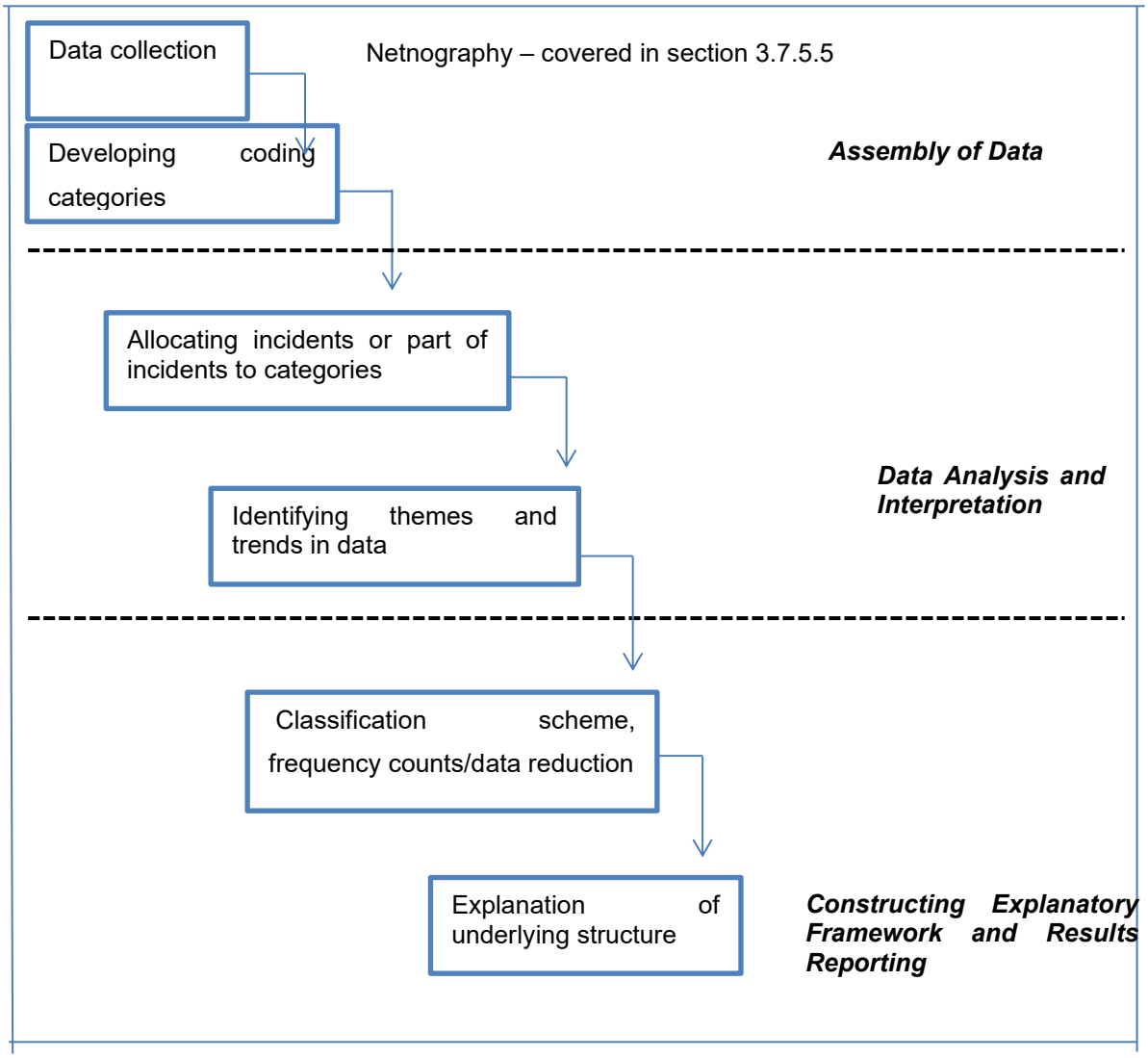


Figure 3.11: Figure 3.11: modified analytical framework in conducting CIT (Zainol and Lockwood, 2014)

As can be seen in the figure above, the three major stages are: first, collecting and assembling data (refer to section 3.7.2 on netnography); second, analysing data; and lastly, constructing a classification or conceptual framework. The six steps are: data collection, developing coding categories, allocating incidents or parts of incidents to categories, identifying themes and trends in the data, data reduction, and explaining the underlying structure. In the following sections, the researcher outlines each of these steps as specified in Figure 3.10 (Flanagan, 1954; Gremler, 2004; Zainol and Lockwood, 2014). The researcher also explains in detail how the study followed – and adapted – these guidelines.

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3.8.6 Stag 2 - Data analysis and interpretation

Following the collection of archived patient experience stories data downloaded from the NHS Choices website using netnography methods, three Microsoft Word files containing participant responses were coded: "*PART1 ID_Disliked*", "*PART1 ID_Liked*", and "*PART1 ID_Participant Advice*." Each file contained 537 participants with responses for participants *P001-P537*. However, many responses were blank and upon further review, the number of participants was reduced to 470.

The three files "*PART1 ID_Disliked*", "*PART1 ID_Liked*", and "*PART1 ID_Participant Advice*" were used to compile 470 individual participant documents. The 470 participant files were renamed with themes identified through the literature and the author's general healthcare knowledge to take advantage of the sorting feature in NVivo 11 for coding reports. Content in the coding reports is sorted alphabetically by document title, assuming the content has been coded from those documents. The attribute value identified in the netnography section data collection was used during analysis:

- NHS Foundation Trust/Non-NHS Foundation Trust: FT; Non-FT
- Acute Hospital Size: *Large; Medium; Small; Specialist* (children)
- Participant: P*xxx*

The category titles are shown in Appendix A of this thesis.

The 470 participants in this study provide rich details relating to the research questions. The researcher's professional expertise and discernment, in relation to these responses, were useful for further relating them to the research questions and for interpreting, consolidating findings, and drawing conclusions. Multiple coding reports (three main nodes with 128 sub-categories) provide coded responses from 470 participants.

Node titles are simplified to aid in interpretation; nodes can be retitled and merged into broader categories. Coding is not exhaustive, and frequency counts may change if additional category merging or coding is performed. Data from within the tables can be used to produce supporting charts. Tables that directly answer the thesis research question may be used in their entirety.

The coding process for qualitative research is logical and intuitive as the researcher utilizes inductive reasoning within three cyclical phases of coding. Inductive reasoning (Latin: a posteriori) starts with observation of parts of the whole or units and ends with generalizations (bottom up). Deductive reasoning (Latin: a priori) starts with generalizations and ends with parts of the whole or units (top down). Terminology is unique within qualitative methodologies for each phase of coding.

The first or initial phase is defined as “open coding” or “first pass” line-by-line coding of the data to develop descriptive themes and assign category titles. This phase includes “in vivo” coding or selection of specific words and phrases from the content for titling purposes. The second phase is defined as “axial coding” for exploration of patterns and emerging themes. In this phase, the researcher begins to merge, cluster, retitle, and eliminate categories. The third phase is defined as “selective (or substantive) coding”, which is the deepest level of analysis. The researcher interprets and synthesizes meaning. Coded content is compared, new themes may be created, and additional merging, clustering, and elimination of categories may be necessary.

The three phases are cyclical and repetitive through data collection until redundancy occurs. The coding in this study is a mixture of all the above. The researcher's analysis will continue with the process of reduction, as the author relates the coding directly to each research question in the final write-up. This may involve using inductive and deductive reasoning, editing or creating new titles, and/or merging some of these sub-categories in the tables into broader categories. In total, 4,949 coding items were generated for customer experience dimensions and attributes.

3.8.6.1 Coding strategy

The content analysis process was performed following standard CIT procedures (Keaveney, 1995; Gremler, 2004). It can be broken down into three main phases: coding, category development, and category validation. These phases were undertaken over 12 months. CE dimensions and attributes were informed by organizing each coded item hierarchically in terms of whether it described a positive or negative evaluation and whether it involved a direct, indirect, or unexpected encounter (Sampson, 2012; Gentile et al., 2007; Lemke et al., 2011; Parasuraman et al., 1998). NVivo 11, a software package for qualitative data analysis, was used to support the coding process. Additionally, the researcher identified themes related

to dimensions, attributes, and outcomes in the data and coded them accordingly. In general, the researcher's coding strategy is to provide reminders across various nodes rather than attempt to code every line of text to every possible node. The researcher also codes for context, so he often captures more content than might seem necessary; this saves the researcher time as there is no need to look for context when the final analysis is made from the NVivo 11 reports.

3.8.6.2 Unit of analysis

The feedback in stories can include judgments about a series of separate interactions as well as an evaluation of the overall experience. This makes the term "significant events of incidents" ambiguous, as it may refer either to experiences based on discrete interactions or to the overall experience (Keaveney, 1995). As the researcher's aim was to capture all the dimensions and attributes of the customer experience that are clearly described within each story, he determined that a story is a significant event or incident comprising individual data items that inform the dimensions and attributes of CE and the negative and positive experiences of the service. Therefore, the three parent nodes were created in NVivo 11 to reflect the categories described in the above section.

- Advice
- Disliked
- Liked

Corresponding Nodes in NVivo 11

The researcher became familiar with the data by re-reading the text, as suggested by King et al. (2004). Following the same author (ibid.), the researcher closely examined the data and, with the help of NVivo 11, not only developed emergent codes but also created causal linkages between the codes and the themes. Regarding the definition of the themes, the researcher received valuable guidance from supervisors to ensure that their definitions would ultimately assist in the exploration of the data and successfully address the research questions (ibid.).

The following figures present the corresponding codes and child nodes in NVivo 11. These tools helped the researcher investigate the relationships in the stories. These working screens are an illustrative example of how the researcher managed the data and preserved the

emerging ideas. For example, Figure 3.11 illustrates how the researcher categorized the "Liked" policies and procedures (liked) and the "wait time" subcategory. Accordingly, separated nodes were created for each category. This figure presents the processes and procedures sub-dimensions detected in the literature review and the patient stories.

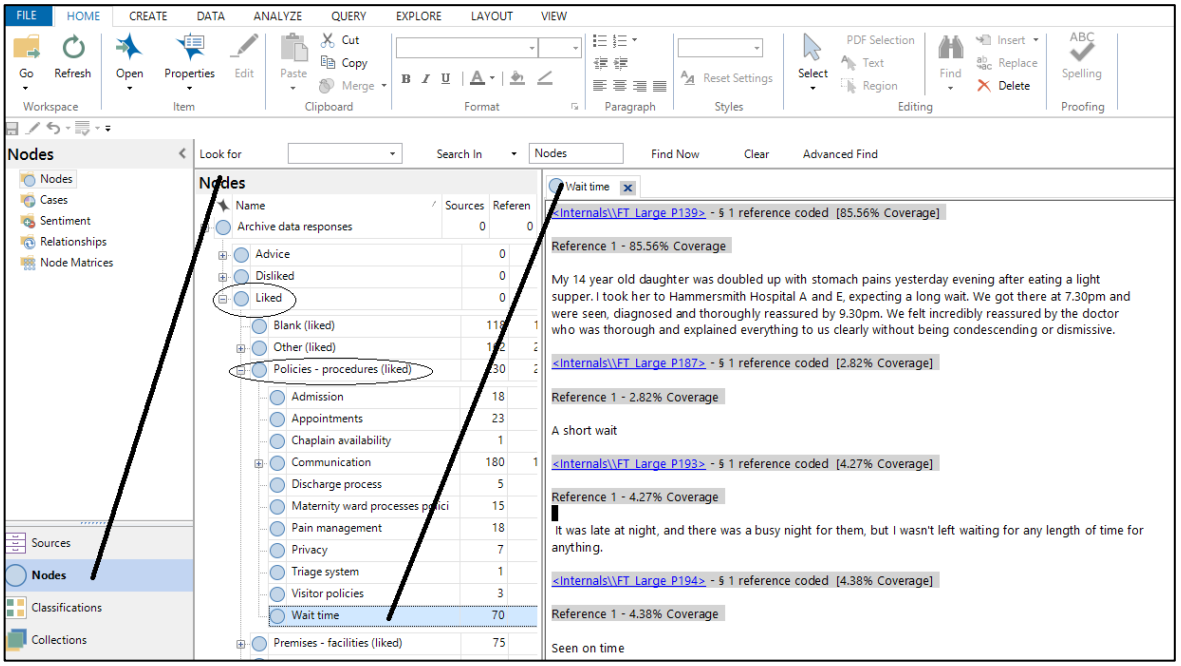


Figure 3.11: Working Screen in NVivo 11 of Liked/Policies-procedures (liked) category/Wait times

Source; Author's own

The following working screen (Figure 3.12), presents the "Disliked" Policies-procedures (disliked)/wait times categories. The researcher created child nodes to further analyze the significant events of incidents. Similar nodes and child nodes were created for the "Advice" Policies and procedures on waiting time

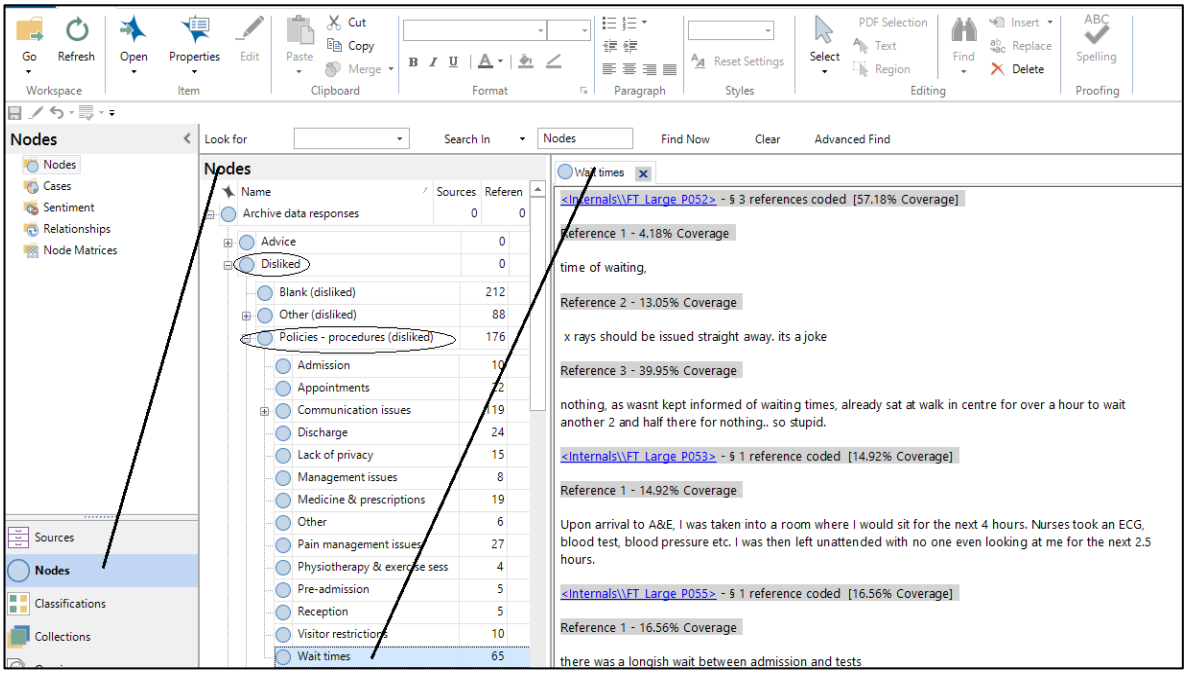


Figure 3.12: Working Screen in NVivo 11 of Dsliked/Policies-procedures (disliked) /Wait times

Source; Author's own

Coding reports

Multiple coding reports (node reports) exported from NVivo 11 have been created and organized into condensed reports for the author's and the reader's convenience (see Appendix A). In this study, up to 128 individual coding reports have been compiled into three reports, each with multiple subcategory sections. Headers for each sub-category section are provided in each coding report to help the researcher or reader identify sub-categories on each page as they read. The three coding report titles are shown below.

1. Advice
2. Disliked
3. Liked

The content in the three coding reports, sorted alphabetically by document title, has been coded from those documents. All node titles are shown in Appendix A of this thesis under the title Node *Listing.docx.*

3.8.6.2 Understanding references and percentages in coding reports:

When reading the coding reports, one can notice the insertion of references and percentages at the end of each appendix's document title; NVivo 11 automatically inserts these numbers. The percentages provide a sense of proportionality, indicating that "a lot" or "a little" was coded from the document into the category. The phrase "references coded" relates to the number of times text was selected and coded from the document; the phrase "*x.xx*% coverage" states the percentage of the document each selection (reference) represents.

Example 1:

The example excerpt below is taken from the coding report "*Liked or Satisfactory comments (liked)*". Three text selections (references) are coded from participant "FT_Large_P050," representing 90.70% (rounded) of the file content. The text coded is separated into reference 1 (7.04%), reference 2 (60.55%), and reference 3 (23.12%), equal to the total coverage (90.70% rounded)*:*

"Liked/Satisfactory comments (liked)"

Name: Satisfactory comments (liked)

<Internals\\FT_Large_P050> - § 3 references coded [90.70% Coverage]

Reference 1 - 7.04% Coverage

"Nothing – all was excellent" [Participant 042]

Reference 2 – 60.55% Coverage

"I was very well looked after during my stay. The care was delivered professionally and sympathetically. I could not fault the excellent care in the Isolation unit, and was put at ease knowing my needs were being met in a well-managed unit." [Participant 132]

Reference 3 – 23.12% Coverage

"I was a visitor to the city when I became ill, and was highly impressed with their healthcare." [Participant 372]

Context is especially important for providing meaning in qualitative analysis when reading the reports. Hence, the researcher focused *on content related to the node title, understanding that some of it* may provide context. Participant responses were often assigned to incorrect categories, and this content was recoded to the appropriate category. For example, the response "*complaint during stay and after discharge fell on deaf ears*" for participant "*NonFT_Medium_P021*" appeared under the "*Advice*" category. This comment was coded as "*Disliked*" instead of "*Advice*."

There are many ways to interpret the data, and coding is a subjective process; therefore, the coding is not exhaustive. In this study, categories had multiple meanings and content was coded to multiple nodes when relevant. However, the researcher did not code everything *everywhere, or it would become burdensome to read and analyse,* since connections can be made throughout. For example, comments pertaining to "*Staff (liked)*" largely overlap across three sub-categories ("*Behaviour and attitudes*", "*Care*", and "*Competence*"); the researcher did his best to separate the content, but much of it has been coded to all three sub-categories. Constant comparison was integrated into the analytical procedure. Constant comparison is a process of constantly "…comparing data with data, data with category, category with category, and category with concept" (Charmaz, 2006, p. 187) or how Glaser and Strauss (1967) put it – "…comparing incident with incident" (p. 108). This suggested that when theoretical saturation had been reached, i.e. analysing additional stories would not have led to further changes to the framework, and that the framework was complete (Miles and Huberman, 1994). This process helped reduce bias in this research (Corbin & Strauss, 1990, p. 9) and enhanced the inductive creation of concepts and categories (Charmaz, 2006, p. 187).

Comments coded to "*Liked*" and "*Disliked*" sub-categories have also been coded to two nodes:

"*Liked/Satisfactory comments (liked)*" and "*Disliked/Unsatisfactory comments (disliked)*".

This is helpful in seeing the overall picture, in that more participants were satisfied than unsatisfied.

	Liked/Satisfactory comments (liked)	*Disliked/Unsatisfactory comments*
Number of responses	*363*	*249*
Percentage of total responses	*77%*	*53%*

There were many blanks in the responses. These were coded as they appeared in the original files, as it is important to note that many of the respondents did not feel compelled to provide responses in one or more of the three main categories. This does not have any implications for this study because not all patients are required to provide their experiences in all three boxes:

	Liked	Disliked	Advice
# of total responses	118	212	211
Percentage of responses (470)	25%	45%	45%

Percentages above reflect comments coded to appropriate sub-categories. (See "Coding Strategy" on section 3.8.6.1 of this thesis.) The count for "*Blanks*" was not changed, even though coding from other questions may have subsequently provided responses in those areas.

All node listing titles of coding reports are shown below, and notably they are parallel or consistent with narrative studies' categories, dimensions or attributes of CE (Lemke, et al., 2011; Parasuraman et al., 1998; Durragila et al., 2008; Klaus and Maklan, 2011; Gentile et al., 2007). A total of three coding reports, with 128 subcategories and titles, were sorted alphabetically, as shown in Appendix A.

3.8.6.3 Node layers:

There are up to four node layers in the files in Appendix A, "Node listing.docx", and Appendix B and C ", *Frequency Counts – Mswaka.xlsx*". The first layer is the parent node title; the second layer contains subcategories emerging from the first layer; the third layer contains nodes emerging from the second layer; and the fourth layer contains nodes emerging from the third layer. (See excerpts shown below from "*Node listing.docx*" and *"Frequency Counts – Mswaka.xlsx*" for the node "*Liked/Policies – procedures (liked)/Communication*".)

Node listing excerpt from "Liked/Policies – procedures (liked)/Communication":

Liked (6 sub-categories)

- …
- Policies – procedures (liked) (11 sub-categories)

- …
- Communication (11 sub-categories)
    - *Chief executive*
    - *Doctors and consultants*
    - *Family*
    - *Honesty*
    - *...*

Frequency count table excerpt from "Liked/Policies – procedures (liked)/Communication":

NODE REPORTS (Titles alphabetical)		
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**
LIKED		
Policies - procedures (liked)	230	49%
Communication	180	38%
Chief executive	*1*	*<1%*
Doctors and consultants	*82*	*17%*
Family	*53*	*11%*
Honesty	*5*	*1%*
...	...	...

3.8.6.4 Multiple coding:

The process of coding content to more than one node is called "multiple coding" (Gremler, 2004). This is due to the nature of responses from a single document having meaning in more than one category. The individual participant document is only counted once within the node; many participants may, of course, provide a variety of responses to a single question, and the same content or different selections of text from a single document can be coded to multiple nodes.

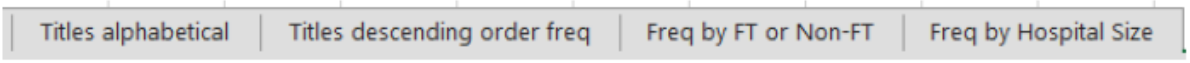
The success of a research project is judged by its products. Except where results are presented only orally, the study design and methods, findings, theoretical formulations, and conclusions of most research projects are judged by publication. According to Gremler, service researchers have not been very prudent in the final phase of the CIT process – describing their application of the CIT method in their publications (Gremler, 2004). For example, more than 38% of the CIT studies in the sample do not bother to report any type of reliability assessment, and nearly 63% of the studies provide little (if any) description of what constitutes a critical incident – the key unit of analysis in most of these studies. Service researchers employing CIT need to be more diligent in describing their methods, and

reviewers of CIT manuscripts need to be more demanding in requiring such details (Gremler, 2004). Many service researchers employing the CIT method may be unsure about what information to report, as there is no clear consensus on what is appropriate to mention. As a researcher employing the CIT method, he was well served by revisiting Flanagan's (1954) original article and studying it carefully.

3.8.6.5 Coding reports

Frequency counts spreadsheet:

The Excel file Appendix B and C, "*Frequency Counts – Mswaka.xlsx*" contains four spreadsheets identified by tabs at the bottom of the worksheet titled "*Titles alphabetical*", "*Titles descending order freq*", "*Freq by FT or Non-FT*" Appendix B, and "*Freq by Hospital Size*" Appendix C.



The first spreadsheet tab titled "*Titles alphabetical*" is organized alphabetically by node titles (Column A). Frequency counts in the example table below, Table 3.8, are shown in Column B, and percentages are shown in Column C; each column is based on 470 individual participant documents. An example is shown below, and a detailed one is in Appendices B and C.

The second spreadsheet tab titled "*Titles descending order frequency*" is organized by frequency counts (Column B) in descending order. Frequency counts are shown in Column B, and percentages are shown in Column C; each column is based on 470 individual participant documents.

A	B	C
NODE REPORTS (Titles descending order of frequency)		
ARCHIVE DATA RESPONSES	Documents (470)	% of 470
LIKED		
Policies – procedures (liked)	230	49%
Communication	180	38%
Patient – during stay	110	23%
Doctors	82	17%
Family	53	11%
Shared decision-making	30	6%
Post-care & follow-up	26	6%

Table 3.8: Titles descending order frequency (sorted by Column B) "Liked/Policies - procedures (liked)/Communication"

Tables with titles in descending order of frequency are helpful to quickly identify nodes with the most or least responses. This is especially useful for tables with many rows. Cut-off points were used to discuss higher percentages. However, the author was aware that lower percentages may reveal outliers of interest that can be included in findings and recommendations for further study, for example, honesty and management.

Excerpts Table 8.9 and 3.10 provide frequency counts filtered by two attributes: "*Freq by NHS Foundation Trust (FT) or Non- Foundation Trust (Non-FT)*" and "*Freq by Hospital Size*". Since the archived patient stories data is organized or identifiable by hospital name and foundation trust status, and hospital size, the researcher considered it insightful to analyse the nodes or categories by the above attributes.

For example, Table 3.9 on "*Freq by FT or Non-FT*" frequency counts by Foundation Trust ("*FT*") or non-Foundation Trust ("*Non-FT*") based on 228 "*FT*" documents and 242 "*Non-FT*" documents are shown in Columns D and F. A formula has been inserted into Column H to check that the frequency counts in Column B minus Column D minus Column F are equal to zero. Percentages for "*FT*" are found in Column E (% of 228) and percentages for "*Non-FT*" are found in Column G (% of 242). Columns D-H are colour-coded to distinguish them from the main Columns A-C. Columns D-E ("*FT*") are colour-coded in blue; Columns F-G

("*Non-FT*") are colour-coded in green; and Column H ("*Check #Docs*") is colour-coded in grey.

A	B	C	D	E	F	G	H
NODE REPORTS (Titles alphabetical)			FT	FT	Non-FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	Documents (470)	% of 470	228	% of 228	242	% of 242	Col B-D-F=0
LIKED							
Blank (liked)	118	25%	53	23%	65	27%	0
Other (liked)	162	34%	85	37%	77	32%	0
Emotional support - sense of safety	102	22%	58	25%	44	18%	0
Everything liked (nothing disliked)	88	19%	46	20%	42	17%	0
Leaving - getting out - going home	5	1%	1	0%	4	2%	0
Policies - procedures (liked)	230	49%	116	51%	114	47%	0
Admission	18	4%	7	3%	11	5%	0
Appointments	23	5%	11	5%	12	5%	0
Chaplain availability	1	<1%	0	0%	1	0%	0

Table 3.9: Partial table for Appendix B "Freq by FT or Non-FT"

Excerpt Table 3.9 "*Freq by Hospital Size*" (see Appendix B). Frequency counts by hospital size are based on 118 "*Large*" hospitals, 148 "*Medium*" hospitals, 178 "*Small*" hospitals, and 26 "*Specialist (children)*" hospitals, as shown in Columns D, F, H, and J.

A	B	C	D	E	F	G	H	I	J	K	L
NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	Documents (470)	% of 470	118	% of 118	148	% of 148	178	% of 178	26	% of 26	Col B-D-F-H-J=0
LIKED											
Blank (liked)	118	25%	28	24%	24	16%	59	33%	7	27%	0
Other (liked)	162	34%	37	31%	57	39%	62	35%	6	23%	0
Emotional support - sense of safety	102	22%	24	20%	35	24%	39	22%	4	15%	0
Everything liked (nothing disliked)	88	19%	24	20%	32	22%	29	16%	3	12%	0
Leaving - getting out - going home	5	1%	0	0%	4	3%	1	1%	0	0%	0
Policies - procedures (liked)	230	49%	57	48%	78	53%	81	46%	14	54%	0
Admission	18	4%	3	3%	11	7%	3	2%	1	4%	0
Appointments	23	5%	6	5%	8	5%	7	4%	2	8%	0

Table 3.10: Partial table for Appendix C "Large", "Medium", "Small", and "Specialist"

A formula has been inserted into Column L to check that the frequency counts in Column B minus Columns D, F, H, and J are equal to zero. Percentages are found in Columns E (% of 118), G (% of 148), I (% of 178), and K (% of 26). Columns D-L are colour-coded to distinguish them from the main Columns A-C. Columns D-E ("*Large*") are colour-coded in blue; Columns F-G ("*Medium*") are colour-coded in pink; Columns H-I ("*Small*") are colour-coded in green; Columns J-K ("*Specialist*") are colour-coded in purple; and Column L ("*Check #Docs*") is colour-coded in grey.

3.8.6.6 Observations and limitations

Guba & Lincoln (1994) state that in qualitative studies, reports should be read and evaluated qualitatively rather than relying on frequency counts. Frequency counts point the researcher in directions, but they should be used with discretion (Gremler, 2004). The tables were based on qualitative coding of multiple open-ended questions and were open to the researcher's further interpretation, as data were selected from the tables to produce supporting charts. Proportionality is helpful with frequency counts/percentages if it is observed that "a lot" or "a little" was coded to various categories.

3.9 Ethical considerations

As already mentioned, formal ethics approval (Approval RD1) of the project was sought and obtained from the University of Gloucestershire's Ethics Committee, early in the researcher's candidature, to ensure that the research satisfies the guidelines and minimum requirements in relation to social science ethics, including informed consent, beneficence, merit, and respect. The researcher maintained a keen sensitivity to and respect for the research participants' status throughout the study. Ethical issues are recognized within this study, and the research will abide by the principles outlined in the University of Gloucestershire (2008) Ethics Handbook and the CIM Ethical Guidelines.

3.9.1 Access

The main ethical issue the researcher considered was the status of the posts or reviews he intended to collect. The Economic and Social Research Council (ESRC) Ethics Framework (2010) holds that forums or spaces on the Internet and web "that are intentionally public" may be considered "in the public domain". Therefore, they do not expect researchers to use these forums to seek informed consent from the authors of sampled posts. Data in the form of patient reviews is available on an accessible public-domain website, NHS Choices. In a similar vein, Haggerty (2004) states that many researchers view online data as "public pronouncements, comparable to letters to the editor, and as such amenable to academic analysis without the necessity of ethical review" (p. 405). Further, the shift to focus on the reviews that materialized on the NHS Choices patient reviews platform rather than on individual participants complies with the code of ethics developed for online research (AoIR, 2002; BERA, 2011). The researcher followed these guidelines and confirmed that, as the

study does not involve the participation of patients or third parties, it would be unnecessary to seek ethical approval for the research.

3.9.2 Confidentiality and non-attribution

The protection of participants' privacy and identity is of utmost importance in this study. The majority sentiment among academics is that "respondents should not be identifiable in print" and that they should not suffer any harm or embarrassment as a result of the research (Punch, 1998, p. 175). Given that the researcher did not intend to interview patients or hospital staff in NHS England acute hospitals, approval from the NHS Local Regional Ethics Committee (LREC) was not required. The purpose of the LREC Review is to "protect the dignity, rights, safety and well-being of all actual or potential research participants" (Central Office for Research Ethics Committee, 2003) and "while still preserving the value of unobtrusive observation" (Kozinets, 2002, p. 66). The lack of consent argument is further substantiated because these are "asynchronous reviews on the Internet, often using a pseudonym, where people can post relatively anonymous messages". Therefore, participants were not asked for their names or other personal identification information. Further, the data they provided is not attributed in any manner which might threaten their anonymity or pseudonymity. By-name references have been removed where possible.

3.10 Research quality and validity

To be credible and worthwhile, all research should be rigorous. The rigour of qualitative research has been the subject of ongoing discussion in the literature (see, for example, Denzin and Lincoln, 2005; Boeije, 2010). Qualitative research has been criticized as lacking generalizability by its counterpart, the quantitative mainstream. The quantitative tradition believes that research should rely heavily on reliability and validity to ensure its replicability and generalizability. Reliability refers to the consistency of measures, whereas validity is concerned with the extent to which it reflects the social phenomena being observed. Therefore, the aim was to raise confidence in the overall research design and the research findings (Miles & Huberman, 1994, p. 263) for the reader and for the researcher (Creswell & Miller, 2000). The terms reliability and validity are historically associated with the positivist quantitative research paradigm (Golafshani, 2003, p. 597) and are "…criteria in establishing and assessing the quality of research for the quantitative researcher" (Bryman & Bell, 2007, p. 410). Various qualitative researchers agreed that if researchers want to use

the terms validity and reliability in qualitative research, the definitions and criteria should be overhauled (Bryman & Bell, 2007; Hammersley, 1992; LeCompte & Goetz, 1982) or changed completely (Lincoln & Guba, 1985). Table 3.12 shows four different approaches to "establishing and assessing the quality" (Bryman & Bell, 2007, p. 410) in qualitative research.

The issues of validity and reliability in research are well documented. However, these traditional concepts of reliability and validity do not fit perfectly into the qualitative research landscape. Following Parker's (2012) stance, qualitative research operates in a distinct domain with distinct missions and agendas. Qualitative research seeks to produce credible knowledge of interpretations on organization and management accounting processes and understandings, with an emphasis more on uniqueness and contexts. In a similar vein, some social scientists (Kalof, Dan, and Dietz, 2008; Bryman 2012) explain that reliability and validity per se cannot be practically used as criteria to assess qualitative research. Some alternative terms have been used to sensitize reliability and validity to the specific nature of qualitative research. There are four criteria of research trustworthiness developed by Lincoln and Guba (1985) and Guba and Lincoln (1989) which have been widely cited in the social science research method literature (e.g. Kalof, Dan, and Dietz, 2008; Bryman, 2012) to evaluate the quality of qualitative research: *credibility*, which parallels internal validity; *transferability*, which resembles external validity; *dependability*, which parallels reliability; and *confirmability*, which resembles objectivity.

3.10.1 Credibility

Credibility in qualitative research is defined as the extent to which the data and data analysis are believable and trustworthy (Lincoln & Guba, 1985). Credibility is analogous to internal validity, that is, how research findings match reality. However, according to the philosophy underlying qualitative research, reality is relative to the meaning that people construct within social contexts (Bryman & Bell, 2007). The careful selection of a case organization (NHS Choices and NHS hospitals) is considered the first practical step towards credibility in case study research.

3.10.2 Transferability

Research findings are transferable or generalizable only if they apply to new contexts beyond the study context. Transferability is analogous to external validity, that is, the extent to which findings can be generalized. Wahyuni states, "*Transferability* refers to the level of applicability into other settings or situations" (2012, p. 77). *Generalizability* refers to the extent to which one can extend the account of a particular situation or population to other persons, times, or settings than those directly studied (Maxwell, 2002). As suggested by Lincoln and Guba (1985), a rich and thick explanation of research sites and characteristics of case organizations should be provided to enhance transferability. While it is certain that the data from a qualitative study is not reproducible, it is not impossible to apply a qualitative study in a different setting. With some careful adjustments to the setting, such research findings, drawn from rich descriptions of the current state of play of observed practices, may be transferred to other studies of other industries within or across jurisdictions. Seale (1999) advocates that "transferability is achieved by providing a detailed, rich description of the settings studied to provide the reader with sufficient information to be able to judge the applicability of the findings to other settings that they know" (p. 45).

Since this study adopts a single-case study approach, the process of generalization that aptly matches it is "inferential generalization", which is best explained as generalizing from the context of the research study itself to other settings or contexts (Ritchie and Lewis, 2003). Therefore, it is a requirement that the researcher documents and justifies the methodological approach and describes, in detail, the critical processes and procedures that have helped him to construct, shape, and connect meanings associated with those phenomena. Further, throughout this study, the researcher was sensitive to potential biases by remaining conscious of the multiple interpretations of reality.

In qualitative research, generalizability is sometimes simply ignored in favour of enriching the local understanding of a situation. However, the researcher provided a rich, thick description of the study such that the data and description speak for themselves, enabling readers to appraise the significance of the meanings attached to the findings and make their own judgment regarding the transferability of the research outcomes. The thesis provides a detailed description of the organizational context of NHS hospitals in Chapter 1 to assist readers interested in making use of the study outcome in other situations, for example, using

it for other NHS hospitals in other countries, such as NHS Scotland, NHS Wales, and NHS Northern Ireland. Hence, the issue of generalizability rests with the reader of the study, depending on how close the researcher's and the reader's interpretations of the contexts are. It is a matter of judgment of the context and phenomena found, which allows others to assess the transferability of the findings to another setting (Ritchie and Lewis, 2003, p. 268). In conclusion, the findings suggest that this research is transferable to other contexts, for example, other sectors in the services industry.

3.10.3 Dependability

Dependability corresponds to the notion of reliability, which promotes replicability or repeatability. According to Merriam (1998), it refers to the extent to which research findings can be replicated (p. 205) with similar subjects in a similar context, such as the examples mentioned above. It emphasizes the importance of the researcher accounting for or describing the changing contexts and circumstances that are fundamental to the consistency of the research outcome. Dependability concerns, considering all the changes that occur in a setting and how these affect the way research is being conducted. Wayhuni (2012) asserts that:

> "dependability can be achieved by a detailed explanation of the research design and process to enable future researchers to follow a similar research framework. It should be noted that the application of the research model by a future researcher is not necessarily targeted at getting a similar result. Enhancing dependability can be achieved by presenting detailed and step-by-step explanations of the research processes undertaken, as well as providing the main instruments used to gather empirical data, e.g. the list of interview questions" (p. 77).

Further, throughout the process of this study, the researcher achieved this by providing a detailed research design, detailed data reports, and NVivo 11 for data management.

3.10.4 Confirmability

Confirmability refers to the extent to which others can confirm the findings to ensure that the results reflect the understandings and experiences from observed participants, rather than the researcher's own preferences. It is analogous to objectivity, that is, the extent to which a researcher is aware of or accounts for individual subjectivity or bias. Seale (1999) argues that auditing could also be used to establish confirmability, in which the researcher provides a methodological self-critical account of how the research was done (p. 45).

In addition to triangulation methods, Lincoln and Guba (1985, p. 317) suggest using an 'inquiry audit' to enhance conformability. Documentation on data and progress of research, therefore, should be carefully kept in the form of research memos and interim summaries as parts of the research workbook. For this research, NVivo 11 archives serve to provide an audit trail that enables examination of both the research process and research outputs by tracing the step-by-step course of the research in a retrievable form, so that it can be made available when findings are challenged.

3.10.5 Rigour

To further enhance the study's rigour, the researcher provides "thick descriptions" within the analysis and discussion of study findings. This entails providing quotes that support each point made and acknowledging reflexivity. Further, as noted by several authors, a thick description of human behaviour is one that entails not only relaying an observation but also explaining it within its context, so that it bears more meaning to an outsider (Cromdal, Osvaldsson, & Persson-Thunqvist, 2008; Luhrmann, 2001; Wears & Karsh, 2008). Additionally, according to Holloway (1997), a thick description provides a detailed account which delineates the social and cultural patterns in the study context and demonstrates their connection to the researched phenomenon. Furthermore, the decision to conduct manual analysis, in addition to computerized analysis, ensured that the researcher could analyse data segments within their context, thus maintaining the integrity of participants' lived experiences. Table 3.10 outlines the criteria used for each phase or component of the present study process and design in relation to rigour in qualitative research.

Stages	Actions taken
Scope and purpose	Clear outline of research rationale and purpose
Systematic literature review	Study interwoven with existing knowledge (narrative review) Study positioned in research gaps
Design	Triangulation of interpretive research netnography and CIT, to maximize richness of data Single data collection method and form: online patient stories/reviews
Analysis	Quotes given as evidence of claims Thick description Content analysis Clear exposition of how interpretation led to conclusions
Reflexivity	The reflexivity of my role as researcher explained Acknowledgement of my self-awareness/insight Explanation of my work background within healthcare in NHS hospitals The emergent, constantly evolving nature of fieldwork techniques, e.g. adjusting numbers of participants or sample size
Ethical dimensions	Formal ethics approval committee RD1 obtained My commitment to integrity, honesty, transparency, equality, and mutual respect in relationships with participants Fair dealing with all research participants Recording of dilemmas met and how they were resolved in relation to ethical issues Documentation of how autonomy, consent, confidentiality, and anonymity were managed
Relevance and limitations of the study	Analysis interwoven with existing theory and other relevant explanatory literature drawn from similar settings and studies Discussion of how explanatory propositions/emergent theory may fit other contexts Limitations/weaknesses of the study clearly outlined: limitations inherent in context-specific formats Results/conclusions supported by evidence provides new insights and increases understanding Significance for current policy and practice outlined Assessment of value/empowerment for participants Outlines further directions for investigation Demonstrates that aims/ purposes of research were achieved

Source: Adopted from Walsh & Downe, 2002

Table 3.11: Summary criteria for rigour in qualitative research

3.11 Chapter summary

In this chapter, several research paradigms were reviewed, and the rationale for conducting this research within the interpretivist paradigm was explained. Justifications have been given for using a qualitative approach. Reasons were provided for using archived participant narratives as data sources. This is the first customer experience study to combine the two new research methods, netnography and CIT, in a single study. This study has demonstrated that netnography and CIT are suitable methodologies for sensitive research topics, such as patient experiences, where consumers are difficult to recruit as informants. The combination of the two methods enables the researcher, in an unobtrusive and covert way, to gain deeper lived experiences and insights into customers' and patients' opinions, motives, worries, and concerns.

Then, the CIT content data analysis step-by-step procedures were discussed to analyse the content of 470 stories and to develop a classification conceptual framework for CE. That is, by dissecting real patient stories related to both positive and negative CE, the researcher gained insight into the phenomena driving customer perceptions of experience and the underlying dimensions and attributes that constitute the customer experience. In this chapter, the role of researcher values was critically reflected upon. To address and to mitigate ethical issues, a University ethics guide (2014) was used. To increase research quality, reliability, and validity of data selected, rigour strategies were developed.

Exploration of phenomena such as CE requires a research methodology that can capture both unique subjective and procedural qualities of services (Bateson, 1985; Edvardsson, 1992; Grove and Fisk, 1992a; Shostack, 1977). The method employed to investigate a service's nature should enable exploration of various aspects of the customer's direct, indirect, and independent service encounters with the firm. CIT meets this criterion. It is not surprising, then, that CIT has been employed to investigate customers' responses to services over a variety of applications (e.g. Bitner, Booms, and Mohr, 1994; Bitner, Booms, and Tetreault, 1990; Bitner, Nyquist, and Booms, 1985; Edvardsson, 1992; Gremler and Bitner, 1992; Gremler, Bitner, and Evans, 1994; Hoffman, Kelley, and Soulage, 1995; Hoffman, Kelley, and Rotalsky, 1995; Keaveney, 1995; Olsen, 1992; Schmidt and Sapsford, 1995; Strauss and Hentchel, 1992).

Interpretation of the classified data aims to provide insights regarding the frequency and patterns of factors affecting a complex phenomenon. As such, CIT is both inductive and subjective in nature (Edvardsson, 1992), yet, when correctly administered, it can produce data that is qualitatively and quantitatively valuable. The method is particularly useful when the purpose of the research is to explore a topic that has been sparsely documented and/or to describe a real-world phenomenon such as CE with a thorough understanding (Bitner, Booms, and Tetreault, 1990, p. 73).

CIT relies heavily upon content analysis and has many of the same advantages and disadvantages. Content analysis has been widely used in advertising and marketing research (Kassarjian, 1977; Kolbe and Burnett, 1991) to generate an accurate and potentially in-depth record of events. Yet content analysis has also been criticized based on the validity and reliability of the categories it sometimes generates (Kolbe and Burnett, 1991; Weber, 1985). Similarly, CIT may successfully extract rich, specific accounts of phenomena, yet to enhance the credibility of its findings, its performance must meet data-gathering and interpretation standards. When so conducted, CIT has been both reliable and valid (Andersson and Nilsson, 1964; White and Locke, 1981).

Of particular interest to the present study was the subject's ability to identify the critical underlying dimensions and attributes of CE, and the significant factors that influence positive and negative CE in the context of NHS England hospitals. The major contributions of CIT studies are the groupings and categories developed during the classification procedure, as discussed earlier. The groupings and categories that the researcher identified are depicted in the next chapter. The information provided in this chapter is analysed and discussed for the insights it offers into the research questions posed earlier in Chapter 4.

CHAPTER 4: FINDINGS

4.1 Results of the study

During the data collection and analysis phases, the documented stories of 470 patients and families were gathered, resulting in a total of 3,957 significant positive and negative events. Overall, each respondent's narrative covered one to eight incidents, with the majority describing five on average, which they considered problematic during their stay in or visit to the hospitals. According to Lockwood (1994), 50 incidents will allow the researcher to proceed with the category-building stage, whereas 100 or more incidents will yield more reliable categories. The development of categories is a subjective process seeking 'natural' groups within the incidents through an iterative process of careful reading and sorting the data until it makes sense to form particular groups (Lockwood, 1994). Each category and sub-category is given a detailed description so that others can understand. Therefore, from the identified nodes during analysis (see Section 3.8), 161 categories are formed following a categorization classification process to describe the essence of the attitude about the incidents reported.

The main outcome of this is to address the research objectives:

- To identify the underlying critical dimensions and attributes of customer experience that have a significant influence on positive customer experience in the NHS England hospitals context.
- To identify the underlying critical dimensions and attributes of customer experience that have a significant influence on negative customer experience in the NHS England hospitals context.
- To develop a holistic conceptual or classification framework that constitutes the construct of customer experience in the NHS England hospitals context.

The main outcome of this study is a classification or conceptual framework for customer experience in NHS hospitals, comprising 30 main categories (dimensions) and 131 sub-categories (attributes). Table 4.1 presents the main categories of the customer experience framework, as well as the frequency of positive and negative evaluations, indicating whether the patient had a positive or negative experience (satisfactory or unsatisfactory outcome)

with the hospital service encounters. The detailed nodes and categories classifications are in Appendix A.

4.2 Dimensions and attributes of CE

The researcher combined common elements for categorization from the literature reviews' studies (Chahal and Dutta, 2014; Ponsignon et al., 2015; Lemke et al., 2011; Gentile et al., 2007; Duggirala et al., 2008; Parasuraman et al., 1998; and others) and from patient experience frameworks produced by the Institute of Medicine (2001), Picker Institute (2008), and NICE (2011). Table 4.1 delineates different categories or dimensions of customer experience and distinguishes between 'relational encounters or interactions' (also known as direct encounters or interactions), 'functional encounters or interactions' (also known as indirect encounters or interactions), and independent (also known as unexpected encounters or interactions) and expected clinical outcomes aspects. Relational aspects refer to interpersonal aspects of care – the ability of clinical staff to empathize, respect the preferences of patients, include them in decision-making, and provide information to enable self-care (Coulter, 2011). They also refer to patients' expectations that professionals will put their interest above other considerations and be honest and transparent when something goes wrong (Thom et al., 2004; Lopes et al., 2009). Functional aspects relate to basic expectations about how care is delivered, such as attention to physical needs, timeliness of care, clean and safe environments, effective coordination between professionals, and continuity. Using these frameworks and the literature review in this area of research (Parasuraman et al., 1998; Lemke et al., 2011; Thom et al., 2009; Coulter, 2011; Safran et al., 1998) as a guide, the researcher identified 131 categories and sub-categories representing the customer/patient experiences of both relational (direct encounters) and functional (indirect encounters) aspects.

Understanding the experience of patients provides insight into healthcare, as well as being a crucial first step towards partnering with patients to drive improvement (Luxford and Sutton, 2014). Increasingly, healthcare organizations gain feedback from patients about their experience through surveys. Patients are also turning to other avenues, including the Internet, to document their experiences, as shown in this study. According to Luxford and Sutton (2014), listening to and learning from patient experience is the first step. Taking the next step of engaging patients and families to improve care delivery has led to a range of outcome benefits for healthcare organizations committed to a 'client focus' (Luxford, 2013).

Learning lessons from approaches to 'experience' by other industries can prove useful to healthcare organizations. Listening to 'customers' to improve service provision implies that the service values feedback about the customer's experience. Capturing patient feedback on healthcare provides insight into the extent to which patient expectations of care are met. As 'consumers' of healthcare services, it is important to acknowledge that patients form a different level of anticipation. Indeed, research on patient experience has taught healthcare professionals the importance of 'assuming nothing', as assumptions can lead to what has been called "patient preference misdiagnosis" (Mulley et al., 2012, pp. 345-351). A few studies about patient experience demonstrate that a gap often exists between 'what patients want' and 'what doctors think patients want' (Lee, Hulsman, and Sepucha, 2010).

4.2.1 Relational aspects (Direct encounters or interactions)

As shown in Table 4.2, the researcher identified 16 dimensions and 95 attributes representing the direct interactions, mentioned in 97% of the total stories as per Table 4.1. Sample quotes of positive and negative stories are discussed under each identified dimension or attribute within the direct encounters. The remaining participants' story data is available for further studies if required.

4.2.1.1 Staff attitudes and behaviours

This category includes all dimensions and attributes related to how staff members express their feelings and emotions and behave toward patients and carers. Staff members include medical (e.g. general and specialist physicians, nurses) and administrative staff. Table 4.1 shows that this category has the highest frequency, appearing in 29% of the total stories. These findings are consistent with Duggirala et al.'s (2008) study, which found that patients' highest expectations were for feeling safe during treatment, with staff behaving in ways that instil confidence.

Sub-categories of "staff attitudes and behaviours" incorporate experience attributes as defined in Table 4.3.

Dimension	Attributes	Definition
Attitude & behaviours	Caring	*staff are kind, supportive, compassionate, and concerned*
	Friendly	*staff are pleasant and nice*
	Helpful	*staff are willing to help and nothing seems too much trouble for them*
	respectful	*staff address and treat patients and carers in a humane and dignified way*
	professional	*the attitudes and behaviours of staff are suitable and appropriate*
	proactive	*staff are proactive in regularly checking on patients and making sure everything is ok*
	Patient	*staff accept or tolerate concerns, problems, or questions without making patients and carers feel rushed*
	dedicated	*staff are hard-working, committed and devoted*
	informed	*staff are sufficiently informed about the patient's case and medical history*
	Honest	*staff are truthful and sincere*
	Through	*staff perform their jobs with great completeness in every detail*

Table 4.3: Staff attitudes and behaviours experience attributes and definitions

From Table 4.1, it appears that patients generally feel very positive rather than negative about NHS hospital staff's attitudes and behaviours. Three hundred and fifty-two participants posted positive comments compared to 148 for negative feelings. There were numerous examples of positive experience and comparatively fewer negative comments in this category:

Sample positive stories:

> "…. All the staff from the lovely tea ladies to senior nurses (not forgetting the consultants) were excellent. They were so cheerful and patient; nothing was any trouble for them. In fact, I had a very pleasant stay on the ward. On the occasions I rang for the nurses, they were very prompt and sympathetic to the reasons as to why I called them. These were acted on very promptly". (Participant 120)

> "..my dad ….. this hospital for three weeks during that time he received excellent everybody from nurses, doctors, cleaners were all friendly". (Participant 137)

It seems that patients evaluate staff attitudes and behaviours based on all encounters they have with all staff, not just nurses, but tea ladies too, and this is consistent with Wolf et al.'s (2014) call for the sum of all interactions across the continuum of care. This shows that patients' experiences are affected by the attitudes and behaviours of all clinical and non-clinical staff. In addition, "cheerfulness, "" patience, and "sympathy" are all viewed as attributes of positive attitude and behaviour. However, "sympathy" is consistent with Parasuraman et al.'s (1998) and Duggirala et al.'s (2008) similar "Empathy" domain.

Sample quotes – negative stories:

As mentioned earlier, patients' experiences of the NHS occur at times when they are at their most vulnerable and emotional. This heightens the intensity of their emotions, and particularly their negative feelings about staff attitude and behaviour. They continually reported feeling emotional when they did not receive the expected attention, care, and empathy from the staff.

> "In my opinion some of the nurses attitudes were terrible as well, although of the 4 I saw, 2 were nice and I thought 2 looked at me like I was nothing, and I actually overheard one say 'we have better things to do than dealing with him' which was a nice thing to hear when you are fearing for you're life, alone". (Participant 053)

Consistent with the dimension of attitudes and behaviours, P053 refers to nurses' attitudes as terrible toward expressing negative experiences.

> "… attitude of the registrar that I saw was appalling…….. I felt that he ignored the fact that I had a right to make my own choice regarding my own body… me". (Participant 08)

Patients' negative experience with the hospital staff's attitude is signified by strong words such as "appalling" and "ignored" by staff.

The "Attitude and Behaviour" are close to the SERVQUAL dimensions Empathy, Assurance, and Reliability, a category of Parasuraman et al.'s (1985) original qualitative study, and to several other items from SERVQUAL, and to "Caring – Attitude", "Caring – Procedures", and "Reliability" of Lemke et al.'s (2011) customer experience dimensions, and to the "Personnel" of Duggirala et al.'s (2008) patient-perceived service quality dimensions.

Customer experience dimension	Positive evaluations		Negative evaluations		Total evaluations		Total stories @470	
	n	%	n	%	n	%	n[a]	%[a]
***Relational (direct encounters or interactions*)**								
1. Staff attitudes and behaviours	352	14.4	148	10.4	500	13.0	134	29
2. Staff & patient interactions	287	11.8	104	7.3	391	10.2	73	16
3. Level of care	264	10.9	92	6.5	356	9.3	48	10
4. Communication	180	7.4	119	8.4	299	7.8	45	10
5. Individualism or personalization	30	1.2	6	0.4	36	0.9	5	1
6. Level of competence	200	8.2	67	4.7	267	6.9	38	8
7. Availability & accessibility	51	2.1	26	1.8	77	2.0	12	3
8. Relationship with Staff	132	5.4	118	8.3	250	6.5	37	8
9. Relationship with other patients	110	4.5	37	2.6	147	3.8	17	4
10. Privacy	7	0.3	15	1.1	22	0.6	5	1
11. sense of safety	92	3.8	75	5.3	167	4.6	18	4
12. staff efficiency	53	2.2	12	0.8	65	1.7	9	2
13. Reliability and responsiveness	10	0.4	24	1.7	34	0.6	4	1
14. Emotional support –relieving fear & anxiety	14	0.8	18	2.0	32	0.8	6	1
15. Involvement of family & friends	42	2.0	25	2.8	67	1.7	7	6
14. Experience context	3	0.1	10	0.7	13	0.3	2	0.4
Total	1827	73.6	896	61.2	2723	69.0	458	97
Functional (indirect encounters or interactions)								
1. Admin procedures & processes	230	9.5	176	12.1	406	10.5	107	23
2. Infrastructure	75	3.1	100	7.0	175	4.6	63	34
3. Waiting time	58	2.4	12	0.8	70	1.6	43	9
4. Appearance & cleanliness	48	2.0	29	2.0	77	2.0	45	10
5. Pain management issues	18	0.7	27	1.9	45	1.2	38	8
6. Food and beverages	18	0.7	20	1.4	38	1.0	27	6
7. Atmospherics & ambience	18	0.7	17	0.4	35	0.9	23	5
8. Timely appointments	1	0.0	27	1.9	28	0.7	17	4
9. Patient choice	13	0.5	30	2.1	43	1.1	36	8
Total	479	19.3	438	27.0	917	23.0	399	85

Customer experience dimension	Positive evaluations		Negative evaluations		Total evaluations		Total stories @470	
	n	%	n	%	n	%	n[a]	%[a]
Independent (Unexpected encounters)								
1. Management & financial issues	15	0.6	48	3.4	63	1.6	37	8
2. Performance & brand reputation	8	0.3	14	1.0	22	0.6	14	3
3. External integrated care coordination	0	0.0	10	0.7	10	0.3	6	1
Total	23	0.9	72	5.1	95	2.5	57	12
Expected clinical outcomes								
1. Patient clinical outcome	136	5.6	32	2.3	168	4.4	71	15
2. Urgency of care	19	0.8	27	1.9	46	1.3	33	7
Total	**2484**	**100**	**1465**	**100**	**3957**	**100**	**470**	**100**

Note: [a]Figure sum greater than the reported and percentages sum to greater than 100 due to multiple customer experience dimensions and attributes per story

Table 4.1: Classification of CE dimensions and attributes in categories

Source: Author's own

4.2.1.2 Communication issues

This category includes dimensions concerning perceptions about the effectiveness and appropriateness of organizational communication relating to the patient's case and condition. It includes 11 sub-categories in Table 4.2 and is mentioned in 10% of the total stories in Table 4.1. "Internal communication" involves evaluating the effectiveness of cooperation and coordination among different departments, teams, and wards. This is consistent with several studies examining the importance of communication in service interactions (Duggirala, 2008). Curry and Sinclair (2002) used SERVQUAL to improve patient satisfaction by enhancing communication with patients and increasing their access to information relating to their condition and its treatment. Frohna et al. (2001) stated that regardless of whether a patient is cured, the outcome of the clinician–patient encounter depends on the communication. "Communication with patients and carers" reflects perceptions about the appropriateness and timeliness of the information provided by the

healthcare provider about processes and outcomes, clarity, openness, responsiveness, proactiveness, explanation, advice, waiting times and delays, and medical records. "External communication" includes dimensions representing the effectiveness of the communication between the healthcare provider and external health service organizations, specifically relating to the patient's case and condition. Table 4.1 above shows that the "Communication" category includes 180 positive evaluations compared to 119 for negative comments – this clearly indicates the importance of communication to patients' experience.

Sample quotes – positive stories

Through effective communication, hospital staff are more likely to positively influence health outcomes for their patients (Duggirala et al., 2008). The positive examples below are consistent with Frohna et al.'s (2001) study, which revealed that to be effective, communication must be a two-way process – both doctor/nurse and patient need to offer and accept information about his/her health concerns, even if they do not seem relevant to the doctor.

> "… my surgeon was excellent, bedside manner brilliant, treated like a family member, even a phone call to my wife at home by the surgeon after surgery". (Participant 007)

The use of words such as "excellent", "brilliant", and "treated like a family member", which are linked to communication with hospital employees, exemplifies positive experiences.

> "my husband ……..sent him straight to the hospital on arriving the care was excellent he was admitted the next day he had a stent fitted the heart ward and dryden staff all cared for him very well everything was explained to us we cannot fault the care at all". (Participant 242)

Doctor–patient communication typically involves only the patient and the doctor, but sometimes a third party, such as a family member, may be involved (e.g., a parent of a paediatric patient, a spouse, or a friend of an elderly patient). In such situations, the third party can potentially facilitate communication if they help to identify the needs of the patient and to ensure that treatment recommendations are followed correctly (Duggirala et al., 2008). This is parallel with the story below:

> "My 14-year-old daughter was doubled up with stomach pains ……took her to Hammersmith Hospital A and E, ……were seen, diagnosed and thoroughly

> reassured by 9.30pm. We felt incredibly reassured by the doctor who was thorough and explained everything to us clearly without being condescending or dismissive". (Participant 139)

Patients, when ill, are seeking some "reassurance" from the medical experts, and the above quote shows the importance of communication between staff and patient for a great positive patient experience.

Sample quotes – negative stories

The most identified negative feelings were confusion, disappointment, annoyance, and frustration. The underlying causes were poor communication about long wait times, condescending staff attitudes, and a sense of being lost in the system.

> "Communication between departments could have been better; the A&E doctor wanted to admit me due to my high temp, but the surgeons didn't because they couldn't find a bed for me. I was left sat on a chair with a drip for about 5 hours with nobody telling me what is really going on. The doctor and nurses in the ED knew I had to be admitted, and had one of the surgeons been bothered to come down to see me, they wouldn't have agreed and I might have been able to have my surgery done the same evening. As as soon as they finally saw me, they were pushing for the surgery to happen asap. Were they busy or lazy? I don't know." (Participant 193)

It is not only communication between staff and patient that impacts the patient experience. P193 quote shows that even a lack of communication between departments or staff can result in a negative patient experience.

> "…and no guidance on after care, dietery advice, excercise etc. no telephone number given for help with such questions." (Participant 121)

Dimensions categories	#	Attributes	Total evaluations	
			n	%
Indirect encounters:				
Attitudes & behaviours			500	13
	1	*Caring*	*74*	*1.9*
	2	*Friendliness*	*51*	*1.3*
	3	*Absence of pushiness*	*11*	*0.3*
	4	*Helpfulness*	*39*	*1.0*
	5	*Respectfulness*	*31*	*0.8*
	6	*Authenticity or genuinely*	*14*	*0.4*
	7	*Concern to elicit customer's objectives*	*9*	*0.2*
	8	*Professional*	*31*	*0.8*
	9	*Proactivity in checking that everything is OK*	*13*	*0.3*
	10	*Interest in problem solving*	*6*	*0.2*
	11	*Taking responsibility*	*11*	*0.3*
	12	*Attitude*	*88*	*2.2*
	13	*Dedication*	*23*	*0.6*
	14	*Informed*	*18*	*0.5*
	15	*Honesty*	*7*	*0.2*
	16	*Thoroughness*	*17*	*0.4*
Communication issues			299	7.8
	17	*Internal communication*	*11*	*0.3*
	18	*Explanation*	*76*	*1.9*
	19	*Communication with patients*	*27*	*0.7*
	20	*Enquiry responsiveness*	*6*	*0.2*
	21	*Openness*	*12*	*0.3*
	22	*Listening*	*23*	*0.6*
	23	*Provision of information to inform choice*	*30*	*0.8*
	24	*Patient involvement*	*42*	*1.1*
	25	*Updating patient on current position*	*15*	*0.4*
	26	*Shared decision making*	*48*	*1.2*
	27	*External communication*	*9*	*0.2*
Individualism/personalization			36	0.9
	28	*Customization*	*4*	*0.1*
	29	*Personalization*	*5*	*0.1*
	30	*One on one (no care without me)*	*9*	*0.2*
	31	*Flexibility*	*5*	*0.1*
	32	*Patient recognition*	*4*	*0.1*
	33	*Focus on specific needs*	*5*	*0.1*
	34	*involved in decision making*	*4*	*0.1*
Level of care			356	9.3
	35	*Respectfulness*	*40*	*1.0*
	36	*Kindness*	*62*	*1.6*

Dimensions categories	#	Attributes	Total evaluations	
			n	%
	37	*Dignity*	*44*	*1.3*
	38	*Empathy*	*72*	*2.1*
	39	*Compassion*	*65*	*1.6*
	40	*Understanding*	*17*	*0.4*
	41	*Courtesy*	*21*	*0.5*
	42	*Honest*	*13*	*0.3*
	43	*Personal care*	*26*	*0.7*
Level of competence			267	6.9
	44	*Expertise/knowledge*	*94*	*2.4*
	45	*Application of up-to-date medical knowledge*	*69*	*1.8*
	46	*Technology/technique*	*33*	*0.8*
	47	*Competence skills*	*71*	*1.8*
Indirect encounters or interactions:				
Availability & accessibility			*77*	*2.0*
	48	*Geographical distance*	*6*	*0.2*
	49	*Responsiveness of staff*	*19*	*0.5*
	50	*Accessibility of information*	*10*	*0.3*
	51	*Accessibility of staff/facility*	*28*	*0.7*
	52	*Convenient hours of operation*	*8*	*0.2*
	53	*Dedicated contact point/navigation*	*6*	*0.2*
Relationship with other patients & carers			147	3.8
	54	*Impact on other patients*	*32*	*0.8*
	55	*Looking after each other*	*24*	*0.6*
	56	*Exclusive*	*39*	*1.0*
	57	*Providing space for patient-to-patient*	*9*	*0.2*
	58	*Relationship development*	*17*	*0.4*
	59	*Personal privacy boundaries*	*25*	*0.6*
Relationship with staff			250	6.5
	60	*Easiness of establishing a relationship*	*56*	*1.4*
	61	*Continuity of care*	*74*	*1.9*
	62	*Breadth of contact*	*26*	*0.7*
	63	*Genuine desire to develop value for both parties*	*29*	*0.7*
	64	*Presence of social relationship*	*36*	*0.9*
	65	*Valuing of custom*	*9*	*0.2*
	66	*Proactive relationship development*	*20*	*0.5*
Privacy			22	0.6
	67	*Right to confidentiality*	*8*	*0.2*
	68	*Dignity*	*10*	*0.3*
	69	*Data medical records protection*	*4*	*0.1*
Sense of safety			177	4.6

Dimensions categories	#	Attributes	Total evaluations	
			n	%
	70	*Infection control*	*47*	*1.2*
	71	*Quick medical intervention*	*51*	*1.3*
	72	*Avoidable deaths*	*79*	*2.0*
Efficiency & proficiency			65	1.7
	73	*Efficiently*	*37*	*0.9*
	74	*Quickness*	*22*	*0.6*
	75	*Competently*	*12*	*0.3*
Reliability & responsiveness			24	0.6
	76	*Ability to check quality*	*5*	*0.1*
	77	*Accurate records*	*6*	*0.2*
	78	*Delivery timeliness*	*9*	*0.2*
	79	*Impression of reliability*	*4*	*0.1*
Emotional support – relieving fear & anxiety			32	0.8
	80	*Loneliness*	*5*	*0.1*
	81	*Fear of pain*	*11*	*0.3*
	82	*Effect of illness on family*	*4*	*0.1*
	83	*Uncertainty*	*12*	*0.3*
Involvement of family & friends			67	1.7
	84	*Informed in treatment decision making*	*28*	*0.7*
	85	*Welcomed*	*10*	*0.3*
	86	*Visitor restrictions*	*16*	*0.4*
	87	*Visiting times*	*13*	*0.3*
Experienced context			13	0.3
	88	*Past experience*	*3*	*0.1*
	89	*Pre-visit experience*	*1*	*0.0*
	90	*Emotive context*	*3*	*0.1*
	91	*Hedonic product/service type*	*2*	*0.1*
	92	*Importance of timeliness*	*1*	*0.0*
	93	*Market competitiveness*	*1*	*0.0*
	94	*Organizational size*	*1*	*0.0*
	95	*Significance of transaction*	*1*	*0.0*
Total			**2723**	**69.1**
Functional (indirect encounters or interactions):				
Procedures & processes			406	10.5
	96	*Staffing levels*	*92*	*2.3*
	97	*Administration*	*96*	*2.4*
	98	*Bed management*	*89*	*2.3*
	99	*Equipment, supplies, drugs*	*73*	*1.9*
	100	*Security and safety*	*56*	*1.4*
Premises & facilities			175	4.6

Dimensions categories	#	Attributes	Total evaluations	
			n	%
	101	*Maintenance*	*29*	0.7
	102	*Amenities*	*55*	1.4
	103	*Layout*	*23*	0.6
	104	*Parking & fees*	*18*	0.5
	105	*Appearance*	*39*	1.0
	106	*Entertainment*	*11*	0.3
Appearances and cleanliness			77	2.0
	107	*Spotless*	*32*	0.8
	108	*Spacious*	*18*	0.5
	109	*Smelliness*	*27*	0.7
Waiting times			62	1.6
	110	*Appointment time*	*22*	0.6
	111	*Treatment & discharge*	*10*	0.3
	112	*Medication & prescription*	*9*	0.2
	113	*Referral time*	*5*	0.1
	114	*Timeliness to diagnose*	*16*	0.4
Food & beverages			38	1.0
	115	*Food taste*	*14*	0.4
	116	*Food quantity*	*6*	0.2
	117	*Food presentation*	*8*	0.2
	118	*Food nutritional value*	*10*	0.3
Atmosphere & ambience			35	0.9
	119	*Quietness*	*13*	*0.3*
	120	*Temperatures*	*5*	*0.1*
	121	*Smells*	*7*	*0.2*
	122	*Atmospherics*	*10*	*0.3*
Timely appointments			28	0.7
	123	*Timeliness to next appointment*	*11*	*0.3*
	124	*Timeliness of results*	*8*	*0.2*
	125	*Booking appointments*	*4*	*0.1*
	126	*Promptness*	*2*	*0.1*
	127	*Efficient use of patient's time*	*3*	*0.1*
Patient choice			43	1.1
	128	*Appropriate degree of variety*	*3*	0.1
	129	*Breadth of services range*	*5*	0.1
	130	*Pick and choose*	*22*	0.6
	131	*Provision of choice*	*13*	0.3
Total (indirect interactions)			**909**	**23.1**

Table 4.2: Classification of direct and indirect experience dimensions and attributes

Source: Author's own

4.2.1.3 Individualization or personalization

This category encompasses perceptions of whether employees listen to patients, adapt their behaviour, and configure care to meet patients' implied or expressed specific needs and preferences. "Individualization" was mentioned in 1.4% of total stories in Table 4.1. This is consistent with Lemke et al.'s (2011) and Parasuraman et al.'s (1989) similar 'Personalization' – dealing with the customers in a personal way and adapting the offer to meet their needs – which builds on the two items of SERVQUAL that concern individualization and relates to much recent work on both personalized dialogue (Homburg et al., 2009; Stuart-Menteth et al., 2006) and customization of the service (Rust and Thompson, 2006). Sub-categories include "recognition", "focus on specific needs", "personalization", and "customization". "Recognition" refers to situations in which patients and carers feel that employees know them personally and recognize, notice, and acknowledge them. "Focus on specific needs" involves perceptions that employees listen to patients and carers and recognize and understand their particular needs. "Personalization" reflects a feeling that employees modify their interpersonal behaviours and adapt their delivery of care in response to patients' needs and preferences. Patients feel that they receive personalized treatment and are treated as persons rather than processed as objects. "Customization" represents a perception that employees change the configuration of the service delivery system to meet patients' specific needs or that patients are offered choices from a set of available options. Additionally, "customization" refers to situations in which patients are involved in decision-making regarding the delivery of care and treatment.

Sample quotes – positive stories:

This was important for all patients and was a feeling considered most lacking in the service many participants had received. It was important for patients' self-esteem; recognition that they and their conditions were important to health professionals.

> "My treatment was patiently and carefully explained to me and my wishes taken into account**."** (Participant 331)

It was also a factor in creating trust and confidence in the health professional–patient relationship. Being treated as an individual involves patients being made to feel important, that they are not rushed through their appointments or pressured to leave, that their concerns or worries are talked through and understood, and that they are respected as individuals and

taken seriously. This was felt to be essential in contact with all professionals and at all stages in the patient journey.

> "I went into A&E in the early evening and once past the initial assessment things moved swiftly and smoothly. I was advised about all decisions concerning my condition and treatment, the nursing staff monitored me every hour and made sure I was comfortable. The surgical team was informative and asked if it would be possible for a student to examine me, when the registrar who did the operation said the student might find the procedure informative I was consulted and agreed. …..I would recommend this hospital to anyone." (Participant 163)

P163 and several other patients associated with being treated as a person with positive factors, such as staff advising them about all decisions concerning their condition, and they were asked if a student could examine them; they were 'consulted and agreed'. This is consistent with Staniszewska and Bullock's (2014) "knowing the patient as an individual". It is clear that a patient's positive experience influences his/her intent to recommend: "I would recommend this hospital to anyone". This is consistent with Westbrook's (1987) research which identified two major dimensions of positive and negative affect using factor analysis. His study found that positive affect positively influences customer experience, customer satisfaction, and loyalty.

> "My sons consultant, provided an excellent service and showed a genuine interest in all aspect of his care. They attended the ward regularly and involved both my son and myself in decision making and explained clearly all that was about to happen. We both felt involved and empowered and were left with a very clear insight into his treatment." (Participant 428)

> "My daughter was on the ward of QMCH. The staff, particularly the nurses, work very hard to ensure that the children receive the best care and are supported during their stay in hospital. We are always involved in decisions about her care and staffs take time to answer queries and explain procedures. We've been to many London and Surrey hospitals with our daughter and it is ……. difference. We feel that we are treated as a family not an NHS number." (Participant 385)

Consistent with Lemke et al.'s (2011) personalization dimension, P428 also described factors that have a significant influence on CE with terms such as staff's "genuine interest" in holistic customer needs and patient involvement in decision making. In this instance, the participants felt empowered. In addition, P385 described emotionally that they "… feel that we are treated as a family, not an NHS number".

Sample quotes – negative stories

Patients felt that being treated as an individual depends on the attitude and manner of the particular health professional. This is consistent with the negative attitudes and behaviours described above.

> "All the patients are treated as objects to be taken through a routine of getting washed, dressed, meds, and breakfast regardless of their condition, needs, or wants." (Participants 013)

Patients wanted to be allowed to be 'self-aware' – to have input into the decisions which health professionals make, based on their own knowledge of their bodies:

> "The consultants should do what they are paid to do and should involve patients in the care plans. Very poor renal consultants. Fine until you start asking questions and would like to help yourself. Never consulted about lifestyle, diet or fitness. Once It was clear I wanted to be proactive in my renal care I was given the cold shoulder". (Participant 439)

Being treated as an individual relates to a desire to be taken responsibility for and feeling that someone is accountable to the patient:

> "If things don't progress normally the hospitals decide they can do what they want with you without any discussion. Out of 6 fetal blood samples, my son had one "borderline" one (the rest were great) and as a result I was told I would not be pushing myself, and would have to have either a forceps or caesarian delivery. I was aiming for forceps but wasn't told about the necessary episiotomy until the last minute when I asked. Despite it apparently being a "straightforward forceps delivery" (as noted on discharge note) I sustained a serious 3rd degree tear, and received no explanation as to why or even what this tear involved. It was recorded as both grade 3a and 3b in my notes."(Participants 472)

Respect was also implicit in this, but was not a word generally used by participants:

> "went to this hospital to get a diagnosis for endometriosis. The consultant gave me the diagnosis but was patronising, unpleasant, and unhelpful with coming up with ways to treat the pain I was in. He seemed to find my living arrangements amusing, and implied in front of me to another member of staff doing work experience there that I was an ignorant fool…I asked about research papers I had read. He seemed to be unable to comprehend that I was not interested in becoming pregnant then or in the future and that relief of pain was of greatest importance to me, and was utterly dismissive in this respect. In all I felt as though I was treated not as a person who did not wish to be in pain, but as some mindless biological sack for gestating foetuses in." (Participant 477)

Patients value healthcare professionals acknowledging their individuality and the unique way in which each person experiences a condition and its impact on their life. Patients' values, beliefs, and circumstances all influence their expectations of, their needs for, and their use of services. It is important to recognize that individual patients are living with their condition, so the ways in which their family and broader life affect their health and care need to be considered. Patients wish to be seen as individuals within the healthcare system. This requires healthcare professionals to recognize the individual, and for services to be tailored to respond to the needs, preferences, and values of the patient. Advice on treatments and care, including risks and benefits, should be individualized as much as possible (Duggirala et al., 2008). Like customer-centric or patient-centred care, the literature review focused on the personal aspect when defining the customer/patient experience (Gentile et al., 2007; Meyer and Schwager, 2007; Staniszewska and Bullock, 2014).

4.2.1.4 Level of care

This category includes dimensions concerning perceptions of whether patients are cared for, supported, and looked after by staff. 'Level of Care' was mentioned in 10% of total stories and represents 9.3% of total direct encounters in Table 4.1. Table 4.2 shows nine attributes: treating patients with 'respect', 'kindness', 'dignity', 'empathy', 'compassion', 'understanding', 'courtesy', 'personal care', and 'honesty'. Although this incorporates many of the elements of being treated as an individual, it is worthwhile highlighting, as these feelings are frequently referred to.

Table 4.1 shows that there were 264 positive patient comments compared to 92 negative comments regarding the level of care in NHS hospitals. This is very significant and consistent with the earlier discussion. Some patients spoke about feeling important, and that they were being taken care of by the NHS, and common positive feelings included feeling cared for, supported, reassured, and looked after.

Sample quotes – positive stories

Patients would like to feel cared for at every stage in the journey (and particularly during after care, where this was often felt to be lacking), and to be cared for by all the healthcare professionals and staff they come into contact with, from receptionists to consultants:

> "I was very well looked after during my stay. The care was delivered professionally and sympathetically. I could not fault the excellent care in the Isolation unit, and was put as ease knowing my needs were being met in a well-managed unit". (Participant 050)

> "The care I received was second to none. All the staff from the lovely tea ladies to senior nurses (not forgetting the consultants) were excellent. They were so cheerful and patient; nothing was any trouble for them. In fact I had a very pleasant stay on the ward. On the occasions I rang for the nurses, they were very prompt and sympathetic to the reasons as to why I called them. These were acted on very promptly." (Participant 120)

P050 and several other participants used terms such as "very well looked", "professional", "sympathetic", and "needs being met", and P120 "second to none" "lovely", "excellent", "cheerful", "patient", "very pleasant" and "very prompt", to describe the factors that significantly influence their CE. P120's appreciation even extends to the tea ladies, not just to clinical staff. This is consistent with Verhoef et al.'s (2007) posits of total customer experience as a journey and Wolf et al.'s (2014 p.xx) definition of patient experience as the "…sum of all encounters or all continuum of care…".

> "….. 10 days after my operation as I had a dangerous lung infections post operatively. I was often quite mentally confused by delusions which was I was aware of afterwards...but despite that I was aware of very caring and competent staff looking after me. They were brilliant and saved my life. I went back to thank them after I left hospital and took a card. I was very lucky to receive such excellent care. I am hugely grateful." (Participant 191)

> "I liked the way i was treated with respect dignity and kindness the staff from Sister down to carers were friendly and efficient - one hears so much about the NHS always the negative views. I am lucky not to have been in hospital except for a day bed since the early 60's when i had my children and i can only thank everyone who looked after me in Dorrell Ward. I was pleasantly surprised how I was kept informed of the operation by the doctor who came around before the operation in the morning and at the end of a busy day to tell me how everything had gone also the anaethetists and other members of his team who again were efficient and friendly and were able to answer any questions. Many thanks to all" (Participant 299)

P191 and other participants perceive "caring" with staff "competence". P191 also used the terms "brilliant", "excellent care", and "hugely grateful" to describe the significant factors that influenced her/his positive experiences. Surprisingly, P191 and P299 both used the term "lucky" and were not expecting the level of service they got, as patients often hear so much about negative views of the NHS.

Sample quotes – negative stories

Patients suggested that staff could be employed specifically to provide this in hospital by visiting the wards and talking to patients; this would fill the void which patients feel exists currently, with nurses particularly being too busy to spend time helping patients feel a sense of well-being and care beyond the essential contact they experience when being treated.

> "I was stunned to see the low level of care given to the older patients on the ward. During the drug rounds the medication was left in pot on the bedside table, sometimes out of reach and on a number of occasions the patients dropped the medication on the floor, which I pointed out to nursing staff who seemed totally disinterested. Meal times the catering staff would be left to ask if the patient wanted food and the more confused patients would say no! or not even understand what they were being ask! same would apply to drinks, with the older patients being given a cup which they were incapable of picking up. I never once saw the bedside tables cleaned or even wiped.

> My own bed side chair had dried blood on it, and despite asking for it to be cleaned it never happened. The older patients often asked for a commode and never once did I see one supplied, which meant the patient soiled the bed (old people have feelings) My own after care involved an injection, missed for a whole day and only picked up the following afternoon, I lost count of the times that my ward records went missing, on one occasion being found in the record holder of a bed on the other side of the ward." (Participant 224)

> "Ward staffs were lazy and incompetent. Old lady was left in soiled bed for hours. Night staff never seen! Visiting seemed to be unofficial tea break for all nurses - gods forbid you needed any medical care during that time. Several ladies wet themselves waiting for commode. Nurses were often rude and abrupt. Would rather suffer at home than go in there again." (Participant 021)

The negative and positive patient stories above indicate that patients have needs other than the treatment of their specific health conditions. There should be recognition of the potential need for psychological and emotional support, as well as of the importance of meeting fundamental needs such as nutrition and pain management. Attention to these fundamental needs is particularly important in inpatient settings, but they should also be addressed in other settings where healthcare is provided.

4.2.1.5 Level of competence

This category includes dimensions that involve a judgment about the level of staff knowledge and skills. Competent employees inspire confidence in patients and carers that

they know what they are doing and do their job properly (competent), while others appear inept and not able to perform their job in a way that is required of them (incompetent). "Competence" was mentioned in 8% of total stories and represents 6.9% of total direct encounters in Table 4.1. There are four attributes identified in Table 4.2. The "expertise/knowledge" sub-category includes dimensions related to patients' evaluations of staff's knowledge, qualifications, and skills. The Level of Competence category is close to the "Application of Knowledge" within Lemke et al.'s (2011) study and the Competence category within Parasuraman et al.'s (1985) original qualitative study. "Technology/technique" refers to whether patients feel that employees use the latest technology and employ innovative medical techniques and procedures.

Sample quotes – positive stories:

> "It really was brilliantly done from start to finish. The surgeon, was really good at explaining what he was going to do and why and delivering it. The auxiliary staffs were excellent, friendly and supportive. Big up King's!" (Participant 192)

> "Every person who I dealt with was professional, efficient and genuinely concerned for my welfare. Bearing in mind this was a Saturday evening, in London, in the snow, and the A&E receptionist had not arrived due to bad weather, I felt that the department was being run extremely well. I've visited many A&E departments in my time and this is certainly one of the best I've seen. Thank you to everyone for looking after me and being so friendly". (P136)

> "…. nurses and doctor I saw were caring and competent …with personal/difficult issues. They were not patronising like some can be to younger patients (I am 20 years old) but were still 'warm" in their attitude. (Participant 223)

> "…the appointment was met spot on time. The procedure was well explained and the staffs involved were very concerned to reassure me at all times-it was the first time in many years I have visited a hospital. I am completely satisfied with the treatment I received. I just hope the report back by my GP of the findings, will be good news. Thank you." (Participants 079)

Sample quote – negative stories:

> "The Royal free have some of the greatest doctors around, however in my experience their communication is appalling. The staff responsible for me did an ultrasound on the wrong patient and only discovered this when I told the doctor I hadn't had one. …..And despite being in specifically for monitoring purposes, when I had an episode that the doctor wanted reported on by other staff members, they failed to monitor it and didn't tell my doctor it had even happened. In a visit two weeks later, I was mistaken called back when I shouldn't have been, and then they had to send me down to A and E, and promptly lost me, nobody seemed to know where I was, the police nearly got called cos they told my carer I'd walked out. I'm in a wheelchair." (Participant 320)

4.2.1.6 Availability and accessibility to care

This category includes dimensions and attributes reflecting how easy it feels for patients and carers to find and access an appropriate staff member, premises, and information whenever needed. Picker Institute Europe's (2007) dimension "Access to care' is described thus: "patients need to know they can access care when it is needed: attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward". This is consistent with Ponsignon et al.'s (2015), Klaus and Maklan's (2013), Duggirala et al.'s (2008), and Lemke et al.'s (2011) similar dimension, "ACCESSIBILITY", i.e. ease of finding and accessing people, premises, transactions, and/or information whenever needed. Table 4.2 shows six attributes categories, comprising "geographical distance", "responsiveness of staff", "accessibility of information", "convenient hours of operation" and "dedicated contact points navigation", and also "Access to care", which is described as patients needing to know they can access care when it is needed; attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward (NICE, 2013). It reflects perceptions of employees' responsiveness to requests from patients and carers. "Availability and accessibility" were mentioned in 8% of total stories and represents 6.9% of total direct encounters evaluations in Table 4.1.

Sample quote – positive stories:

> "He provided me with his secretary's extension number so I could call as soon as I received the date for my MRI scan". (Participant 130)

Participant 130 considers the accessibility of information, such as the secretary's number, to be a significant factor in his/her positive experience.

Sample quotes – negative stories

> "There did seem to be a need for more staff to be available at weekends. The available staff were stretched at times but coped admirably." P017

It could be because of financial budget cuts in the NHS that staff numbers are reduced during weekends, and patients seem to blame management rather than the staff. Patients are also sympathetic to the strained conditions that nurses operate under but still cope admirably to serve them.

> "I found that when I rang my bell, usually to ask for pain relief following a hysterectomy, I waited for at least 20 minutes before anyone came. Despite saying that you were to press the bell if you needed to, some of the staff made me feel that it was a bit of a chore sorting me out. I was no where near as demanding as some of the other ladies on the ward, especially one who was prone to calling out for the nurse during the night." (Participant 315)

It is clear from P315 that waiting time and staff availability are linked – hence, if staff are unavailable, it prolongs your waiting time.

4.2.1.7 Relationship with other patients and carers

This category includes dimensions relating to how the attitudes and behaviours of some patients and carers can affect the experience of others, mentioned in 4% of total stories, and represents 3.8% of total direct encounters evaluations in Table 4.1. Six attributes emerged. "Impact on others" includes perceptions that the health and happiness of some are affected by the actions of others, which could be positive or negative. "Looking after each other" denotes a feeling shared among patients that they get along and form a united community. This is consistent with Lemke et al.'s (2011) "Relationship with other customers", which they discussed in examining the role of other customers, including their identity and their involvement in value creation. Other attributes include "exclusive", "providing space for customer to customer", and "relationship development". "Privacy" reflects perceptions that patient privacy and intimacy may be compromised by the presence of others.

Of the reported significant events or incidents, 110 (4.5%) were positive reports of cases in which the presence of other customers significantly enhanced the participant's satisfaction with hospital services. There were 37 (2.6%) negative incidents, reflecting occasions when

respondents were significantly dissatisfied with hospital service due to the behaviour of other customers/patients.

Sample quote – positive stories

> "The Midwives of central delivery and ward 11 were fantastic, they made me feel well cared for and helped me to feel relaxed. I am amazed by the amount of work that the midwives have to do and yet they still manage to provide excellent care. Can't rate them highly enough! Other patients on the ward were very friendly and we spend time sharing stories about our babies" (Participants 167)

Sample quotes – negative stories

> "The ungrateful attitude of some of the other patients, drunk and making noise at the waiting area of A&E and shouting at busy nurses" (Participant 188)

> "I didn't like some patients attitude and respect towards the staff." (Participant 448)

Obviously, the unruly behaviour of other patients, such as "drunkenness" and "noise", can also directly impact the experience of patients negatively.

> " I did not sleep because I was put in a ward with an old man with dementia who spend the whole night walking about and making noise" (Participant 065)

Beyond the necessary cooperation between hospital and customer, the service encounter is often characterized by the condition of multiple customers whose presence may influence each other. The service encounter has been defined as "a period of time during which a consumer directly interacts with a service" (Shostack, 1985, p. 243). The service encounter is often a complex phenomenon that may comprise a wide array of elements (Shostack, 1987). Separately or collectively, the myriad elements found at a hospital service encounter may affect positively or negatively the CE of customer/service provider interaction and, ultimately, the CEs as per the above sample quotes. One such element is the presence of others in the service environment (Baker, 1987; Langeard et al., 1981; Lovelock, 1996; Martin and Pranter, 1989).

Second, apparently satisfying all customers with the same level of patient care is virtually impossible in the NHS. This is particularly true because people seem to have different ideas about what is appropriate and reasonable in any situation. As the old phrase states, "One

man's ceiling is another man's floor." For example, one group of customers can be having a "great conversation" that enhances their CE, while those around them are miserable because the conversation is too loud. Perhaps the solution to this problem is for NHS hospitals to educate patients and their families about the types of behaviour expected of them and those that are not allowed when visiting their hospital servicescape (Bowen, 1986; Bowers, Martin, and Luker, 1990). Signage, recorded messages, or even verbal instructions from the NHS hospital's management might help to establish a common understanding of appropriate conduct among a hospital's customers or patients.

4.2.1.8 Relationship with staff

This category reflects judgments about whether employees genuinely value, build, and maintain relationships with patients and carers over time, as mentioned in 8% of total stories and representing 6.5% of total direct-encounter evaluations in Table 4.1. In Table 4.2, the identified seven attributes or sub-categories represent "continuity of care" ", breadth of contact", and "ease of establishing a relationship". The former involves situations in which patients are dealt with by the same staff members throughout the healthcare experience. The latter reflects a sense that it is easy to build and maintain close relationships with individual employees. The other reflects the level of contact between the patient and staff. The attributes include 'genuine desire to develop benefit for parties', 'presence of social relationship', 'valuing of customer', and 'proactive relationship development'.

Sample quotes – positive stories:

Sympathy for staff tends to mean that participants feel the blame for NHS failings lies primarily with top-level management and government. They also make the explicit link between staff satisfaction and patient satisfaction. They believe that happier staff will result in a better emotional experience.

> "I don't think it's just the patients though that have got frustration and intolerance, the nurses and the doctors I think they're frustrated with the way things are going, you know, they have lack of resources and, you know, lack of staff and stuff like that, you know, so they're a bit cheesed off as well and it comes through in their work." (Participant 061)

> "When I arrived I was treated in a professional and friendly manner by both the reception and medical staff. I think it is an excellent service which is provided in a

> very accessible way. Equally, during my appointment I felt I was treated with the utmost care and attention by the staff. I was really impressed." (Participant 135)

Sample quotes – negative stories:

> "there was no organisation or communication between staff, we were left in a 4ft bed and after complaining 3 times that my partner I even fit in the bed they eventually removed the foot plate!" (Participant 421)

> "The receptionist was condescending and I'didn't like her tone. I got the impression that she would rather be anywhere else than at work. She'wasn't very helpful, and there was an evident lack of communication between the various members of staff." (Participant 122)

4.2.1.9 Privacy

This category includes dimensions that involve a judgment about the level of staff respect for the patient. All staff are expected to respect the patient's right to confidentiality, such as not discussing the patient in their presence without involving them in the discussion. "Privacy" was mentioned in 1% of total stories. In Table 4.2, the three identified attributes or subcategories represent 'right to confidentiality', 'dignity', and 'medical records data protection'.

Sample quotes – positive stories:

> "Women were accommodated separately to men" (Participants 061)

> "Sensitive issues were dealt with well…" (Participants 475)

> "when I was finally seen by my surgeon he respected my privacy and took me to a separate room with a male nurse to discuss my illness and what was to be expected he spoke to me in a very friendly tone and in plain and simple terms he then left me to talk to my partner and come to terms with my illness." (Participants 013)

Overall, P061, P475, P444 and P013 felt that being "treated with respect and dignity" while you were in the hospital was a significant factor that influenced their positive experience.

> "Having a gastroscopy and colonoscopy, I was anxious and embarrassed. Medical and nursing staff put me at ease and ensured my dignity was maintained even during intimate examinations. The explanations given during my consultation were clear

and the specialist nurse took time to explain everything with thoroughness and empathy. Everyone I met was very kind and polite." (Participant 444)

Sample quotes – negative stories:

"Little privacy, bed curtains opened … patients wearing open gowns have to walk around with physiotherapist in public at visiting times." (Participant 121)

"Total lack of information, at nearly every level, had to walk through the hospital to Xray with a form with a diagram of the femal form printed on it, which was not placed in an envelope of folder to protect privacy and dignity" (Participant 300)

"The area where blood is taken is totally lacking in any kind of privacy - blood is taken in a closet with the door open and a heaving queue of people waiting to give their bloods." (Participant 343)

"Notes for another mother and baby were wrongly written in my record – slightly concerning in terms of confidentiality". (Participants 472)

In contrast to the positive quotes above, P121, P300, P343, and P472 describe little privacy, open bed curtains, wearing open gowns, exposed medical records, a lack of privacy and dignity, and erroneous medical records of other patients as significant factors that contribute to a negative experience. Figure 4.1 depicts the volumes of patient records in a hospital when BBC News reported the NHS missing patient records.

Figure 4.1: NHS hospital medical records

Source: www.bbc.co.uk

In sum, the relationship between healthcare provider and patient is one characterised by intimacy and trust, and confidentiality is embedded at least implicitly in patient–provider interactions (Randolph et al., 1996). The notion of confidentiality in healthcare has a strong professional tradition that has suffered progressive erosion due to budget cuts, managed care and other healthcare organizational structures, and the perceptions and culture of professionals within NHS systems. DOH (2010, p. 536) states that one-third of medical professionals have indicated that information is given to unauthorized people "somewhat often".

4.2.1.10 Sense of safety

This category includes dimensions that involve a judgement about the level of feeling in safe hands, i.e. safe medical treatment. Safety culture is defined as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organization's health and safety management" (Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations, 1993). Patients also wanted to feel safe from infections in the hospital, such as Methicillin-resistant Staphylococcus aureus (MRSA). "Sense of safety" was mentioned in 4% of total stories and represents 4.6% of total direct encounters evaluations in Table 4.1. In Table 4.2, three attributes or sub-categories are identified that represent 'infection control', 'quick medical interventions', and 'avoidable deaths'. This is consistent with Andrea et al.'s (2015) and Duggirala et al.'s (2008) safety measures/dimension, which they described as the safety measures a hospital has in place to safeguard patients physically and that influence patients' perceptions of hospital quality. As mentioned earlier in the literature, healthcare leaders must ensure that patient safety becomes (stays) one of the hospital's primary goals and business imperatives. Duggirala et at. (2008) state that "the ethical imperative of patient represents the fundamental philosophy of medical care dating back to ancient Greece and physicians' Hippocratic Oath" (p. 566).

Sample quote – positive stories:

> "i visited st helens hospital on 29th march 2012 at 10:45 am for a flexible sigmoidoscopy, i was very nervous about this, but the staff explained everything to me before, and during the procedure they talked to me about what was going on, i was very impressed with their professional and caring attitude, they are a credit to the nhs" (Participant 380)

> "The staff were efficient without being officious, did everything with a smile and made me as comfortable and feel as safe as I have ever felt in a hospital. Very impressed." (Participant 298)

It is clear from the above quotes that patients feel reassured and safe when clinical staff explain the procedures.

Sample quote – negative stories:

> "My mother in law has been shunted from ward to ward. Her belongings were just dumped on the floor in a bag. She is bed bound due to an UNTREATED fractured leg, it was put in a crepe bandage and they are trying to discharge her, complete with fracture, and she is totally unable to weight bare. Her catheter bag has been left unepmtied several times to the point that it has burst all over the ward. The staff are rude and dont seem to care at all. If you ask them a question about the treatment/patients condition, you get rude abrupt answers and are basically told to go away and stop bothering them". (Participant 111)

The sense of feeling safe is important for patients and carers. For her elderly mother, P111 strongly uses the terms untreated, forced discharge, unemptied catheter, and dismissive to describe significant factors that influence negative experience.

In sum, the Sir Robert Francis Report (2011) of the Mid Staffordshire NHS Foundation Trust Public Inquiry called on healthcare providers to foster a common culture of putting the patient and their safety first to enhance support for staff providing healthcare. The failings at Mid Staffordshire NHS Foundation Trust were an extreme example of what can go wrong when patient safety culture is poor. But seeing the person in the patient, and supporting staff in the difficult work of care, even when it is delivered on an industrial scale with tight resources and competing demands, is always going to be a challenge.

4.2.1.11 Efficiency

This category includes perceptions that employees value and attempt to make efficient use of time in their dealings with patients and carers. It involves situations in which staff members do their best to attend to patients' needs quickly and to minimize waiting times and delays, such as treating patients "efficiently", "quickly", and "competently". In all, i.e., the 2% of total stories, these issues and categories represent 1.7% of direct encounters and 1.7% of total evaluations in Table 4.1. Patients wanted to feel that the service was efficient, from making an initial appointment through to being discharged from the hospital. They felt that

there should be speedier care. They wanted to feel that everything possible was being done to help them and deal with their problem quickly and effectively. Duggirala et al. (2008) state that one important dimension of administrative processes is the delays at different stages of patients' stay in the hospital.

Sample quotes – positive stories:

> "My fiance was rushed into Accident and Emergency following a fall down the stairs; he had broken his neck in 3 places. Being that it was a very serious injury, he was seen quickly and immobilised". (Participant 238)

From the findings above, it is clear that patients rate the efficiency of the hospital staff, including their responsiveness and speed in dealing with emergency situations, using terms such as "rushed" and "seen quickly".

> "Very speedy from my MRI (Eccleshill hospital) through to GP to neurosurgeons decisions to get me in for surgery (5 hours!) so I was very impressed". (Participant 195)

Similar to P238, P195 above also used expressions such as "very speedy" for efficiency.

> "The teamwork between nurses and doctors was second to none. Every single member of staff that I met was amazing. They work together, communicated with each other and with me and my husband, explaining options and involving us in decisions. I honestly dont think that they could have done more, They should be very proud of the team work and leadership throughout ambulatory care and the EAU/ward 8. You were all amazing - thank you". (Participant 487)

Teamwork and coordinated work are indispensable to efficiency because they foster the production of desired results with minimal waste of time, effort, or skill, according to P487.

Sample quotes – negative stories

Studies in the service sector have shown that delays perceived to be unreasonable or unnecessary by patients could result in not just dissatisfaction, but also anger (Diaz and Ruzz, 2002; Curry and Sinclair, 2002).

> "Complete lack of communication re timescales regarding future outpatient appointments following diagnostic tests. When manage to get an appointment, hospital are not adverse to ringing you up (more than once) trying to get you to

agree to cancel the appt and wait another 4 months - starting to feel bullied." (Participant 366)

4.2.1.12 Reliability and responsiveness

This category involves perceptions that the service provided by staff is dependable and consistent, regardless of individual employees' personal attitudes and behaviour. It was mentioned in 1% of total stories and accounts for 0.6% of total direct-encounter evaluations in Table 4.1. In Table 4.2, the identified six attributes or sub-categories represent "reliability and responsiveness" and comprise "consistency of experience over time", "delivery timeliness", "impression of reliability", "service quality", "promise of fulfilment", and "reliability of clinical process". This is consistent with Ponsignon et al.'s (2015) and Lemke et al.'s (2011) category of "Reliability" and Parasuraman et al.'s (1989) dimension of "Reliability and Responsiveness".

Sample quote – positive stories

"When I telephoned 8 times to speak with someone before attending the cetre it would have been good for them to actually answer the phone or return my call as it asked me to leave my number for them to call back. As I wasn't able to speak with someone I made my way to the centre." (Participant 370)

Sample quotes – negative stories

"Following the ultrasound scan my daughter's notes went missing which caused further delays on the ward. Eventually the consultant visited my daughter at approx 1.00pm, since no blood test results were available he advised that another night's stay was necessary for observation. Within two hours of that judgement being made (and written in her notes) we were informed, by a member of the nursing team, that my daughter was to be discharged. Subsequently, she was discharged without any indication as to what had caused her initial illness." (Participant 092)

"I would be able to rate it if i could talk to someone!!! I've been on the phone for the last hour trying to get through & all the staffs do is cut the line!!! Absolutely disgusting service!!! I'm proud that the taxes i pay goes into paying for such disgusting service!!!" (Participant 167)

4.2.1.13 Emotional support – relieving fear and anxiety

This category involves the patient's perception that suffering is more than just physical pain and other distressing symptoms; it also encompasses significant "emotional" and "spiritual" dimensions. "Patient-centred care" attends to the anxiety that accompanies all injury and illness, whether due to uncertainty, fear of pain, disability or disfigurement, loneliness, financial impact, or the effect of illness on one's family. In all, 1% of the total stories in Table 4.1 mentioned these issues. In Table 4.2, the identified four attributes or sub-categories represent "emotional support – relieving fear and anxiety" and comprise 'loneliness', 'fear of pain', 'effect of illness on family', and 'uncertainty'.

4.2.1.14 Involvement of family and friends

This category involves patients' perception of whether staff focus on accommodating family and friends on whom patients may rely, involving them as appropriate in decision-making, supporting them as caregivers, making them welcome and comfortable in the care delivery setting, and recognizing their needs and contributions. In all, i.e., 6% of the total stories in Table 4.1, the category accounts for 1.7% of the total evaluations of direct encounters. In Table 4.2, the identified four attributes or sub-categories represent "involvement of family and friends" and comprise 'informed in treatment 'decision-making, 'welcomed', 'visitor restrictions', and 'visiting times'. This suggests that first impressions are often lasting and play an important part in influencing a patient's or visitor's overall view of hospital services. For example, the first personal contact will often be at reception, and it is vital that this encounter be positive. See sample quotes below.

Sample quote positive:

Patients or visitors appreciate being acknowledged as soon as they approach the hospital reception desk and given a warm welcome by staff being friendly and courteous, always with a smile and making eye contact:

> "I was acknowledged as soon as I arrived and was greeted with a smile; straight away I felt at ease" (Participant 371)

Sample quote negative stories

> "we had to wait while the receptionist had a conversation with another member of staff. She wasn't very friendly - there was just a bored look on her face" (Participant 464)

4.2.1.15 Experience context

This category includes perceptions of aspects of the NHS healthcare service that may shape expectations of experience. In all, 0.4% of the total stories in Table 4.1 mentioned these issues, and the category represents 0.3% of the total evaluations of direct encounters

. Six attributes or sub-categories identified in Table 4.2 include "past experience", "emotive", "hedonic service type", "important timeliness", "hospital competitiveness", and "hospital size".

> "Every time I have to come to hospital I am always greeted by the receptionist with a smile and a hello. She remembers that I have been here before and is always very helpful" (Participant 027)

> " I prefer big Foundation Trusts hospitals because they have the resources to do major operations" (Participant 218)

4.2.2 Functional aspects – indirect encounters or interactions

Table 4.2 shows nine categories (dimensions) and 35 sub-categories (attributes) of CE associated with indirect encounters or interactions, mentioned in 854% of total stories in Table 4.1.

4.2.2.1 Procedures and processes

This category includes perceptions relating to the appropriateness of the processes and procedures that support the provision of care. It is mentioned in 23% of the total stories in Table 4.1 and accounts for 10.5% of the total evaluations of indirect encounters. Judgements about "procedures and processes" are almost exclusively associated with negative experiences. Six attributes or sub-categories in Table 4.2 represent this category or dimension. "Staffing levels" refers to perceptions of whether there are sufficient staff in healthcare premises and facilities. For the second sub-category, "administration", patients

and carers assess whether efficient and effective administration processes, procedures, and systems are in place. The third sub-category includes judgements about the availability and accessibility of appropriate "medical equipment, supplies, and drugs". "Service recovery" includes dimensions related to the presence and appropriateness of a system for handling feedback and complaints. "Bed management" reflects concerns about bed availability. "Security and safety" reflect a sense that patients and their belongings are secure.

Sample quotes – positive stories

> "My Dad was admitted via A&E in January, after he fell and broke his hip. He was seen and operated on in the same day. Staffs were caring and efficient. They involved my Dad fully in all treatment decisions, despite his longstanding poor memory. On the ward he was treated really well by a great staff team" (Participant 479)

Being seen and operated on in the same day and the patient's full involvement in treatment decisions is perceived as effective clinical procedural process.

> "I arrived at the radiology department for an dray after being referred by my gp. I arrived at 3.05pm and braced myself for a reasonable wait as there were twenty plus people in the waiting area. I was politely greeted by the reception staff and the waiting area was sufficient. Staff were very polite and human towards other patients when they were coming to greet them. Within ten minutes I was called by a nurse who asked me to follow her, she then explained exactly what I needed to do in terms of getting changed into the hospital gowns and keeping hold of my possessions. This had been my main concern and her clear statement pre-emptied my questions, simple but effective communication". (Participant 422)

> "As someone who previously nursed I would like to say how impressive the DTC unit is and what a terrific idea. The time spent with pre-op check-in and post op on the day of your surgery is very well organized especially as there needs to be visits by busy Surgeons, Anaesthetists and Nurses who are also operating. The whole process is very well developed and the time spent is kept to a minimum. Thank you to all the staff for your pleasant and efficient care". (Participant 038)

P422 and P038 perceive or make judgements about efficient procedures and processes with staff levels, waiting time, being greeted, organization of processes, and clear explanations of the procedures by their use of terms such as "politely greeted", waiting area sufficiently managed, "time spent", "very well organized", very well developed process, "efficient care", and "effective communication" to describe the significant factors that influence their positive experiences.

Sample quotes – negative stories

> "Comments from surgeon on ward round - He was really angry with theatre as he couldn't do all the surgery he wanted to - he should have 8 cases & only did 3. I should have gone down 1.5hrs ago but they told him that they didn't have enough equipment for me. He then addressed his team & said this is how patient care is suffering because of other dept ineptitude." (Participant 180)

> "Following decision to operate tomorrow I had no information given to me concerning my attendance tomorrow. I asked reception if I could eat or not and they had to find a nurse to tell me what I needed to do prior to admission. This may have been because I have had this operation before." (Participant 424)

P180 surprisingly describes how even doctors/consultants are angry with the ineffective administrative processes, procedures, and systems in place, including the lack of availability and accessibility of appropriate medical equipment, and for P424, the expected pre-operation information, which is a normal procedure. The consultant used expressions such as "department ineptitude" to describe the negative patient experiences.

Bed management has always been a problem in NHS hospitals due to the pressures they face. P071 used expressions such as "feeling abandoned" to describe the significant factors that influence negative experience.

> "When a member of staff tells you that you will be admitted to a temporary ward because beds have been closed and the wards are being reorganised you just know you are on a very special journey. I was, prepared for things to be a little different but was not prepared for the bay of ladies on ward 14 feeling so abandoned". (Participant 071)

This is consistent with Duggirala et al.'s (2008), Ponsignon et al.'s (2015), Lemke et al.'s (2011), Hogstrom et al.'s (2009), and Parasuraman et al.'s (1985) dimension and attributes of "Procedures and processes", which state that a critical dimension of healthcare quality is the experience of a patient with different procedures and processes that are a part of his/her stay in the hospital. Many other studies have been conducted on procedural and process management in services. Lewis (1990) stated that a process refers to service delivery systems, the various physical features associated with an organisation and its services, and the roles of an organisation's employees (both customer-contact and backroom staff) in the service encounter and the delivery of service quality. Zeithmal et al. (1990) and Parasuraman et al. (1985) described a process (in the service context) as the actual procedures,

mechanisms, and flow of activities by which service is delivered, i.e. the service delivery and operating system.

4.2.2.2 Infrastructure of hospital (premises and facilities)

This dimension includes evaluations of the pleasantness, appeal, and appropriateness of the physical tangible environment. "Premises and facilities" is mentioned in 34% of total stories in Table 4.1, represents 4.6% of indirect encounters total evaluations, and comprises six attributes. "Maintenance" reflects perceptions that facilities and premises are maintained and cleaned in a timely and effective manner. "Amenities" refers to the comfort of the service facility and the availability of useful, adequate services, such as coffee shops, vending machines, and Wi-Fi. "Appearance" involves evaluations of the attractiveness and pleasantness of the physical environment, including interior decoration, furniture, colour schemes, and lighting. "Layout" and "parking and fees" encompass dimensions concerning the physical arrangements of the premises and facilities, such as the perceived ease of navigation within the facilities or the size of the rooms. "Premises and facilities" relate to the "Atmosphere" category of Lemke et al. (2011), or the extent to which the company enables a pleasant and relaxing environment. It is close to the "Tangibles" dimension of Parasuraman et al.'s (1985) original qualitative study, and to several items from SERVQUAL, although again perhaps with more explicit indication of the importance of the service attribute in the customer's goal hierarchy, in this case to hedonic utility during the service encounter (Sanchez-Fernandez et al., 2009). Below are sample negative and positive quotes pertaining to this category.

Sample quotes – positive stories

> "In my case there was nothing that needs comment here. I was treated very well and all my needs were catered for. The building is self-contained, so all of the patients various treatments can be managed in the one building, without having to leave the cardiothoracic unit." (Participant 037)

> "The car park was reasonably priced, and my husband was always able to find a parking space" (Participant 398)

Sample quotes – negative stories

> "My five-day stay would have been much less boring and tedious if there had been strong, free wifi. In this day and age there is no excuse for its absence or need to payments In addition, the ward provides phone/tv/radio services only to 4 out of the 5 beds, leaving my wife feeling isolated - couldn't call people, bored - no TV/radio and inferior to the rest of the ward attendees. Can't understand why the same level of service is not provided to all on the ward" (Participant 349)

> "the only thing i dont really like about the hospital is the new parking eye, there really unfare with people and staff, ticketing people, its stressful enough going into hospital without having to deal with parking tickets/fines" (Participant 414)

> "Collecting me after surgery was similar and I would have preferred to have walked a shorter distance to the car! Maybe a few well defined 'drop off' parking spaces for day surgery would be something to consider in the furure please rather than being told it's OK to park in the 'yellow box' for short periods." (Participant 364)

4.2.2.3 Appearances and cleanliness

This category includes evaluations of the cleanness of the surroundings. It is mentioned in 10% of the total stories in Table 4.1 and represents 2% of the total evaluations of indirect encounters. Table 4.2 identifies three attributes of the "Appearances and cleanliness" dimension. These are 'clean and spotless', 'spacious' and 'smell of the surroundings' with a personal touch that would make patients more comfortable.

Sample quotes – positive stories

> "The modernisation and cleanliness is to be applauded" (Participant 332)

> "The waiting room was clean and there were plenty of seats." (Participant 473)

> "The ward was kept spotlessly clean by very friendly and kind staff, and it was so nice to have fresh laundered cotton sheets every day." (Participant 398)

> "I had a planned knee replacement operation at the Riverside Treatment Centre, and then stayed in Larch Ward for 5 days. The ward was kept very clean. The ward environment was very light and spacious, and the building is very modern" (Participant 486)

"The only toilet available in the A&E ward was covered in faeces and urine (and used by paramedics). Sick spouse's feet therefore covered in the same. I then had to clean feet of sick spouse." (Participant 399)

"The care I received was appalling. I spent over 5 hours in A&E, and part of that time was spent in an assessment room with blood splattered on the floor and over the trolley." (Participant 185)

4.2.2.4 Waiting times

The "Waiting time" dimension reflects perceptions that the provider meets the A&E units' NHS performance waiting times target of four hours and demonstrates that they value and attempt to make efficient use of patients' time while they are on the healthcare premises (mentioned in 9% of total stories). Table 4.2 identified the five attributes that the "waiting time" dimension is comprised of: "Appointment time" relates to whether appointments run on time; "Treatment and discharge" involves evaluations of the waiting time for admission, registration, medical treatment or intervention, and discharge; "Medication and prescription" refers to perceptions about the length of the waiting time for medication and prescriptions; "Referral time" refers to the time taken to refer the patient to a specialist or imaging examinations, etc.; and "Timeliness to diagnose" refers to how speedily a patient's illness is diagnosed from prognosis. Fig 4.2 depicts the true picture of NHS England hospitals' waiting times. Sample quotes are shown below.

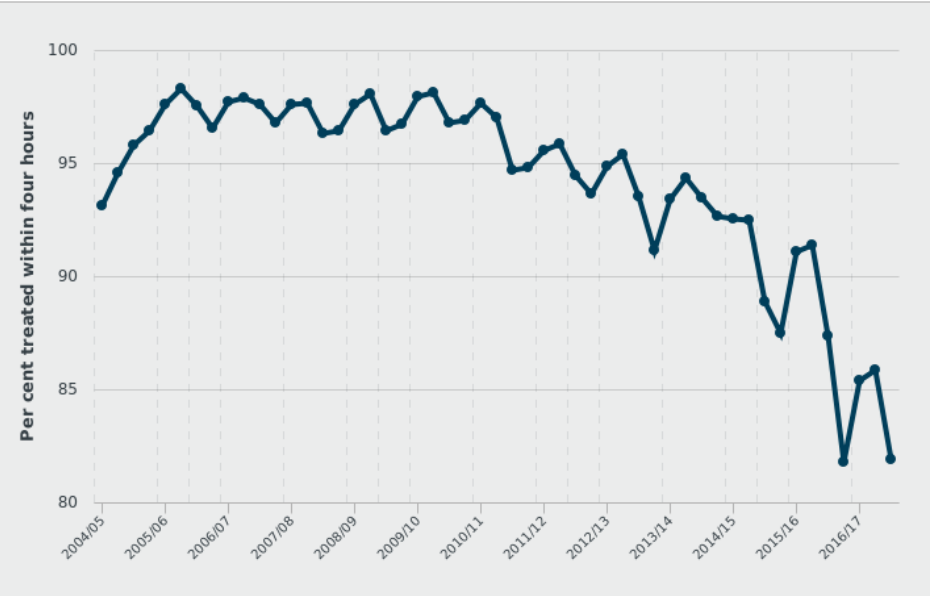


Figure 4.2: Performance against the four-hour A&E waiting time standard 2004/05 to 2016/17, quarterly data

Data source: A&E attendances and emergency admissions NHS England (2017)

Sample quotes – positive stories

> "My 14 year old daughter was doubled up with stomach pains yesterday evening after eating a light supper. I took her to Hammersmith Hospital A and E, expecting a long wait. We got there at 7.30pm and were seen, diagnosed and thoroughly reassured by 9.30pm. We felt incredibly reassured by the doctor who was thorough and explained everything to us clearly without being condescending or dismissive" (Participant 139)

> "Very speedy from my MRI (Eccleshill hospital) through to GP to neurosurgeons decisions to get me in for surgery (5 hours!) so I was very impressed" (Participant 195)

> "Early morning I know but I was received, assessed for a broken big toe,x-rayed and diagnosed with broken toe,toe strapped and advice on recovery given and I was out and on my way home within 90 minutes. I was expecting to be there for hours. Well done." (Participant 239)

Sample quotes – negative stories

> "..time of waiting,….. x rays should be issued straight away. its a joke - nothing, as wasnt kept informed of waiting times, already sat at walk in centre for over a hour to wait another 2 and half there for nothing.. so stupid" (Participant 052)

> "Upon arrival to A&E, I was taken into a room where I would sit for the next 4 hours. Nurses took an ECG, blood test, blood pressure etc. I was then left unattended with no one even looking at me for the next 2.5 hours." (Participant 053)

> "Everything... My visit for something totally routine took 4 hours (not including the two hours it took me to get there and back). I waited for 1.5 hours to be seen by a doctor. I waited for 1 hour 20 mins to get a prescription filled (and for some insane reason, only the hospital can prescribe the medication I was given...which defeats the whole purpose of the licensed pharmacy system). ……..... The reception staffs were also rude on each of my visits, often carrying on their conversations about personal matters while a queue formed and waited to be served." (Participant 343)

First, standing in line is clearly a serious challenge for many people. Often, service encounters in hospitals involve extended waits, which can put patients and their families in a bad mood, tempers can flare, and disruptive behaviour can result. The researcher discovered through data that dissatisfying critical incidents caused by others' physical behaviour while waiting in an A&E queue were quite common. Katz, Larson, and Larson (1991) argue that service organizations should entertain, enlighten, and engage their

customers while they wait, to increase their satisfaction. This study's results suggest that failing to manage customers' or patients' waiting time may be a serious oversight for CE.

4.2.2.5 Food and beverages

This dimension includes perceptions about the provision and availability of food and drinks, mentioned in 6% of the total stories in Table 4.1, and represents 1% of the total evaluations of indirect encounters. "Food quality" relates to the tastiness of food and drinks. Evaluations of "food quantity" centre on the amount of food and drinks available (and/or provided) whenever patients need them. Patients also assess the "food nutritional value" of the food and drinks served, indicating whether the types of food and drinks are appropriate for their conditions. Finally, "food taste" relates to perceptions about the appearance and appetizing variety in the range of food and drinks served. As mentioned earlier, the NHS Choices website introduced a food quality evaluation tool for patients to compare hospitals' performance on this dimension prior to their visit (refer to Fig. 2 .3 in Chapter 2).

Sample quotes – positive stories

> "I must mention the food I received; it was excellent, very fresh, tasty and plenty of it." (Participant 120)

To express satisfaction with hospital food, P120 used terms such as "excellent", "very fresh", and "tasty and plenty" to describe a positive experience.

> "The food was nutritious and there was a good choice."(Participant 037)

> "The food was good and varied and was served in an appealing manner." (Participant 163)

Sample quotes – negative stories

> "Back at N&N, last night he was too tired to see me and I said to the nurse that he badly needs to eat. He has lost 3 stone in 3 months or so, and had hardly eaten in hospital. This morning I spoke to him and he was very befuddled and said he was worn out, ascetic fluid was making it hard to get comfortable or breath. He was not supposed to eat until rounds." (Participant 222)

> "And as a side note, may I also remark at how utterly disgusting the food was. After my niece was told she could go home, they offered her a dinner - a small jacket

potato dumped on a plate with some cold soggy sweet corn, a side order of two dried cream crackers and a dessert that tasted like mouthwash and had the texture of furry washing up liquid! Luckily she had missed out on lunch but I fail to see how a soggy sandwich, a bag of crisps and a couple of custard creams is a nutritious meal for a recovering child. Shame on you, Frimley Park Hospital" (Participant 105)

"My husband recently spent three weeks in Canterbury Hospital. He received very good medical care but I would like to draw your attention to the quality of the food he received.

A decent meal greatly contributes to a patient's well-being and recovery. I appreciate budgets are tight but it's a waste of resources to provide meals that are unappetising and unpalatable. Many of them were discarded with the result that they provided no nourishment whatsover. The liver dish, normally a favourite meal for my husband, was one thick slab of pig's liver visually resembling the sole of a slipper; the Sunday roast chicken was a piece of tough greasy meat on the bone and the fish meal was fish in batter with only just a few forkfuls of meat between an enormous piece of greasy batter. Added to that was the bewildering daily decision whether or not to ask for gravy. For breakfast only highly processed cereals were on offer when fruit, yoghurt or muesli would have been more appropriate. A cooked breakfast was sometimes available but its presentation made it extremely unappealing.

I realise it's not possible to cater to individual tastes, but sick people often suffer a reduced appetite and experience a reluctance to eat. …… I feel strongly that this ought to be a matter of high priority for East Kent Hospital Trust." (Participant 180)

According to the National Clinical Guideline Centre (2012, p. 55), all healthcare professionals directly involved in patient care should receive education and training, relevant to their post, on the importance of:

- providing adequate and appropriate nutrition
- ensuring that the patient's nutrition and hydration are adequate at all times, if the patient is unable to manage this themselves, by:
  - providing regular food and fluid of adequate quantity and quality in an environment conducive to eating
  - placing food and drink where the patient can reach them easily
  - encouraging and helping the patient to eat and drink if needed
  - providing appropriate support, such as modified eating and/or drinking aids

4.2.2.6 Atmospherics and ambience

In this category are dimensions representing evaluations of the pleasantness, appeal, and relaxing effect of the atmosphere. It relates to the intangible aspects and elements of the environment, including noise levels, temperature, and odours. "Atmosphere" was mentioned in 5% of total stories in Table 4.1 and represents 0.9% of total indirect encounters evaluations. Similar to "Appearance and cleanliness", the "atmospherics and ambience" are peaceful surroundings in the sense of the mood a ward or hospital setting has. If a hospital waiting area has soft lighting and peaceful music, it creates a pleasant, soothing atmosphere that makes patients more comfortable. A bright, welcoming, and colourful environment would help reduce feelings of depression.

Sample quotes – positive stories

> "I have been visiting the Gary Weston Centre..part of Hammersmith hospital since 2009. may I say that every member of staff, medical, reception, everyone in fact has been kindness personified.....There is always a pleasant atmosphere when entering the reception area." (Participant 141)

> "very calm professional atmosphere throughout my visit. Excellent service." (Participant 335)

> "Chairs in waiting room very comfy, even when sitting in it for 6 hours!!" (Participant 467)

> "I had a planned knee replacement operation at the Riverside Treatment Centre, and then stayed in Larch Ward for 5 days. The ward was kept very clean and all staff were polite and considerate. The ward environment was very light and spacious, and the building is very modern." (Participant 486)

Sample quotes – negative stories

> "lights on made it difficult to catch up on lost sleep" (Participant 121)

> "The appearance of the hospital overall is very negative. I was there for a transplant assessment and was supposed to be there as an inpatient for 3 days. On seeing the ward and where I would be expected to remain for the tests throughout the 3 days, I refused to go ahead with the assessment, although I did have part of the assessment carried out (bloods taken, ECG, spirometry testing). (Participant 084)

> "The ward itself was dark and the atmosphere very depressing. The entrance to the building where Mallard Ward is situated was filthy!!! The automatic doors were so dirty that it looked as though we were looking through a fog. The mat at the entrance had not been hoovered in a long time and small stones/pieces of grit filled the mat and surrounding flooring area. The lift up to the ward did not have clear instructions on how to get to the floors as the buttons were so worn that the numbers/letters could not be seen. There was a sign on the wall, some of the letters were missing and filled in with a permanent marker.
>
> When a patient is going there to be assessed for heart transplant, seeing shoddy inconsistencies at 'grass roots' level does not instil confidence in the more serious aspects of patient care pre and post transplant. There was a smell of stale urine on the ward and rather than feel I was in safe hands, I actually felt immense fear and a total lack of confidence, leading me to abandon my assessment." (Participant 046)

4.2.2.7 Timely appointments

This category encompasses perceptions that the healthcare provider values and makes efficient use of patients' time when they are not present in the service facility, mentioned in 11.5% of total stories, and it represents 0.7% of total indirect encounters in Table 4.1. "Timeliness of appointment" includes perceptions that the waiting time before the next appointment date is appropriate. "Timeliness of results" refers to perceptions about whether the results of a medical act, intervention, or test are provided in a timely fashion.

Sample quotes – positive stories

> "The department of the hospital I visited was actually the Lloyd Clinic (not on the list). I found it very easy to book an appointment through the text to book service. When I arrived I was treated in a professional and friendly manner by both the reception and medical staff. I think it is an excellent service which is provided in a very accessible way. Equally, during my appointment I felt I was treated with the utmost care and attention by the staff. I was really impressed." (Participant 135)
>
> "Requests for appointments etc are always treated promptly and in the event of requiring an emergency appt...the system seems to work very well." (Participant 141)
>
> "I recently attended the antenatal clinic for my 13 week scan. The reception staff were lovely and welcoming. My appointment was on time which i wasn't expecting as it was a late afternoon appointment. …….. The reception staff then organised my next appointments and were again very friendly. All in all it was a very refreshing hospital experience!" (Participant 129)

Sample quotes – negative stories

> "When the nurse took me through to the inner waiting area she asked me who I was seeing and then informed me that he didn't even have a clinic that afternoon so she would find out who I was seeing. This was surprising as my appointment time and date had been changed four or five times in the previous few months (this was a six month follow up appointment). I eventually was seen around 5pm (my appointment was at 4pm)." (Participant 051)

> "After waiting over 52 weeks for a date for surgery at the BRI, I was offered a date for this to be carried out. This date was cancelled. I was offered another date, which would have seen me having the procedure at about 62 weeks - this date was cancelled. So, after waiting for about 59 weeks, having 2 cancellations for surgery, I've been given another date. At the moment, I'm not holding out my hope that this will actually go ahead. Maybe I'll have my operation sometime before 2015....!" (Participant 070)

4.2.2.8 Patient choice

This dimension reflects patient perceptions that the healthcare provider offers an appropriate variety of care and treatment services. "Patient choice" was mentioned in 8% of total stories in Table 4.1 and represents 1.1% of total indirect encounters evaluations. In Table 4.2, the four attributes representing the patient choice dimension comprise "appropriate degree of variety", "breadth of services range", "pick and choose", and "provision of choice". Since April 2008, patients in England have been able to choose treatment from any hospital listed in a national directory of services, which includes NHS acute Trusts, Foundation Trusts, and independent sector providers, so-called 'free choice' of provider. This will include many private hospitals as long as they provide services to the NHS, and it does not cost the NHS any more than a referral to a traditional NHS hospital. They can also choose a clinical team led by a consultant or named healthcare professional, if that team provides the treatment they require (see the example in Fig. 2.2, Chapter 2). This study's findings show that 9% of respondents said choice was either "very important" or "important" to them.

Sample quotes

> "I liked being able to choose where I went for treatment. Knowing there were different hospitals and teams available made me feel I had some control, rather than just being sent somewhere without any say." (Participant 162)

4.3 Independent – (unexpected encounters or interactions)

The researcher identified three main dimensions and eight attributes or sub-categories of CE, representing independent or unexpected encounters, mentioned in 12% of the total stories.

> "It was often the things that were not scheduled or formally part of my care that made the biggest difference to my overall experience." (Participant 103)

4.3.1 Management and financial issues

This category or dimension encompasses perceptions that the healthcare provider is sound both in management and financial performance, mentioned in 8% of total stories. This is a great concern, particularly with focus on NHS deficit cuts which impact negatively on the hospital services and "investment" in improvements and medical equipment, and "staffing recruitment". In 2015-16, NHS England recorded £2.45bn overspend. Chris Hopson, chief executive of NHS Providers, which represents trusts, described the latest figures as worrying. He said trusts were expected to operate with a "wafer-thin" margin for error. "We shouldn't kid ourselves. The NHS's underlying financial position is not sustainable," he added. The NHS is in the middle of the tightest financial settlement since its creation. Since 2010, the budget has risen by an average of 1% per year, compared to more than 4% during the rest of its history, as shown in Figure 4.3 (NHS, 2017). Similar concerns have been raised by several participants, including their impact on healthcare experiences; see the sample quote below.

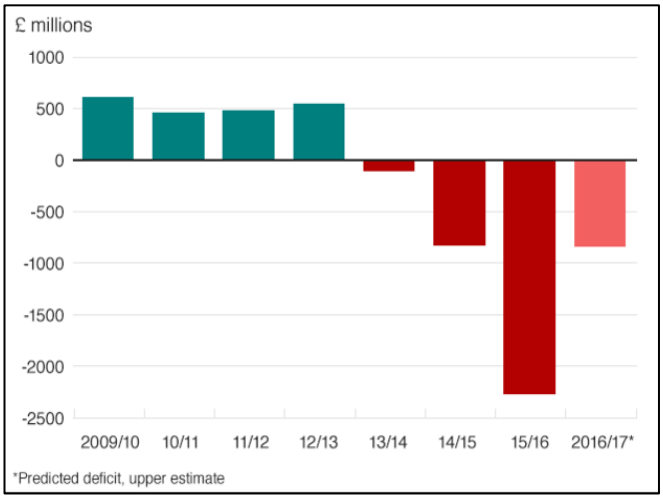


Figure 4.3: NHS budget trends since 2009

Source: Department of Health (2017)

(www.gov.uk/government/organisations/department-of-healthwww.nhs.uk)

According to IFS (2017), since the NHS was created in 1948, the average annual rise has been just over 4%. During the Labour years under Blair and Brown, this was closer to 7%. Fig. 4 .4 shows the financial challenges mentioned by participants.

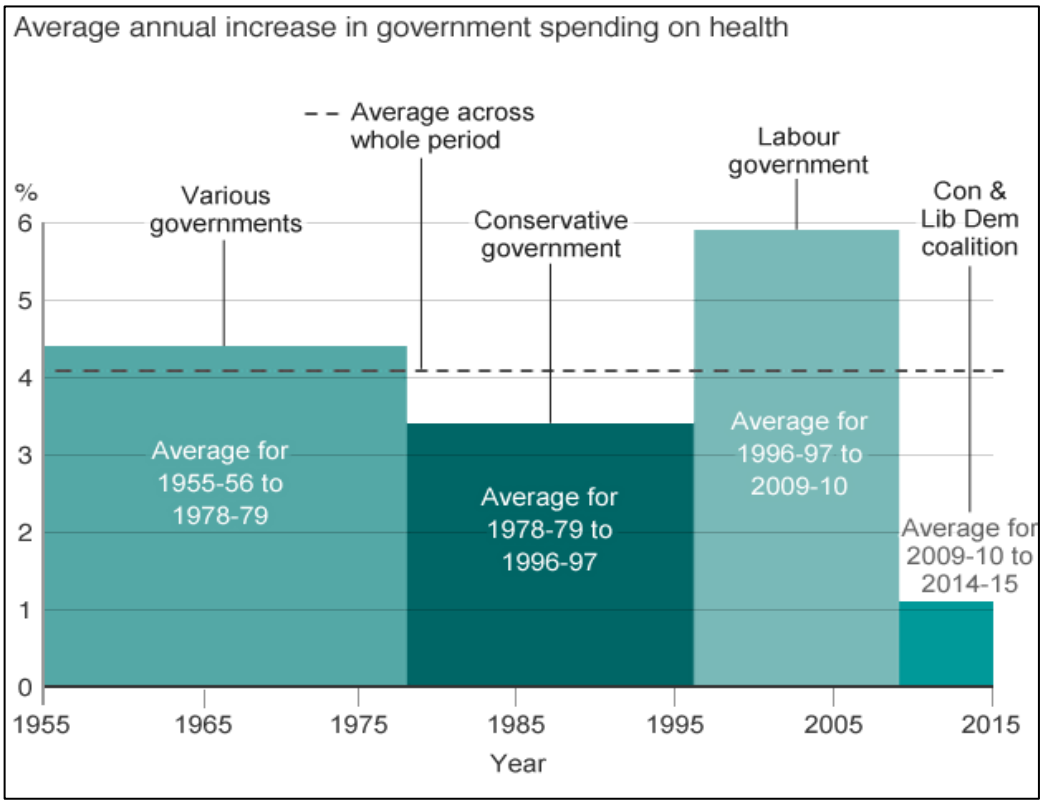


Figure 4.4: How spending on health slowed down

Source: IFS (2017) (www.ifs.org.uk/)

4.3.2 Performance and brand reputation

In this category are dimensions that reflect perceptions of the healthcare provider's reputation, brand, or name. “Reputation and brand” can shape expectations of the healthcare experience. It was mentioned in 3.5% of stories. For example, recent negative stories, such as the BBC Panorama documentary on NHS hospitals, the Dr Foster Hospital Guide on hospital mortality rate benchmarks, and previous horrendous stories from Mid Staffordshire NHS Foundation Trust, create negative expectations about healthcare experiences prior to visiting the hospitals. This is also linked to relationship outcomes, such as word-of-mouth or recommendation intentions.

Add quote

4.3.3 External integrated care

This category represents perceptions about the effectiveness of communication between the healthcare provider and external health service providers and third parties. Integrated care, also known as integrated health, coordinated care, comprehensive care, seamless care, or transmural care, is a worldwide trend in healthcare reforms and new organizational arrangements focusing on more coordinated and integrated forms of care provision. It was mentioned in 0.5% of stories. Despite the media focus on A&E, patients' main concerns are delayed transfer of care, staff morale, high bed-occupancy rates, and Figure 4.5, which supports patients' perceptions, as evidenced by the sample quotes below.

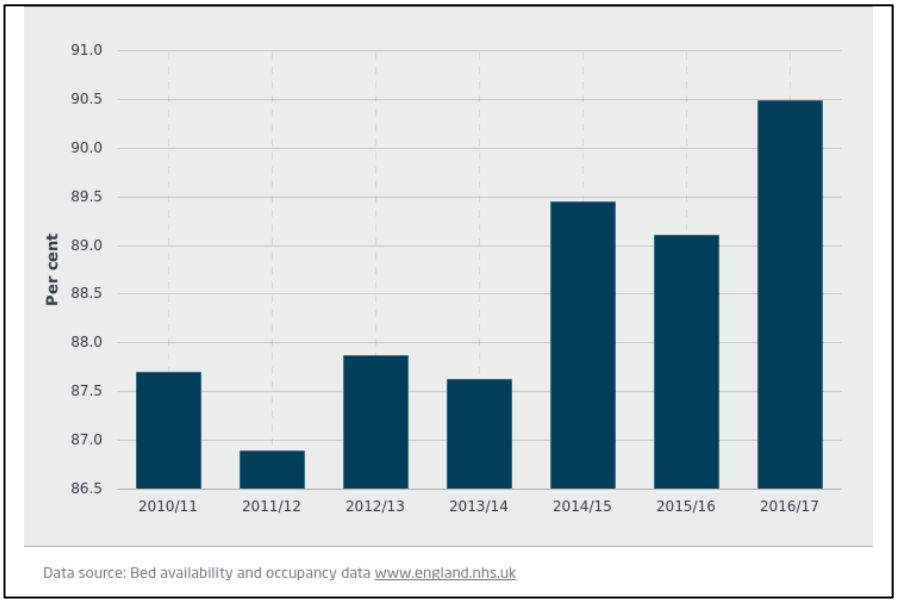


Figure 4.5: Bed occupancy at quarter 3, 2010/11 to 2016/17 general and acute beds

Data source: Bed availability and occupancy data (www.england.nhs.uk)

Sample quotes

> "I cannot get a bed for my urgent operation because the wards are full of frail older people and those with long-term conditions, care is too often fragmented when it should be co-ordinated around their needs within social care" (Participant 077).

> "…most people in the NHS are unfamiliar with the methods that can achieve this …The poverty of integrated care in the NHS should not be surprising – we all know how difficult it is to build trusted relationships, and how easily they break down. The NHS is large and full of divisive structures. Practitioners are trained in one-to-one care and not in whole system collaboration to manage integrated care". (Participant 123)

4.4 Clinical outcomes

> "Clinical outcome" refers to judgements about the final outcome of the healthcare experience (e.g. cured or not cured) or about the outcome of a specific medical intervention or treatment, mentioned in 14% of stories. Sub-categories include "affective commitment", "feel cured or healed factor", and "impression impact".

quotes

4.5 Participant advice

Apart from commenting on the positive and negative experiences of the NHS, the NHS Choices website encourages patients to provide "Advice" to the hospitals. All participants were given the option to suggest how their ideal experience may be achieved. Many were cynical about this and left the text box empty, but a few gave numerous practical suggestions on the way forward. Specific suggestions on the identified main categories or dimensions are outlined in the next sections. Even though the aim of this thesis is not to consider CE as a road map for hospitals' improvement or service redesign, the literature identifies customer/patient experience as the single most important indicator of quality in healthcare and health service improvement. For those reasons, this study includes these reviews in the findings.

There are a few factors and underlying issues that informed and influenced participants' reviews or stories of their hospital experiences. The interplay among patient expectations, experiences, and satisfaction is complex. Patients tend to report having low expectations and not being surprised by low-quality service; however, there is a deep-rooted expectation that their personal experience will be better than the norm. They profess to being resigned to not being treated as an individual, but a more personal touch is an underlying theme in many discussions about their experiences and feelings.

Recently, patient participation in co-creating value has received much credence in healthcare research. Their active participation in clinical encounters is well documented to improve expected service outcomes (Bitner et al., 1997; Gill et al., 2011; McColl-Kennedy et al., 2012). Furthermore, the upsurge of consumerism in healthcare (Jaakkola and Halinen, 2006), whereby patients seek information from several sources, including the Internet or online communities, is changing the face of clinical encounters and provider relationships

(Gutierrez et al., 2014; Heidenreich and Handrich, 2015; Nambisan and Nambisan, 2009; Silver, 2015).

4.5.1 Participant advice – the ideal patient experience

As discussed earlier in Section 3.8 of the data analysis, 16 categories were identified from participants' responses under "Advice," which appeared in 51.3% of all "Advice" stories, as shown in Table 4.4. The main participant advice categories comprise "Appointments", "Parking and fees", "Staff levels", "Communication", "Emergency complaints procedure", "Environment layout", "Waiting area", "Noise", "A&E closures", and "Waiting time". The Department of Health (2015) wants stories on NHS Choices to help improve healthcare in NHS hospitals and other healthcare settings – and to do so in ways which everyone can see and understand. Differences among participants largely disappeared in the text narratives of the ideal patient experience at the emotional level. There was a very strong convergence of opinion about what would constitute the ideal, with patients wanting to feel reassured, confident, cared for, informed, safe, and relaxed. Many of these ideal emotions are interlinked, making it difficult to disentangle them to rank them by importance. However, the notion of reassurance was key – being reassured that they were safe and 'in good hands'. Table 4.4 shows the category frequencies of advice given by participants. Many were cynical about this and felt it was unlikely, but gave numerous practical suggestions or advice – specific advice is outlined below by dimensions.

NODE REPORTS (Titles alphabetical) ARCHIVE DATA RESPONSES	Documents (470)	% of 470 stories
ADVICE (collective customers advice to NHS)		
Blanks	-299	0.0%
A&E closing hours	15	3.2%
Amenities	9	1.9%
Appointments	17	3.6%
Communication	36	7.7%
Do not change or close hospital	9	1.9%
Emergency complaints procedures	16	3.4%
Infection control	8	1.7%
Layout	13	2.8%
Matron	7	1.5%
Miscarriage care	5	1.1%
Noise	9	1.9%
Parking	16	3.4%
Second birthing pool	4	0.9%
Staff	16	3.4%
Waiting area	29	6.2%
Waiting times	32	6.8%
Total	**241**	**51.3%**

Table 4.1: Collective customers' advice to NHS hospitals management by category

Sample quotes – participants' advice on appointments:

"Advice on appointments" was mentioned in 3.7% of total "Advice" stories. Sample quotes are given below:

> "I recently received an appointment for the eye department and needed to change it for a different date. I rang the number on the letter hour upon hour, morning and afternoon and day after day. At no time did anyone answer the telephone.

I notice when attending various departments in your hospital that you are publishing how many patients are failing to attend appointments. This could easily be reduced if it were possible to speak with the staff to change the date and time.

To pay you a compliment I then received an appointment for an MRI, I rang the department with a query on several occasions and the telephone was answered promptly by a member of staff who was capable of answering my questions in a professional manner.

I wonder if you check your figures if you will find that there are less non attenders in the MRI department than in the eyes department!" (Participant 026)

"Getting swabbed etc on the day of the initial consultation was fine, would it not save patient and hospital time if the pre-op could be done at the same time?" (Participant 367)

Sample quotes – advice from participants on communication issues

"Advice on communication issues" was mentioned in 7.7% of total "Advice" stories. Sample quotes are given below:

"Outbreaks of norovirus and similar will continue - this is another issue entirely but when it happens, please increase accessibility to doctors and nurses (who have knowledge of the patients). Call back when you say you will. Have someone take responsibility for taking messages and don't make it the patients' relatives responsibility to keep telephoning, fruitlessly".(Participant 018)

"On the Sunday we were informed at two pm that my father was well enough to go home. We would have to wait for the doctor to sign my fathers script before discharge. We were told that the doctor would be coming around soon. We were told on numerous occasions that the doctor was in fact on her way. We finally received the script at seven o clock that night. My father was in a emotionally frail state of mind and physically drained, this waiting caused both of my parents a great deal of unwarranted stress. The doctor did not even come in and see my father but sent an auxiliary nurse in with the script (a list of medication). We waited five hours for something which would in fact have taken a couple of seconds to complete. I realise that it was a weekend and staff will be short but feel it is very important that a procedure is put in place to prevent this situation happening again. That is without even mentioning the car parking charges!!" (Participant 237)

Sample quote – advice from participants on matron system

> "Advice on matron system" was mentioned in 1.5% of total "Advice" stories. A sample quote is given below:
>
> "I would like to see the matron more often. I know they wear red but no one I spoke to said they had seen her". (Participant 030)

Sample quote – advice from participants on pregnancy miscarriage care

"Advice on pregnancy miscarriage care" was mentioned in 1.1% of total "Advice" stories. Sample quotes are given below:

> "…I attended various appointments for bloods after the miscarriage and was very pleased that the hospital did not discharge me until I had a negative pregnancy test but I just felt that women who suffer miscarriage should be treated with a little bit more sensitivity.
>
> I now know that miscarriage is common but it is not common for the woman who is suffering from the loss of a future with their child. They should not be put in EPAU where you have to sit "outside" of the main ante-natal unit and see women who are in a position that you wish you were in or be told that it is game of russian roulette and that you are the unlucky one - I already knew that!
>
> I believe that for something that is so common more sensitivity should be given -a designated room/unit to go to so that you do not have to sit with pregnant mums. A unit that has much more information about miscarriage for you to look at so that you know that you are not the only one - telephone numbers that you can call etc.
>
> I just hope that more can be done because having a miscarriage is dreadful enough and just needs a little more thought into how and where women are treated after". (Participant 107)

Sample quote – advice from participant on noise

"Advice on noise issues" was mentioned in 1.9% of total "Advice" stories. A sample quote is given below:

> "Extremely noisy metal trolleys rattling around the wards emitting noise louder than a jet engine!! I would estimate louder than 90 dB(A)- investing in quieter versions or oiling the wheel would cut noise considerably".(Participant 361)

Sample quote – advice from participants on hospital environmental layout:

"Advice on hospital environmental layout" was mentioned in 2.8% of total "Advice" stories. A sample quote is given below:

> "How rubbish is this hospital they just don't seem concerned about people's health they make you sit waiting up to sometimes a 4hr wait with only 2 doctors sometimes working then they send you of for X-ray in different department and then you have to sit and wait another hour or more to find out the outcome and they still then send you home with just pain tabs and get you to return next day to fracture clinic and then they the same do now just send you home with fractured arm that's twisted and a sling no cast dam joke.why can't they do the a&e so they have an X-ray department in the clinic so they would then half people's waiting times the whole hospital is a joke I now refuse the hospital as quicker to attend Norfolk n Norwich as far better care and understanding with there patients than JPH have." (Participant 091)

Sample quotes – advice from participants on hospital car park

"Advice on hospital car park and fees" was mentioned in 3.4% of total "Advice" stories. Sample quotes are given below:

> "Even worse, one staffer explained to me that staff either plan to arrive 30 mins early just to chase down parking, for which they must pay out of their salaries. And if there are no spaces, they have to pay- additionally- for public parking & do not get reimbursed. The stress of that must diminish the quality of service they are able to offer. More often, the staff explained, staffers call in late for their shifts because of parking. My concern is that that if I arrive at A&E, the staff member that could save my life could be roaming around the parking lot, or arrived stressed over the horrid situation. This is unacceptable & there are several areas where this could be improved. Certainly A&E needs ample free, accessible parking. But even a change machine would help. Or excess change in the restaurant. Simple things." (Participant 241)

> "I have just received a letter from Parking Eye who have responsibility for the hospital car park. I've been reading up on them and they are a very unpleasant company who make their money by threatening people with fines which are not legally enforceable. If you get one of their letters read some of the advice available on line before you decide how to respond. It is shocking that the NHS is allowing companies like this to be involved in running their premises" (Participant 413)

Sample quotes – advice from participants on staff

"Advice on staff" was mentioned in 3.4% of total "Advice" stories. A sample quote is given below:

> "All nurses & employees of hospitals should also be stopped from giving personal reviews. Also employees should be band from using Facebook whilst on hospital grounds, via mobile phones, texting mates. This is a hospital lets have some discipline please." (Participant 062)

Sample quotes - advice from participants on waiting times

"Advice on waiting times" was mentioned in 6.8% of total "Advice" stories. This category had a greater significant frequency than others. A sample quote is given below:

> "Getting swabbed etc on the day of the initial consultation was fine, would it not save patient and hospital time if the pre-op could be done at the same time?" (Participant 367)

> "Just wish you had more space for respiratory beds as the waits are tough when you feel unwell and going downhill health wise." (Participant 234)

Sample quote – advice forom participant on waiting area:

"Advice on waiting times" was mentioned in 6.2% of total "Advice" stories. This category had a significant frequency compared with others. A sample quote is given below:

> "Different seats in the waiting room - they are hard and cold to sit on". (Participants 088)

Sample quote – advice from participants on A&E closing hours:

"Advice on A&E closing hours" was mentioned in 3.2% of total "Advice" stories. A sample quote is given below:

> "I do however think that the A&E dept should NOT close at 10 pm until 8 am, as i think that will mean anyone with an emergency such as heart problem or like me breathing problems, will have to travel up to Stoke. I do not think this is acceptable". (Participant P408)

Sample quotes – advice from participants on not to close hospital

"Advice on not to close hospital" was mentioned in 3.2% of total "Advice" stories. According to the NHS Confederation 2017 report, hospital services in nearly two-thirds of England could be cut or scaled back, and it was found that 28 proposals would affect hospital care, from full closures to centralizing services, such as A&E and stroke care, on fewer sites. Figure 4.6 depicts the closure of this hospital and its impact on patients and staff. Sample quotes are given below:

> "All I ask, please don't close or move George Eliot. Coventry Hospital is to far for some people to travel to, plus there is never any parking at Coventry Hospital and the parking is to expensive". (Participant 128)

> "Please don't alter the NHS. The only thing wrong is the general wards, otherwise it works really well and does a marvellous job". (Participant 429)

Figure 4.6: Impact of closed hospital on patients and staff

Source: (www.bbc.co.uk)

4.6 Factors influencing positive and negative customer experiences: findings

As mentioned earlier, participants' sympathy for staff tends to lead them to believe the blame for NHS failings lies primarily with top-level management and government for the current NHS England hospitals' overcrowded A&Es, bed capacity shortages, and staff shortages. They also make the explicit link between staff satisfaction and patient satisfaction or

experience. Happier staff will result in a better emotional experience; for example, the P188 quote below. Figure 4.7 depicts staff's frustrations under the current conditions.

> "I don't think it's just the patients though that have got frustration and intolerance, the nurses and the doctors I think they're frustrated with the way things are going, you know, they have lack of resources and, you know, lack of staff and stuff like that, you know, so they're a bit cheesed off as well and it comes through in their work." (ParticIpant P188)

Figure 4.7: Picture depicts staff's frustrations with the system

Source: (www. bbc.co.uk)

Many participants link their emotional health to their physical health. Many believed a positive emotional experience was an important part of the healing process.

> "[in an ideal world] We'd be listened to and we'd be treated individually. We'd be happy and healthy, confident and hopeful in our treatment and safe and comfortable. I think it's important so that you've got peace of mind as that alleviates all your stress and you can get on with it afterwards and get on with your life. You've got some self-esteem because you're more individually treated. (Participant 186)

The participants expressed a strong desire to feel proud of the NHS and of the service they had received, particularly compared with the service provided in other countries. Patients wanted to be able to recommend the service to others, i.e. to be active advocates of the NHS. Opinions and feelings differed enormously, as they depend on several factors, including location, illness, age, and the extent of NHS contact. Some participants (especially those receiving specialist treatments such as cancer care) have had very positive experiences in

primary care and/or hospital treatment. However, a large percentage also experienced negative feelings in NHS care; this is particularly common in urgent emergency care in A&E and elective care. There also appears to be a distinct divide between people who use small general NHS hospitals, who have generally more negative experiences and feelings, and those who use large NHS FT hospitals and specialist hospital trusts.

4.6.1 Exploring the emotional valence of customer experience in NHS hospitals

Emotional valence refers to whether an emotion is positive or negative. This is relevant to this study, which aims to better understand the significant factors influencing positive and negative customer experiences in NHS England hospitals. Positive and negative emotional findings from experience or feelings will be discussed separately below, beginning with NHS hospital customers' positive emotions. When investigating the role of emotion, most studies have examined emotional valence (see, for example, Bagozzi et al., 1999; Botha & Reyneke, 2013; Botha & Botha, 2013). This study focuses on specific emotions in CE within the NHS hospital context and sheds light on the emotional valence of CE, with attention to both positive and negative emotions.

4.6.1.1 Positive emotions or feelings:

Earlier, in Chapter 2, the circumplex of emotion in CE, adopted from Giannakopoulos et al. (2009) and originating from Russel (1980), was discussed. In the circumplex of emotion, certain emotions, such as excitement, interest, content, and calm, can be classified as comprising positive emotion (see Giannakopoulos *et al*., 2009). Within positive emotion, some are considered high-arousal, such as excitement and interest, and others low-arousal, such as contentment and calm (see Giannakopoulos *et al*., 2009).

Scherer's (2005) definition of emotion, as "an episode of interrelated, synchronised changes in the states of all or most of the five orgasmic subsystems in response to the evaluation of an external or internal stimulus event, as [being] relevant to major concerns of the organism", was applied to this study and explains that emotional reactions are responses to events that occur. Positive emotional reactions occur when individuals are assisted in achieving their goals (Rimé, 2009) or when they achieve their goal (Bagozzi et al., 1999). The section below addresses the finding of CE negative emotion.

4.6.1.2 Positive experiences

There are numerous examples of good experiences with the NHS hospitals. Some patients spoke about feeling important and that they were being taken care of by the NHS. There was a greater incidence of this in the specialist NHS hospitals. It was also particularly common for inpatients to feel this way, rather than those in A&E care. Common positive feelings included feeling supported, reassured, and looked after, and patients also felt excited to finally be treated or to have their operation. They were appreciative of the staff's efforts to make them feel relaxed before their treatment and were also calmed by detailed explanations of the procedure they were undergoing. Many reported feeling happy and relieved after receiving their treatment.

Patients generally felt that private hospital treatment is more likely to result in:

- Being treated as an individual, and your 'visitors looked after'
- Receiving the 'personalized touch'
- Being well cared for and looked after – *'proactively, responsively'*
- Feeling more relaxed
- Experiencing a quiet and 'calm hospital environment'

The quality of medical care provided by NHS hospitals was generally considered at least as good as that of private hospital healthcare. However, there was a sense that NHS hospitals could learn from private healthcare in terms of providing positive experiences and a relaxed, calm environment where staff have time for you. At its best, the typical NHS does provide this and is as good as private healthcare. Many participants felt that private healthcare would be preferable to NHS hospitals if available. However, this belief seemed strongest among those with no experience of private healthcare or those who had negative experiences of the NHS. It was felt that private healthcare did provide a quicker service. The speed with which patients could be seen, particularly when their ailments were minor or required less urgent attention, was cited as the main reason to pay (or via NHS patient choice referral system) for private healthcare if NHS treatment received had been satisfactory:

> "If it's a minor ailment it will be quicker private but the more serious it is the better the National Health is." (Participant 346)

> "The same job but done quicker" (Participant 167)

Participants who had more negative experiences of NHS hospitals focused on the individual time spent with patients in private hospital care. Participants felt that they were made to feel more special and important, and that they were listened to and cared about. Those who had positive experiences of the NHS felt the level of care was much the same between the two services (it was the speed that made the difference), and they would not pay for private care.

> "I felt like they had time to talk to me, and even the lady that I saw before the doctor, the way she spoke to you, and the way she had time, then like this lady said, surroundings was lovely as well." (private care, Participant 023)

Another key area of difference concerned the surroundings and environment that private healthcare can offer. There were many references to private healthcare being like a 'hotel'. Private rooms, en-suite facilities, television and videos, and better food were all desirable to patients. It was noted that the atmosphere was calmer, allowing patients to feel more relaxed and peaceful.

> "Because there's more money invested into the private care, as you, like when you go in they make it all so comfy for you, you know, it doesn't feel like a hospital, when you're going in." (Participant 006)

4.6.1.3 Negative experiences

In light of Scherer's (2005) definition of emotion, which explains that certain events trigger emotional reactions, negative emotion can be explained. Negative emotion arises when people are prevented from achieving their goal (Bagozzi *et al.*, 1999), leading to negative emotional reactions, such as anxiety and insecurity, due to lower self-esteem, self-confidence, and self-efficacy (Rimé, 2009). Therefore, when events prevent people from achieving their goals, they experience negative emotional reactions.

Similar to positive emotions, this study's findings show that certain emotions, such as anger, annoyance, sadness, and boredom, are classified as negative emotions (see Giannakopoulos *et al.*, 2009). Within these negative emotions, some are considered high-arousal, such as anger and annoyance, while others are low-arousal, such as sadness and boredom (see Giannakopoulos *et al.*, 2009). Thus, the following discusses the findings of the patients' negative emotions or feelings.

Patients' experiences of the NHS occur at times of their lives when they are at their most vulnerable and emotional; therefore, the intensity of their feelings becomes heightened. They can feel 'tired' and 'tearful', and there are numerous references to feeling generally 'emotional'. However, according to patient stories, many initially found it difficult to articulate their personal feelings. They tended to project negative feelings onto the NHS as a whole and expressed frustration and irritation at perceived management failings. They tended to avoid blaming health professionals for failings, as they perceived them as providing a service under difficult circumstances, particularly given the current NHS austerity budget cuts.

> "Sometimes they forget that you're feeling very emotional for whatever reason. You might be upset, you might be stressed, confused and they don't always accept that you've got varying emotions" (Participant 239)

Several common negative feelings were identified. Feelings of confusion, disappointment, annoyance, and frustration with the current system were expressed. This was attributed to a number of causes, including 'poor communication', 'lack of information', ' long periods of waiting', being passed from 'pillar to post', and unfamiliarity with medical jargon. A perceived lack of 'personal care and attention' leaves patients feeling insignificant, unimportant, ignored, and fundamentally alone. This is compounded by the sheer size and complexity of the NHS system. There was a strong call for more personalization.

> "They try to explain it to you but they haven't got the time anymore, there's not enough of them and they haven't got the time to come and sit by your bed and hold your hand and have a chat with you…which is what you want" (Participant 073)

Patients often felt they were treated as a number rather than as an individual. They felt they were not given sufficient time with health professionals. Patients referred to feeling like a number, part of the process. Some felt as though they were shunted from one place to the next, rather like moving down a production line. They can feel patronized by doctors, nurses, and consultants, and there were numerous references to being made to feel 'stupid'. There are also feelings of guilt associated with this; patients can feel they are taking up too much time, and this can lead them to feel unable to ask or repeat questions or have their diagnosis re-explained. This reduces confidence levels while increasing frustration. Some patients feel overwhelmed by the whole experience, particularly in A&E. Patients described feeling overpowered by the situation, people rushing by, and feeling unimportant. They can feel

isolated and, furthermore, they feel unsafe, which can lead to feelings of helplessness and stress.

> "We've got someone left in the dark, a man with his blindfold on, all sorts of voices going round in your head, the sort of confusion part of it and the different advice keeps spinning round…it's [a picture] of the loneliness that you feel on your own" (Participant 047)

> "All the little GPs' surgeries are feeding this monster of a hospital and I'm over there you see and quite insignificant in the whole process and just getting lost when I get in the hospital" (Particpant 083)

Patients identify a number of synonyms for fear (scared, terrified, anxious, worried, frightened), and while they acknowledge that many of these experiences or feelings are natural due to their health condition, they feel that the NHS is not responsive enough to even recognize these feelings.

4.6.2 The ideal world

There was a strong convergence of opinion on experiences and emotions that would result from an ideal NHS hospital. Some of the key positive experiences identified are experienced currently, and there was not necessarily a large gap between reality and the ideal. For example, 67.9% of participants felt satisfied, confident, and cared for. However, some emotions are important but not currently part of the patient experience; patients are less likely to feel informed or special/individual. There are two key divisions that form the basis for the ideal emotions patients want to feel: firstly, the experience of knowing that the staff are competent, and secondly, the experience of how they are treated by those staff.

4.6.2.1 Findings – key ideal experiences or feelings

Reassured

This constitutes one of the most important feelings to experience, and it was reported by 72.4% of participants. It encompasses feelings of confidence, safety, and being cared for. Reassurance was important at all stages of the continuum of patient care or journey. Also, reassurance was derived from knowing that staff are highly skilled and trained (including, for some, sharing best practice), and from being kept well-informed by staff through clear explanations and continuity of relationships with the consultant, doctor, or other health

professional. Additionally, reassurance was dependent on whichever health professional was treating the patient, and, presumably, on the one with the most active role in the treatment or diagnosis.

Confident

This finding relates to three key aspects. Firstly, it relates to feeling confident that staff are competent and are doing their utmost for all patients. Secondly, it is connected to feeling confident that there are sufficient staff levels to cope with all situations and demands, regardless of the austerity budget cuts. Third, it is linked to feeling confident that the NHS provides an equal and quality service to all, e.g. no postcode lottery – positive NHS press was seen as a means of building confidence.

Additionally, feeling confident in staff and the system was seen to be most important during the initial diagnostic and treatment stages, where early diagnosis and effective treatment facilitate a quick recovery; it was especially important to feel confident in doctors and nurses in A&E. If patients feel confident, it helps them to feel relaxed and secure. Trust was implicit in this, but participants seldom mentioned it explicitly, yet it underpins many of the ideal experiences and the values the NHS should aspire to. On that note, if patients trust the NHS, they are more likely to feel many of the ideal emotions. Trust also refers to trusting staff to do their job; trusting that they are given the 'right' information; trusting in staff's skill, knowledge, and professionalism; and trusting that it is a clean, safe, and secure environment.

Treated as an individual and not a number; special, personalized touch

This was important for all patients and was a significant experience factor, most notably lacking in the NHS hospital service that many participants had received. It was important for patients' self-esteem: recognition that they and their conditions were important to hospital staff. It was also a factor in creating trust and confidence in the health professional–patient or carer relationship.

Being treated as an individual involves patients feeling important, not being rushed through their appointments or pressured to leave, having their concerns or worries talked through and understood, and being respected as individuals and taken seriously. This was felt to be essential in contact with all professional staff and at all stages in the patient journey. Additionally, participants felt that being treated as an individual depends on the "attitude"

and manner of the health professional; patients make frequent references to returning to the traditional values of the 'Florence Nightingale' kind of matron who knew their patients and their individual history well. Also, being treated as an individual relates to a desire to be held responsible and to feel that someone is accountable to the patient. Patients and carers wanted to be allowed to be 'self-aware' – to have input into the decisions which health professionals make, based on their own knowledge of their bodies. Respect was also implicit to this; see sample quotes below.

> "It's good when you are made to feel special and given tailored attention and it's just reassuring despite what you're having to go through, to be faced with a smile was a nice way of having to go through it" (Participant 033)

> "They make you feel valued even though they've probably got a 100 other people they are dealing with. You at that moment are the special one" (Participant 193)

Cared for, supported, looked after

Although this incorporates many of the elements of being treated as an individual, it is worthwhile highlighting, as these feelings are frequently referred to. Patients would like to feel cared for at every stage of the journey (particularly during aftercare, where this was often felt to be lacking) and to be cared for by all the healthcare professionals and staff they come into contact with, from receptionists to consultants. Being cared for involves being listened to and empathized with. Patients suggested that staff could be employed specifically to provide this in hospital by visiting the wards and talking to patients; this would fill the void which patients feel exists currently with nurses, particularly being too busy to spend time helping patients feel a sense of well-being and care beyond the essential contact they experience when being treated.

Healthy, cured, or treated (medical outcomes)

At a basic level, all patients and carers wanted to feel this, and it is perceived as the core service the NHS hospitals provide. This relates to participants seeing their experience as a process with a positive, healthy end result.

Informed

This was another significant factor for positive or negative experience and includes two aspects. Patients and their families wanted to be informed about the issues surrounding their condition and to be kept updated on their progress through the system. Generally, patients and carers wanted to understand all elements of their problem, its treatment, and any possible side effects. Feeling informed allowed patients or carers to feel in control and involved with what would/could happen, which in turn made them feel confident and eased their anxiety or stress. Many elements are important to achieve this:

- more time for consultations to allow time to cover all possibilities
- health professionals avoiding using medical jargon or assuming too much knowledge, which can leave patients feeling confused and stupid
- not patronizing patients and carers, by enabling them to ask questions or to have points repeated or re-explained
- providing written material for patients to read at their leisure afterwards, which covers the key points and prepares them for side effects and outcomes
- staff who speak English well and who try to make sure that patients understand

> "The summary of my NHS so far would be sort of two halves in that attention from the less senior people has generally been more caring and they have more time for me and then with the more senior, male, I've been rushed, I've been delayed, I've been waiting and they've been abrupt" (Participant 017)

> "They just make you feel stupid. You know some of their comments are very condescending and they just assume you know nothing whereas, actually, we know more about our own bodies than most doctors" (Participant 199)

> "I just feel helpless when I got to see the doctor, it's the last thing I want to do, because if I can sort myself out then I would, but it's relying on others" (Participants 231)

Treated efficiently, quickly, and competently

Patients wanted to feel that the service was efficient, from making an initial appointment through to being discharged from the hospital. They felt that there should be speedier care. They wanted to feel that everything possible was being done to help them and deal with their problem quickly and effectively.

Happy/satisfied

Patients wanted to feel happy and satisfied with the medical and emotional treatment they received. At the end of the process, patients wanted to feel satisfied with the service they had received. This would be the result of knowledge that everything possible had been done by all concerned; patients acknowledge that, if this were the case and the desired positive result was not achieved, a feeling of satisfaction with the NHS would remain.

Safe, secure, clean

Patients ultimately wanted to feel they were being treated professionally and in safe hands, i.e., safe medical treatment. They also wanted to feel safe from infection in the hospital (the prevalence of MRSA was commonly discussed). Personal safety/security was also an issue to patients in A&E, especially those going late at night with small children, where patients do not want to feel threatened or intimidated (particularly in urban/suburban areas). Some patients suggested that separate areas could be made available to different age groups, for example, children, adults, and elderly people, to assist this feeling.

Relaxed and comfortable

Not stressed, peaceful, not hurried. Relaxed environment. Time to talk, and time to be treated properly. During time spent in a GP's surgery or in hospital, the surroundings were an important factor in helping patients to relax and feel comfortable. Clean surroundings with a personal touch, equipped with books, up-to-date magazines, and drinking water, would make patients more comfortable. A bright, welcoming, and colourful environment would help reduce feelings of depression.

Pride

There was a desire among patients to feel national pride in the service the NHS provides and to be impressed with their treatment, despite NHS spending on health relative to other EU countries. But is it just a matter of more money? (See below Figure 4.8.) Participants want to be able to praise the NHS and recommend it to others:

> "I think we are the poor relations as far as Europe is concerned about the amount of equipment and the waiting times that we have to wait for serious things, I think treatment should be readily available without waiting" (Participant 005)

The Nuffield Trust and The Health Foundation (2015) report states that the UK spends a lower proportion on health than other EU countries and that, if we look at other European nations, the UK is certainly spending less as a proportion of GDP, as shown below in Fig 4.8. Also, Fig 4.9 shows that the UK has the lowest doctor staffing levels among EU countries, and the same applies to nurse staffing levels, as in Fig 4.10. In addition, NHS England hospital bed occupancy rates have hit 95%, which is also reported to be the lowest compared to other EU countries, as shown below in Fig 4.11. These comparison indicators pose significant challenges for NHS England hospitals in achieving superior customer/patient experiences.

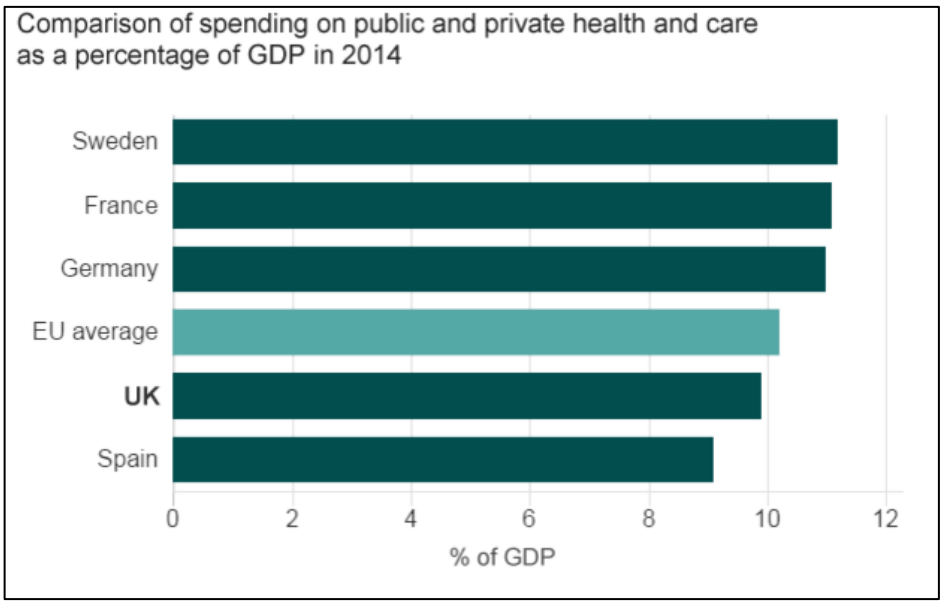


Figure 4.8: Comparison of UK spending on health with other EU countries

Source: Nuffield Trust and Health Foundation (2015)

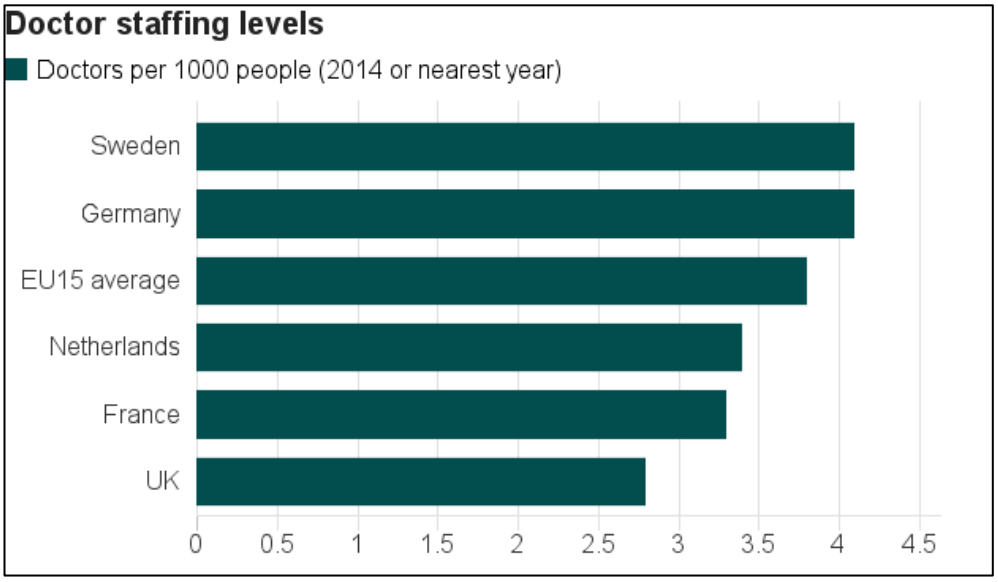


Figure 4.9: Comparison of UK doctor staffing levels with other EU countries

Source: Health Foundation/OECD (2015)

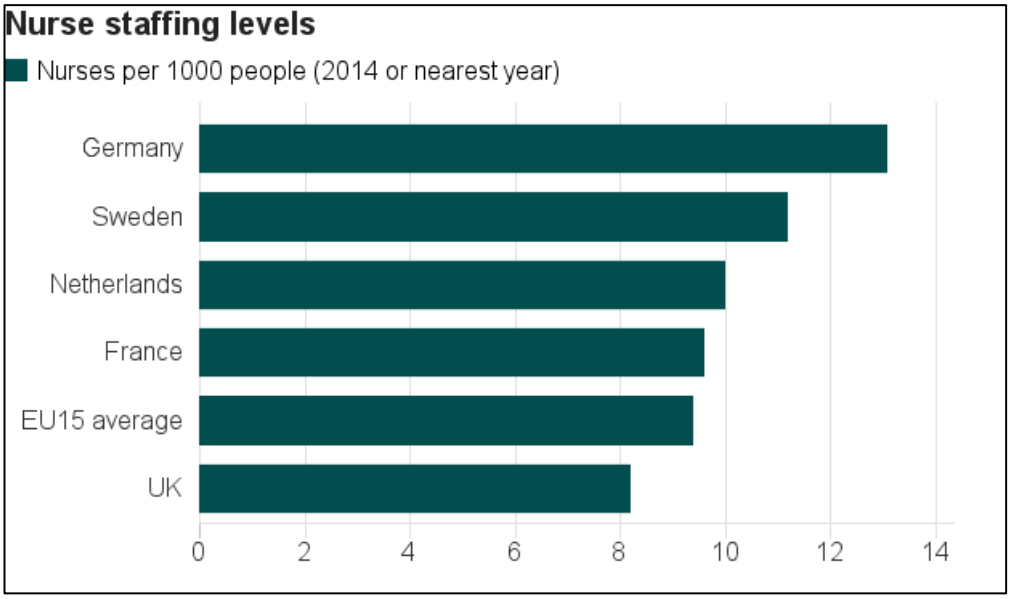


Figure 4.10: Comparison of UK nurse staffing levels with other EU countries

Source: Health Foundation/OECD (2015)

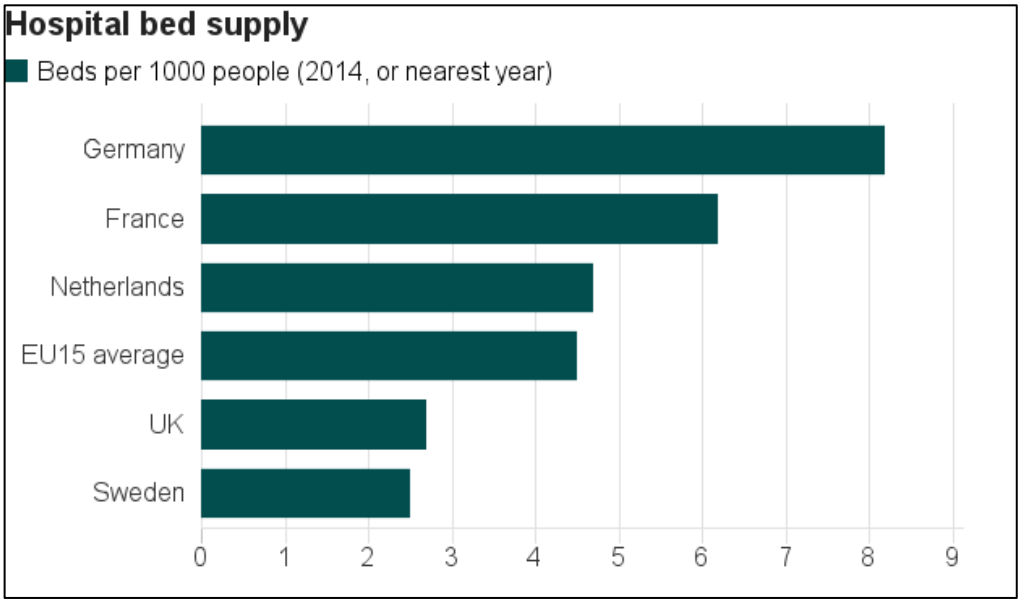


Figure 4.11: Comparison of UK hospital bed supply with other EU countries

Source: Health Foundation/OECD (2015)

In addition, two key ideal feelings emerge from the maternity participants:

Excited and pampered

Staff sharing in your excitement at having a baby. Staff recognizing your individual experience. Being treated as a person who needs extra care and support, but who is not ill.

To conclude, many of the participants' ideal customer experience feelings are interlinked, making it difficult to disentangle them to prioritize or rank them. The most identified significant factors include feeling reassured, confident, cared for, and safe. Many of the identified ideal emotions can be linked to being treated as an individual. The need for patient-centred care was an underlying requirement of most participants. Surprisingly, participants felt that NHS England hospitals do not consistently deliver an ideal emotional customer experience, yet this is an extremely important aspect of patient care.

Fig. 4 .12 below is an alternative way of portraying the ideal emotional customer experience by separating the emotions participants would like to feel as they go through the process from those they would like to feel because of their experiences. Some key emotions do cut across both:

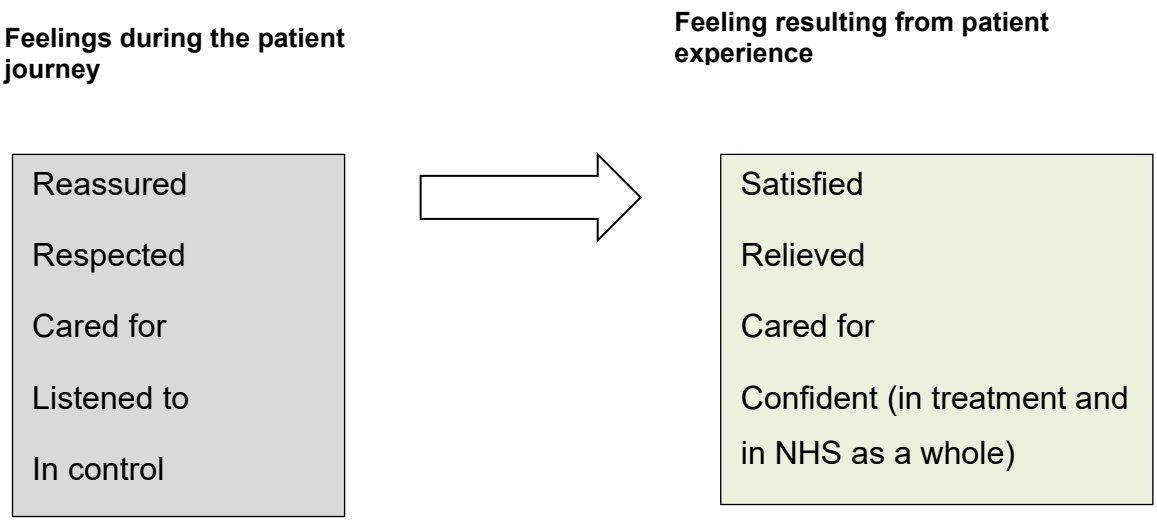


Figure 4.12: Ideal emotional customer experience (Own source)

4.7 Other important findings

As mentioned earlier in the data collection and analysis chapter, the archived data on the NHS Choices website is organized participant story by hospital name, and in NVIvo 11, the researcher was able to classify and run a frequency analysis of each participant story by hospital name. The findings are derived from the frequency of participants' positive and negative customer experience categories, compared with hospital size (large, medium, and small), and from a comparison between NHS Foundation Trusts (FTs) and Non-NHS Foundation Trust (Non-FT) hospitals. Since the literature posits that the CE concept is context-specific, it is important to understand that, even within NHS England hospital Trusts, there are sub-contexts within the main context. Hence, the researcher considered it beneficial to conduct this comparison, since the literature suggests that customer experience opinions and feelings differ enormously, as they are dependent on a number of factors including the location of organization and the size of the firm. Furthermore, the literature suggests that, regardless of hospital size and location, hospitals compete for patient referrals, and their performance is measured by indicators such as positive patient experiences (NICE, 2014). The section below will briefly discuss the findings.

Findings of positive and negative customer experience categories frequency by size of hospital (small, medium, large, and specialist trusts):

According to the analysis of positive and negative category frequencies by hospital size (small, medium, large, and specialist trusts) in the appendix, some consistent patterns emerged, with some hospitals within each size group performing better than others. The researcher examined positive and negative comments across individual categories, including those with wide variation in mean scores for trusts (for example, the category on procedures and processes), to assess whether there was evidence of any NHS hospital trust maintaining good performance. There was a consistent pattern showing that specialist trusts had the highest proportion of positive or satisfactory comments at 88%, with the lowest proportion of negative evaluations at 42%, compared to the largest trust hospitals. The largest hospital trusts recorded 79% positive comments and 55% unsatisfactory or negative patient experience evaluations. That said, there were considerable variations among large London trusts, with some performing better than others. As well as the tendency towards negative experiences in London, the researcher typically observed more positive experiences in the North-East NHS hospitals. This is also consistent with the Dr Foster Hospital Guide, an annual comparative performance analysis of all England NHS Hospital Trusts, which ranks the North-East hospitals higher than those in other regions. This could be because the North-East hospitals have less patient traffic than those in more populated areas such as London. This provides an opportunity for further research into customer experience comparisons by hospital size, region, etc.

CHAPTER 5: DISCUSSION

This study responds to the call by (Osei-Frimpong et al., 2015; Helkkula et al., 2012; Gentile et al., 2007; Ponsignon et al., 2015; Lemke et al., 2011; Maklan and Klaus, 2012; Verhoef et al., 2009) to study customer service experiences delving deeply using phenomenological/interpretivist methods, including customer narratives, diaries, etc., to enable a better understanding of how customers make sense of their lived and imagined experiences. The objectives of the thesis were:

RO1. To identify the critical dimensions and attributes of customer experience in the NHS England hospitals context.

RO2. To identify the factors that have a significant influence on positive customer experience in the NHS England hospital context.

RO3. To identify the factors that have a significant influence on negative customer experience in the NHS England hospitals context

RO4. To develop a holistic conceptual framework that constitutes the constructs of customer experience in the NHS England hospitals context.

The underlying critical dimensions and attributes that constitute customer experience by which patients and carers construe positive and negative customer experience were identified and categorized into 30 categories (dimensions) and 131 sub-categories (attributes), shown in Table 4.2. The researcher derived a holistic classification or conceptual framework of customer experience in Fig. 4.14; this model, the derivation of which is described below, confirms the role of service constructs and the collective customers in co-creating the redesign of NHS hospital experience. The researcher will discuss the results with respect to each of the study's three objectives in turn.

As Table 4.1 shows and as the researcher discusses in detail below, this study includes commonly identified categories of Lemke et al.'s (2011) CE categories, Ponsignon et al.'s (2015) health experience quality dimensions and service quality as "Time" (close to

Parasuraman et al.'s (1988) timeliness), a "Caring Attitude" (close to the empathy dimension), and "Reliability". Customer experience goes beyond the notion of service quality, however, spanning Pullman and Gross's (2004), Gentile et al.'s (2009), and Maklan and Klaus's (2011) delineation of customer's responses resulting from interacting with "Relational" (e.g. direct interaction) and the physical or indirect interaction (e.g. the "Functional" category), which the researcher incorporated in the definition of CE. This perspective emphasizes the importance of the customer's perceptions of their interactions with both employees and the environment. This is consistent with the work of Sampson (2012), who asserts that a CE involves either a direct interaction between staff and customer (e.g. a physician draws blood from a patient), an indirect interaction (e.g. a patient waits for a consultation in a waiting room), or an independent activity that is independent of customer–provider interactions (e.g. cleaning the hospital). This distinction is important because each class of interactions creates different opportunities and presents different problems in service delivery (Wemmerloev, 1990; Sampson and Froehle, 2006), which has implications for quality assessment and improvement. Similarly, improving the quality of direct interactions is likely to involve employee training, while indirect interactions are more likely to require changes in process design or in the arrangement of tangible resources. The researcher therefore proposes that CE in healthcare refers to the perceptions and evaluations of the customers and their families and carers, also known as collective customers' perceptions and evaluations, of all of the direct, indirect, and unexpected encounters that occur during the provision of care and treatment.

These categories (dimensions, attributes, negative and positive evaluations) were not explicitly prompted by the researcher but rather emerged unprompted from the CIT analytical technique process and three simple open-ended questions to patients and carers that gave them the opportunity to comment about what they 'Liked' or 'Disliked' and to offer 'Advice' about their experience with the NHS hospitals via the NHS Choices feedback platform. This suggests that customers or patients do indeed assess their customer experience holistically, consistent with previous suppositions (Payne et al., 2008; Verhoef et al., 2009, Gentile et al., 2009; Lemke et al., 2010; Ponsignon et al., 2015; McColl-Kennedy et al., 2015; Osei-Frimpong et al., 2015). Hence, to meet the definition of positive or negative customer experience requires that customers also assess its excellence or superiority. The researcher found that participants could readily articulate the axis of their experience constructs and rate hospitals on each construct. It was also apparent from the narrative data

that this rating had a bearing: participants had a preferred axis and frequently commented on why a "positive" rating for the category was preferred.

4.8 5.1 Implications for current theory

This thesis explores how NHS England hospital patients, their families, and carers perceive and evaluate the healthcare experience, and presents the attributes and dimensions that constitute CE within a classification conceptual framework. As shown in Figure 5.1, the conceptual model is informed through the categorization of direct, indirect, and independent interactions and inspired by Gentile et al.'s (2007) holistic definition. The main contributions of this thesis lie first in a holistic classification conceptual framework for CE in healthcare; second, in dimensions that extend existing healthcare experience quality and service quality frameworks; and third, in dimensions and attributes that contextualize the generic holistic model to hospital healthcare. In this section, the researcher first briefly describes the overall conceptual framework and the general results of this thesis. Then, he discusses the commonalities or differences between this study's conceptual framework and previous research. Finally, the researcher shows how this study extends existing models of healthcare experience quality, service quality, and CE.

4.9 5.2 The construction of the customer experience conceptual framework

The classification framework comprises 30 dimensions and 131 attributes that reflect the concept of experience in healthcare. "Staff attitudes and behaviours", "personalization", "communication", "premises and facility", "patient outcomes", "staff interactions", "waiting times", "level of care", "management and finance", and "procedures and processes", the 10 most frequently mentioned dimensions, are central for articulating significant factors that influence positive and negative CE with NHS hospitals. Besides, positive experiences are significantly more associated with direct encounters than with indirect encounters (73.6% vs 19.3% of all positive evaluations). For instance, the interpersonal attitudes and behaviours of staff account for nearly 50% of all positive evaluations. Similarly, the share of negative experiences is less balanced too between direct and indirect encounters (61.2% vs 27.0%). As an example, 7.7% of all negative experiences are associated with required standards in hospital procedures and processes (such as bed shortages, A&E long waiting times) and untimely appointments.

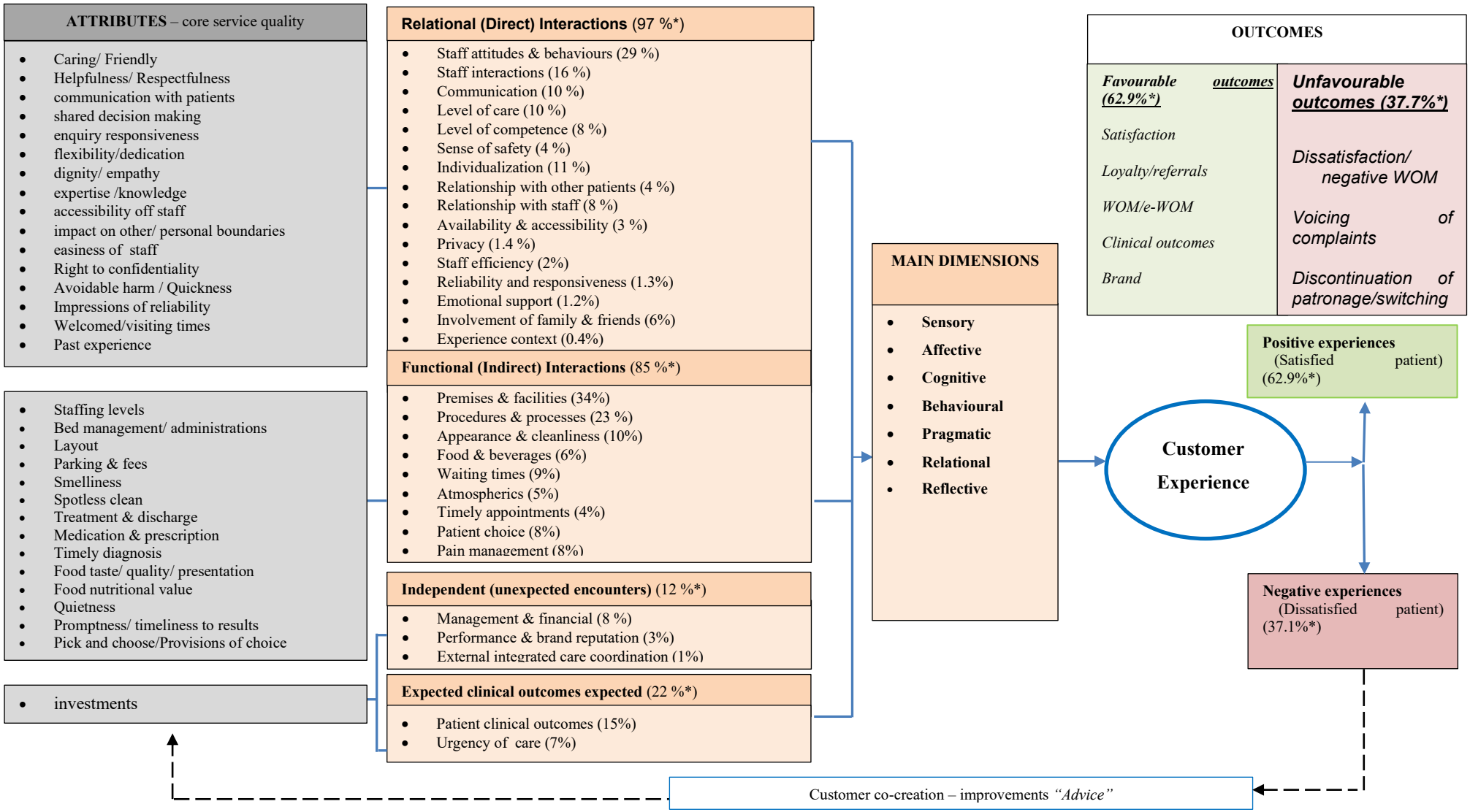


Figure 5.13: Conceptual framework of customer experience in England NHS hospitals. Note: * 1% of stories

This is consistent with a recent report in which Chris Hopson, chief executive of NHS Providers, which represents hospitals, said the bed shortages were "extremely worrying" (NHS England, 2017). The analysis showed that nine in 10 NHS England hospitals were 'overcrowded', i.e., rates above 95%, compared to the maximum targets of 85%. But the analysis showed 137 out of 152 hospital trusts have been above the 85% occupancy threshold level for a very long time. Table 5.1 illustrates that NHS England hospital 'long waiters' now number over 350,000, a 163% rise since 2012, bringing the total to 3.7 million people on the waiting list since the start of December 2016 (NHS Digital, 2017).

NHS England	Up 163%
NHS Northern Ireland	Up 95%
NHS Scotland	Up 82%
NHS Wales	Up 74%
The figures are the percentage rise in the number of waits over the target time for treatment in each nation	

Table 5.1: How 'long waiters' have risen since 2012 by NHS regions

Source: NHS England (2016) (www.england.nhs.uk)

The findings revealed remarkable times of worst waiting times in A&E, with patients left for hours on trolleys and vital cancer operations being cancelled. This has been an ongoing issue for years, as per Fig. 5 .2, a humanitarian crisis in the making described by the Red Cross (BBC News, 2017).

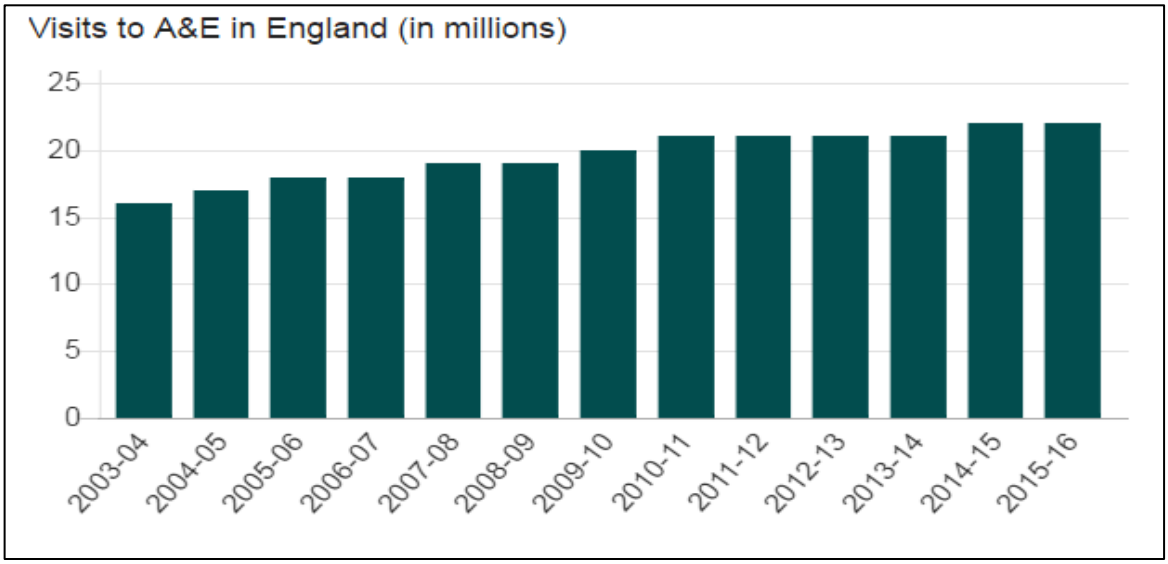


Figure 5.2: Increasing demand for urgent treatment in NHS England hospitals

Source: Institute of Fiscal Studies (2017)

These findings suggest that, amid all these challenges, staff do their best to absorb the difficulty caused by system failures and broken processes, and participants have described the efforts of staff at their local hospital as "extraordinary" and "extreme dedication". Finally, the findings reveal that positive and negative customer experiences significantly influence clinical outcomes, including satisfaction, loyalty intentions, and word of mouth.

At the dimension level, there is significant consistency between this study's framework, the generic model of customer experience quality (Lemke et al., 2011), healthcare experience quality (Ponsignon et al., 2015), the generic models of CE (Chahal and Dutta, 2014; Garg et al., 2011; Gentile et al., 2007), and Dagger et al.'s (2007) service quality model in healthcare. Three of these studies, which are from the genre of this study, include the primary dimensions of "sensory", "affective", "cognitive", "behavioural", "relational/social", "pragmatic", and "reflective" (Gar et al., 2015; Chahal and Dutta, 2014; Gentile et al., 2007). Based on the multiple CE dimensions and diversity of CE definitions (refer to Table 2.3 in Chapter 2), the most important primary CE dimensions were identified as comprising other context-specific secondary dimensions, for example, in classification (see Table 2.4 in Chapter 2). Since the objective of this study is to develop a holistic conceptual model that could be applied to different healthcare contexts, Table 5.2 below adopts all seven primary dimensions of Gentile et al. (2007) and Schmit (2001) and classifies all sub-dimensions identified in the study findings accordingly (please refer to Table 4.1).

Main dimensions	Sub-dimensions from results
Sensory: these experiences appeal to all the five senses of the customer (Schmitt, 1999; Gentile et al., 2007).	Personalization, appearance and cleanliness, sense of safety, privacy, atmosphere & ambiance
Affective: these experiences appeal to the feelings, emotions and moods of the customer (Gentile et al., 2007)	Attitudes and behaviours, waiting time, level of care, staff efficiency, privacy, infrastructure, food & beverages
Cognitive: these types of experiences are linked to the conscious mental or thinking process of the customer (Gentile et al., 2007).	Pain management, communication, availability and accessibility, level of competence, patient choice, clinical outcomes, admin procedures & processes, urgency of care
Behavioural: these types of experiences generate from the alternative methods of doing the things and also from the values and beliefs the customer possesses in his/her lifestyle and behaviour (Schmitt, 1999; Gentile et al., 2007).	Reliability and responsiveness, brand reputation
Pragmatic:	Management & finance, integrated care coordination
Relational/social: these experiences are generated from beyond the private life of any individual (Schmitt, 1999; Gentile et al., 2007).	Involvement of the family, relationship with other patients& carers, relationship with staff
Reflective: this experience is generated by the comparison of the present and past lifestyles (Garg et al., 2011).	*Experience context – (past experience, pre-visit experience, emotive context, hedonic service type)*

Table 5.2: Classification of this study's 30 customer experience dimensions

The remaining studies include dimensions and attributes of "staff attitude and behaviour", "reliability and responsiveness", "relationship with staff", "personalization or customization", "competencies", "accessibility and availability", and "efficiency". These commonalities suggest that a similar set of customer experience characteristics broadly exists at a high level of abstraction. In addition to these commonalities, this study reveals several points of departure from the existing literature. First, the researcher identifies a number of dimensions and attributes that are omitted from existing models (Ponsignon et al., 2015; Dagger et al., 2007; Lemke et al., 2011; Chahal and Dutta, 2014; Garg et al., 2011; Raleigh et al., 2012; Gentile et al., 2007). Several differences emerge at the dimension and attribute level, suggesting that the CE concept differs by context. The "privacy", "sense of safety", "emotional support – relieving fear and anxiety", "involvement of family", "experience context", "pain management", "patient choice", "management and financial performance", and "external integrated care" dimensions are not mentioned in these studies.

The researcher first identifies four "privacy" attributes reflecting perceptions of the right to confidentiality, dignity, protection of medical records, and non-erroneous medical records. Of note is their link to "patient sense of safety", which assesses avoidable medical errors and

patients' trust in the NHS to look after their confidential information. At the time of writing this thesis, coincidentally, NHS England is investigating how the NHS misplaced half a million patient records and whether any patient has been harmed by an administrative mix-up.

Secondly, "emotional support – relieving fear and anxiety" attributes reflect perceptions of loneliness, fear of pain, the effect of illness on family, and uncertainty. This is consistent with the literature, as studies investigating the role of emotion have most often examined emotional valence (see, for example, Bagozzi et al., 1999; Botha & Reyneke, 2013; Botha & Botha, 2013).

Thirdly, "involvement of family" attributes reflect perceptions of being informed about treatment decision-making, being welcomed, visitor restrictions, and flexible visiting times, for example, to support the family's work balance.

Fourth, "experience context" attributes reflect perceptions of past experience (Maklan and Klaus, 2011), pre-visit experience, emotive context, hedonic services, importance of timeliness, hospital size, and significance of ailment, and the researcher found that aspects of these may shape expectations of the customer's or patient's experience.

Fifth, "patient choice" attributes reflect perceptions that the healthcare provider offers an appropriate variety of care and treatment services, a broad range of services, the ability to pick and choose through i-appointment booking, and the provision of a choice of hospital, either independent or NHS, and of a consultant. Surprisingly, Raleigh et al. (2012), Ponsignon et al. (2015), Duggirala et al. (2008), and Dagger et al. (2007) did not mention patient choice as an important dimension of CE. Based on the findings, patients consider patient choice, as a CE dimension, very important.

Sixth, "management and financial performance" attributes encompass perceptions that the healthcare provider is sound in both management and financial performance and can make the necessary investments to improve hospital services, medical equipment, and staffing levels. Additionally, the researcher again expected these healthcare studies (Ponsignon et al., 2014; Duggirala et al., 2008; Dagger et al., 2007) to include this dimension, particularly given the current focus on NHS budget deficit cuts, which have a significant negative impact on hospital services.

Seventh, “external integrated care” attributes reflect perceptions about the ‘integrated’ health, care, and support; to be effective, it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care, and support that puts the needs and experience of people at the centre of how services are organized and delivered.

Additionally, consistent with Ponsignon et al. (2015), differences lie in “value for money”, which was not present in this study dataset, as well as in the “infrastructure” and “clinical outcome” categories, which are not mentioned in Lemke et al.’s (2011) work. “Value for money” dimensions are absent from this study framework because the UK healthcare system is largely publicly funded, and care is provided free at the point of need.

At the sub-category level, additional differences appear, further supporting the contention that significant variation in the concept of CE exists by context. Lemke et al. (2011) identify 119 sub-categories (attributes) that describe customer experience quality in a generic way, and Ponsignon et al. (2015) identify 51 sub-categories, whereas this thesis presents 131 attributes and dimensions that are specific to NHS England hospitals and the healthcare context. Similar to Ponsignon et al. (2015), within the “procedures and processes” category, this study's analysis reveals healthcare-specific dimensions, including the appropriateness of administrative procedures, the accessibility of medical equipment, supplies, and drugs, and bed availability and staffing levels. Moreover, omitted from healthcare-centric models are the categories of “availability of staff” and “accessibility of premises” (Dagger et al., 2007; Raleigh et al., 2012), which describe dimensions relating to the ease of finding and accessing an appropriate staff member as well as to car park costs and availability, opening and visiting hours, and geographical distance. Similarly, this study reveals dimensions relating to the quality of “staff-to-staff communication”.

Patients and carers are particularly attentive to how individual staff members, teams, departments, and wards work together and coordinate their activities to deliver care and treatment. Consistent with Duggirala et al. (2008), Lemke et al. (2011), and Ponsignon et al. (2015), the researcher also shows that the attitudes and behaviours of some patients and their carers affect the experience of others, both positively and negatively, in terms of well-being and feelings of unity and privacy. This finding suggests that CEs with healthcare are social phenomena that go beyond the dyadic interactions between patients and providers (Osei-Frimpong et al., 2015; Verhoef et al., 2009; Helkkula et al. 2012; Caru` and Cova, 2014). It

extends healthcare models (Ponsignon et al., 2015; Dagger et al., 2007; Duggirala et al., 2008; Raleigh et al., 2012), while providing a finer-grain view of the "relationship with other customers" dimension reported by Lemke et al. (2011) and Ponsignon et al. (2015).

4.9.1 5.2.1 Outcomes

Fig. 5 .1 of the developed CE conceptual model shows two category outcomes, "favourable outcomes" and "unfavourable outcomes", both derived from the positive and negative CEs. "Favourable outcomes" include six outcome perceptions reflecting 'satisfaction', 'loyalty', 'WOM/e-WOM', 'clinical outcomes', 'increase in patient referrals', and 'intention to recommend'. Favourable outcomes are mentioned in 62.9% of total evaluations (i.e., 2,484). "Unfavourable outcomes" include four outcomes perceptions reflecting 'dissatisfaction', 'negative WOM', 'discontinuation of patronage', 'decrease in patient referrals', and 'voicing complaints'. "Unfavourable outcomes" are mentioned in 37.7% (i.e. 1,465) of total patient evaluations. Moreover, these CE outcome variables were identified in the literature review (see Table 4.2, Section in Chapter 2). This suggests that, amid the huge challenges the NHS England hospitals currently face, most patients enjoy positive customer experiences.

Customer satisfaction

Kumar et al. (2007), while discussing favourable customer experiences, remarked that positive expectations along with positive experiences create a high satisfaction score, whereas negative expectations and positive experiences of a service create the highest satisfaction score. They further suggested that negative expectations and negative experiences, together, generally yield a low satisfaction score, whereas positive expectations of a service, along with negative experiences, yield the lowest satisfaction score. Kim et al. (2008) and Shankar et al. (2003) opined that, overall, the more favourable the prior experience is, the higher the level of satisfaction. In other words, a highly reliable but invalid service or a highly valid but unreliable service will make a customer dissatisfied. However, Chen, Chang, and Fan (2008) in their research described actual experience and expectation as significant predictors of satisfaction. They remarked on the gap between expectation and actual experience that leads to satisfaction/dissatisfaction. For instance, a customer with positive/negative perceptions would evaluate satisfaction as positive/negative. Consistent with this study's "pain management dimensions", Kumar et al. (2007) also linked positive

and negative expectations and experience with customer satisfaction in healthcare services. They identified four levels of satisfaction:

> *1. highest satisfaction*, which relates to negative expectations of medication, and a positive experience;
>
> *2. high satisfaction,* which relates to positive expectations of medication, and a positive experience;
>
> *3. low satisfaction*, which relates to negative expectations of medication and a negative experience; and
>
> *4. lowest satisfaction*, which relates to positive expectations of medication, and a negative experience

This is consistent with Chahal and Dutta's (2014), Ponsignon et al.'s (2015), Garg et al.'s (2011), and Lemke et al.'s (2011) models, which show satisfaction as an outcome of positive and negative customer experiences. This study's findings suggest a positive and significant relationship exists between favourable customer experience and satisfaction, and a negative and significant relationship between unfavourable customer experience and dissatisfaction.

Loyalty

Kim et al. (2008) observed that when product or service performance exceeds customer expectations, the repurchase rate increases. In other words, customers who trust or have confidence in a hospital will continue to use its services. In addition to a direct, positive relationship between satisfaction and loyalty, Oliva et al. (1992) also discussed a nonlinear relationship between these two constructs. They pointed out that when satisfaction increases above a certain level, customer loyalty increases rapidly. On the other hand, Mittal, Ross, and Baldasare (1998) contemplated that a high level of dissatisfaction might have a large and deleterious impact on retention. Arnold et al. (2005) noted that a customer who has endured terrible experiences may use negative WOM, voice his complaint by sending emails, writing experience stories on the NHS Choices feedback platform or social media, or discontinue his hospital visits and switch to a competitor hospital. The findings suggest that patient satisfaction influences hospital customer/patient loyalty, and their dissatisfaction

significantly influences negative "WOM", "voicing of complaints", "discontinuation of hospital visits/patronage", and "patient referral flows".

Brand reputation

Keller (1993) established that one characteristic of brands with strong brand presence is stronger brand loyalty, which is a function of variables such as satisfaction and word of mouth, as is the case with NHS hospitals as brands. He believed that a brand possesses positive customer-based brand equity when a customer reacts more favourably to the service, and negative customer-based brand equity when a customer reacts less favourably to the publicity or marketing activities associated with a brand, which is the case with NHS hospitals. For instance, the Mid Staffs NHS Hospital Trust is currently struggling financially due to low patient referrals, thereby affecting Payment by Results income, as a result of a negative brand reputation promoted via media and NHS Choices patient reviews. The findings suggest that all favourable outcomes positively influence hospital brand reputation, and all unfavourable outcomes negatively influence it.

4.9.2 5.5.2 Customer co-creation

The findings emphasize that customer advice for hospital improvement is consistent with an emerging body of literature regarding patient involvement or collaboration – that is, co-creation (e.g. Helkkula et al., 2012; Prahalad and Ramaswamy, 2004; Ramirez, 1999; Schau et al., 2009; Vargo and Lusch, 2008; Vargo et al., 2008). Surprisingly, 16 categories were identified from participants' responses under "Advice" mentioned in 51.3% (i.e. 241) of "Advice" total stories (refer to Table 4.4). The main participant advice categories comprise "Appointments", "Parking and fees", "Staff levels", "Communication", "Emergency complaints procedure", "Environment layout", "Waiting area", "Noise", "A&E closures", and "Waiting time". Recently, patient participation in co-creating value has received much credence in healthcare research. This is consistent with the Experience-Based Co-Design (EBCD), an approach that empowers patients and staff (or collective customers) to co-create services and/or care pathways together in partnership (NHS Improvement, 2017). EBCD involves gathering experiences from patients and staff through in-depth interviewing, or observations and group discussions, identifying key 'touch points' (emotionally significant points) and assigning positive or negative feelings. The approach was designed for and within the NHS to develop simple solutions that offer patients a better experience of

treatment and care. However, as an alternative to the NHS management conducting long and expensive personal interviews and setting up focus groups, this study proudly introduces a new, innovative, cheap, and quick way to use archived NHS Choices customers' collective reviews for EBCD using netnography. Their active participation in clinical encounters is well documented to improve expected service outcomes (Bitner et al., 1997; Gill et al., 2011; McColl-Kennedy et al., 2012). Furthermore, the upsurge of consumerism in healthcare (Jaakkola and Halinen, 2006), whereby patients seek information from several sources, including the Internet or online communities, is changing the face of clinical encounters and provider relationships (Gutierrez et al., 2014; Heidenreich and Handrich, 2015; Nambisan & Nambisan, 2009; Silver, 2015).

In related studies on co-creating healthcare, some authors have focused on patients value - creating practice styles (McColl-Kennedy et al., 2012), micro-level influencing factors of value co-creation from the focal dyad (doctor–patient) perspective (Osei-Frimpong et al., 2015), and models of co-creation taking into consideration the nature of leadership of the online health community and the nature of knowledge activity facilitated by the online health community (Ayers and Kronenfeld, 2007; Gutierrez et al., 2014; Nambisan and Nambisan, 2009; Woo et al., 2015). To my knowledge, there exist no empirical studies that examine the influence of online information-seeking on patient co-creation activities in NHS healthcare at the micro level (service-for-service exchange among individual actors), despite an increased e-health literacy rate. According to the most recent study on this issue, 59% of all adults in the United States looked for health information online in 2012 (Fox and Duggan, 2013). None of the current CE models included customer co-creation, which is such an important area. This study, therefore, fills this void by providing an empirical perspective on the influence of online health information search on patient co-creation activities in healthcare service delivery at the micro level. The study primarily sheds light on the influence of information-seeking on the encounter process and how this cumulative impact affects the expected service outcomes. Prahalad and Ramaswamy (2004, p. 7) further argue, "High-quality interactions that enable an individual customer to co-create unique experiences with the company are the key to unlocking new sources of competitive advantage."

4.10 5.3 Contrasting the conceptual model with previous experience frameworks:

The researcher concludes his discussion of Fig. 5.1 with some reflections on its relationship with previous models of customer experience, service experience, healthcare experience quality, and customer experience quality. Ponsignon et al.'s (2015), Dagger et al.'s (2007), Lemke et al.'s (2011), Hogstrom et al.'s (2009), Chahal and Dutta's (2014), and Parasuraman et al.'s (1985, 1989) models commonly share similar CE dimensions, attributes, and outcomes with the researcher's proposed model, which holistically integrates service quality dimensions, attributes, and customer co-creation, not generalized beyond the NHS England hospitals context. A vital distinction, however, is that Ponsignon et al. (2015), in common with Lemke et al. (2011), regard such elements as value, atmosphere, and service as attributes of the CE, whereas this thesis's emphasis on CE focuses on the perceived excellence or superiority of these categories as only being relevant if they appear in the customer's construction. This study's findings confirm the views of Verhoef et al. (2009) among others (McColl-Kennedy et al., 2015; Tregua et al., 2015; Galvagno and Dalli, 2014), though, that experience is co-created. Payne et al. (2008) usefully distinguish provider processes, customer processes, and encounter processes, which may contribute to the co-creation of customer experience and mutual value. The data of this study confirms that each of these is present in the customer's conception of CE.

Finally, the researcher shows that perceptions of staff and patient interaction, privacy, sense of safety, emotional support – relieving fear and anxiety, involvement of family and friends, experience context, pain management, patient choice, management and financial issues, integrated care coordination, urgency of care, and patient clinical outcomes are important in healthcare. However, all these dimensions are absent from the healthcare models by Ponsignon et al. (2015), Dagger et al. (2007), Duggirala et al. (2008), and Raleigh et al. (2012). This omission may be due to the focus of those whose models are listed above being limited to a single condition, such as Ponsignon et al.'s (2015) study of inpatient cancer patients. Therefore, such an omission is likely because cancer inpatient treatments and chronic long-term conditions require specialist treatment facilities, so Ponsignon et al. (2015) may not have specified the number of NHS hospitals and regions covered. Additionally, the Patient Opinion website, which they used to collect patient stories, is limited and has very short stories compared to those collected from the NHS Choices website, which has over 2 million visitors per day. Based on Wolf et al.'s (2014) definition

of customer or patient experience, “The sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care”, this study examined all collective customers’ sums of interactions across multitudes of interactions of the continuum of care, i.e. inpatients, outpatients, accident and emergency. For instance, according to the NHS Confederation (2017), key statistics on the NHS hospitals:

- The NHS deals with over one million patients every 36 hours.
- There were 16.252 million total hospital admissions in 2015/16.
- The total annual attendances at Accident & Emergency departments was 22.923 million in 2015/16.
- The total number of outpatient attendances in 2014/15 was 85.632 million.

Based on this discussion (summarized in Table 5.3), the researcher argues that this study affords a more comprehensive, holistic, and context-specific understanding of CE dimensions, attributes, and significant factors that influence positive and negative CEs in the NHS England hospitals and healthcare in general across the continuum of care.

Customer experience - **Main dimension**/sub-dimensions	Customer experience in NHS hospitals (2017)	Health service quality (Dagger et al., 2007)	Customer experience generic (Garg et al.,2011)	Healthcare experience quality (Ponsignon et al., 2015)	Customer experience quality (Lemke et al., 2011)	Customer experience (Chahal and Dutta, 2014)	Customer experience (Gentile et al., 2007)
Sensory	**X**		**X**			**X**	**X**
Affective	**X**		**X**			**X**	**X**
Cognitive	**X**		**X**			**X**	**X**
Behavioural	**X**		**X**				**X**
Pragmatic	**X**		**X**				**X**
Relational	**X**					**X**	
Reflective	**X**						
1. Staff attitudes and behaviours	**X**	X		**X**	**X**		
2. Staff & patient interactions	**X**		X				
3. Level of care	**X**	X		**X**	X		
4. Communication	**X**	X		**X**	X	X	
5. Individualism or personalization	**X**	X	**X**	**X**	**X**		
6. Level of competence	**X**	**X**		**X**	**X**		
7. Availability & accessibility	**X**			**X**	**X**	**X**	
8. Relationship with Staff	**X**	**X**		**X**	**X**		

Customer experience - **Main dimension**/sub-dimensions	Customer experience in NHS hospitals (2017)	Health service quality (Dagger et al., 2007)	Customer experience generic (Garg et al.,2011)	Healthcare experience quality (Ponsignon et al., 2015)	Customer experience quality (Lemke et al., 2011)	Customer experience (Chahal and Dutta, 2014)	Customer experience (Gentile et al., 2007)
9. Relationship with other patients	**X**		X	**X**	X		
10. Privacy	**X**						
11. sense of safety	**X**						
12. staff efficiency	**X**			**X**	**X**		
13. Reliability and responsiveness	**X**	**X**		**X**	**X**		
14. Emotional support –relieving fear & anxiety	**X**						
15. Involvement of family & friends	**X**						
16. Experience context	**X**				X		
17. Admin procedures & processes	**X**	X	X	**X**	X		
18. Infrastructure	**X**	X		**X**			
19. Waiting time	**X**	X		**X**	X		
20. Appearance & cleanliness	**X**			**X**			
21. Pain management issues	**X**						
22. Food and beverages	**X**			**X**			

Customer experience - **Main dimension**/sub-dimensions	Customer experience in NHS hospitals (2017)	Health service quality (Dagger et al., 2007)	Customer experience generic (Garg et al.,2011)	Healthcare experience quality (Ponsignon et al., 2015)	Customer experience quality (Lemke et al., 2011)	Customer experience (Chahal and Dutta, 2014)	Customer experience (Gentile et al., 2007)
23. Atmospherics & ambience	**X**	X		**X**	**X**		
24. Timely appointments	**X**		X	**X**	X		
25. Patient choice	**X**			**X**		X	
26. Management & financial issues	**X**						
27. Performance & brand reputation	**X**			**X**	**X**		
28. External integrated care coordination	**X**						
29. Patient clinical outcome	**X**	X		x			
30. Urgency of care	**X**						
31. Value for money					**X**		

Note: '**X**', the category exists; 'x', the category exists but several sub-categories are missing

Table 5.3: Comparison between the NHS hospitals customer experience framework and previous research

CHAPTER 6: SUMMARY AND CONCLUSION

6.1 Introduction

The conclusion is the final chapter and summarizes the main points from the analysis and discussion chapter derived from research, including the holistic conceptual framework of CE in the NHS England hospitals context. It is shown how the data addresses the research questions. Although scholars have begun to recognise CE as an important topic worthy of research, the 'newness' of this phenomenon in the healthcare service industry has left several areas unexplored. To date, there have been limited attempts to examine CE holistically empirically, so this study was designed to contribute to the current research on CE by identifying the underlying critical dimensions and attributes of CE from a customer's perspective in the NHS England hospital context. In this chapter, an overview of the thesis is presented, and the theoretical, methodological, and managerial research contributions are discussed. The chapter concludes by outlining the study's constraints and suggesting directions for future research.

6.2 Summary of the main points

The topic under investigation, "Conceptualization of customer experience within the NHS England hospitals context: A netnography study", consists of three research questions (RQs):

RQ1: What are the critical dimensions and attributes that constitute the construct of customer experience within the NHS England hospitals context?

RQ2: What are the factors that have a significant influence on positive customer experience in the NHS England hospitals context?

RQ3: What are the factors that have a significant influence on negative customer experience in the NHS England hospitals context?

In Chapter 2, a narrative review was presented to address and answer these research questions. The researcher scrutinized and critically reviewed the pertinent literature on CE. The literature review, presented in Chapter 2, enabled the researcher to gain an in-depth understanding of the existing research on CE from both a healthcare and business perspective

and to identify theoretical foundations and methodological gaps in the literature that informed the direction of the current study. The narrative review aimed to identify and define the elements that encompass customer experience, its origin, definitions, theoretical foundations, and related theories and models, as presented in Chapter 2. The most common technique in management research is the traditional literature review in which the researcher summarizes and interprets previous contributions in a subjective and narrative fashion. This study reviews the literature on CE and summarizes CE dimensions, attributes, and other significant findings from more than 90 research papers published in as many as 41 relevant journals. To identify the attributes and dimensions of CE, this study reviewed 90 studies published between 1984 and 2015 from selected online databases. The conclusion drawn from the assessment of these studies and the resulting empirical results is that the field is vast and that there is still a lack of a generalised, holistic, and comprehensive CE framework for healthcare. A few authors have proposed and validated models that reflect on the attributes and dimensions of CE, but the dimensions and attributes of these models are sector specific. The service marketing constructs or concepts of service quality, customer satisfaction, consumer behaviour, customer centricity, customer relationships, and customer engagement, and their contribution to CE, also come within the purview of the present study. After analysing the results, the following conclusions, in the form of trends, a future agenda, and limitations, have been drawn.

In Chapter 6, the research study's conclusions are presented. In this chapter, the theoretical, methodological, and managerial contributions of the research are outlined and discussed. The focus, then, turns to the challenges and constraints of the research along with the directions for future research. Overall, the thesis has generated evidence to answer the research questions outlined below.

In terms of RQ1 (What are the underlying critical dimensions and attributes that constitute the construct of customer experience within the NHS England hospitals context?), it was found through this research that customer experience critical dimensions and attributes within the NHS England hospitals context consisted of 30 dimensions and 131 attributes (detailed in Table 5.3 of Chapter 5).

Regarding RQ2 and RQ3 (What are the factors that have a significant influence on positive and negative customer experience in the NHS England hospitals context?), it was revealed

through the findings that there are 12 factors that significantly influence positive or negative CE in NHS hospitals:

- Reassured
- Confident
- Treated as an individual and not a number, special/individual, personal touch
- Cared for, supported, looked after
- Healthy, cured
- Informed
- Treated efficiently, quickly, and competently
- Happy/satisfied
- Safe, secure, clean
- Relaxed and comfortable
- Pride
- Excited and pampered

In addition, it was found that there was diversity in customer experience definitions, with no consensus on what constitutes the CE from a healthcare perspective. With the data gathered in the present thesis, the researcher was able to define the term customer experience holistically from a healthcare perspective and develop a definition framework for managers (refer to Figure 2.1 in Chapter 2). This process is influenced by the continuum of all encounters or interactions, direct, indirect, and unexpected, focusing on expectations, individualism, alignment with customer-centricity, and satisfaction.

The holistic conceptual model of Customer experience in NHS hospitals

A holistic and comprehensive conceptual model of CE in NHS England hospitals was created that displays the different critical dimensions, attributes and outcomes of CE from a customer's perspective.

The dimensions "staff and patient interactions", "privacy", "sense of safety", "emotional support", "involvement of family and friends", "experience context", "pain management", "patient choice", "management and financial issues", "integrated care coordination", "patient clinical outcomes", "reflective" and "urgency of care" were not mentioned by

existing literature and previous models but are considered by the model of CE in NHS England hospitals and are therefore a new contribution to knowledge. These dimensions emerged inductively and are displayed in bold in the holistic conceptual framework of CE in NHS England hospitals.

As displayed in Figure 6.1, the holistic conceptual model of CE in NHS hospitals, the main dimensions “sensory, affective, cognitive, pragmatic, behavioural, relational and reflective" consists of the sub dimensions under the headings “relational (direct encounters or interactions”, “Functional – indirect encounters or interactions”, “independent – unexpected encounters” and “expected clinical outcomes”. These sub-dimensions also emerged inductively and are displayed in bold. Corresponding attributes of the sub-dimensions are also shown on the left side of the conceptual framework. “Customer co-creation” was not mentioned by previous models, but is considered by the model of CE in NHS England hospitals and is therefore a new contribution to knowledge. This aspect emerged inductively from the patient advice data to NHS hospitals and is displayed in bold in the holistic conceptual framework of CE in NHS England hospitals.

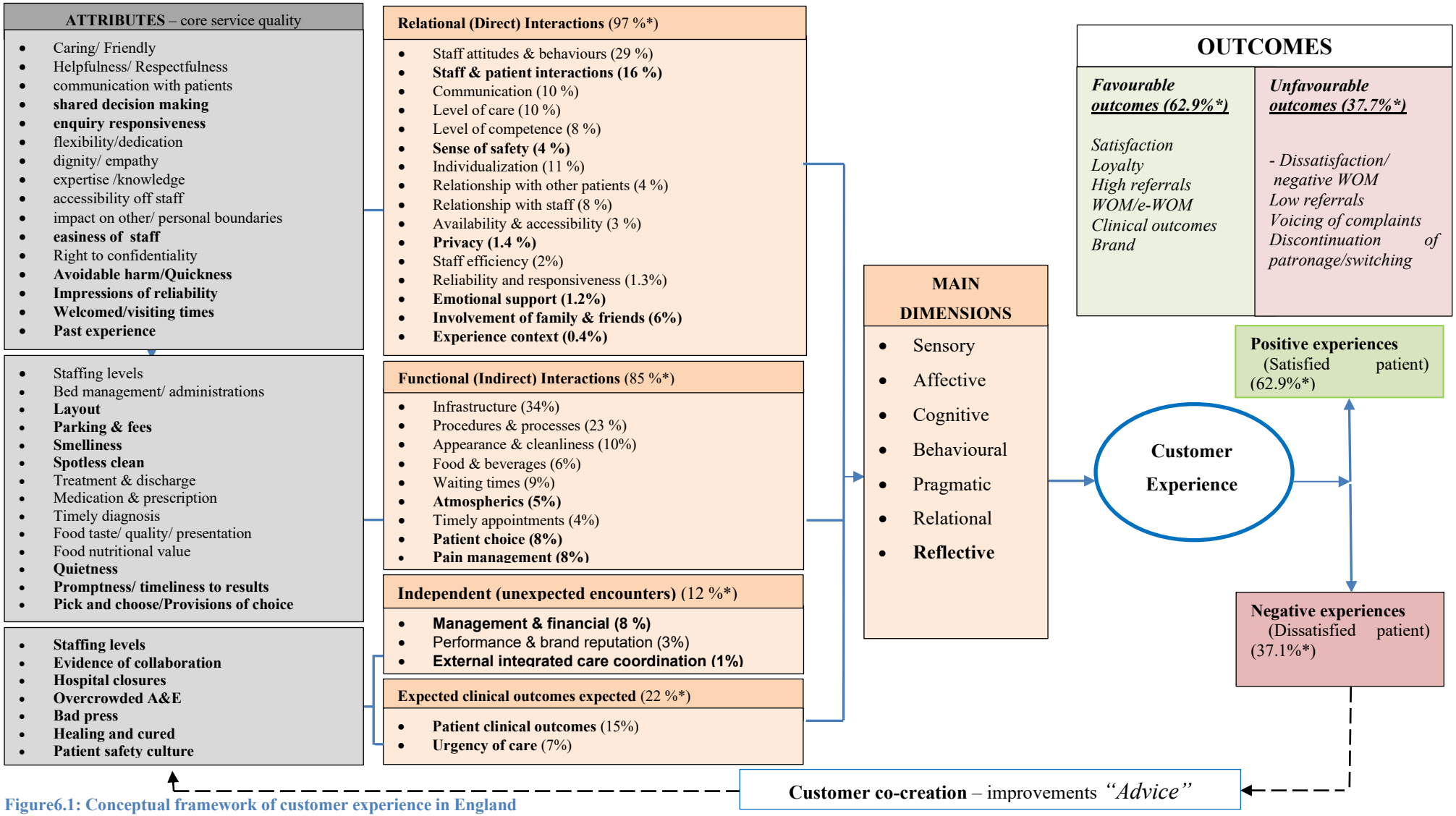


Figure6.1: Conceptual framework of customer experience in England NHS hospitals. Note: * 1% of stories Source: Author's own

6.3 Research contributions

To move forward the body of knowledge on CE, the researcher explored the gaps in the extant literature (identified in Chapter 2). The results of the research provide several theoretical, methodological, and managerial contributions, with implications for both academics and practitioners. A summary of the contributions of the research is presented in Table 5.1, followed by a detailed discussion of each contribution.

Research Contributions	
Theoretical contributions	Identification and definition of critical dimensions and attributes that constitute customer experience in NHS England hospitals from a collective customer perspective
	Identification of factors that significantly influence positive and negative customer experience within NHS England hospitals from a collective customer perspective.
	Development of a first holistic conceptual model of customer experience in NHS England hospitals that includes dimensions, attributes, and outcomes of CE from a customer's perspective.
	First CE conceptual model to incorporate the customer experience construct for improvement or service experience design from a collective customer perspective.
	Critical review of the relationship between the established service marketing constructs, service quality, customer satisfaction, consumer behaviour, customer engagement, customer relationship management, and their contributions to CE. Also, a critique of healthcare service researchers' modification of these constructs by prefixing "patient".
	Examination of the CE construct across different service contexts, journal types, and publication countries.
	Development of a new definition of CE and its framework from a healthcare perspective.
Methodological contributions	First study to investigate CE dimensions and attributes within NHS hospitals using patient stories archived on the NHS Choices website and using the netnography method for data collection.
	First known CE study to develop a hybrid approach between netnography and CIT.
Implications for practice	Unique approach to analysing unsolicited collective customer feedback data when evaluating patient experience in NHS England hospitals.
	Informing the development of evidence-based policy that has the potential to impact all NHS hospitals. Findings and the developed conceptual framework got the approval from industry experts.
	The study provides a robust evidence base to inform the design and improvement of NHS hospital services that deliver positive customer experiences consistently.
	Classification conceptual framework can be used as a diagnosis and benchmarking tool and definition framework for a commonly shared definition across NHS hospitals.
	The conceptual framework can also be used to produce a comparative analysis of experience within and across health institutions, such as comparing the performance of similar departments across different healthcare providers and the performance of different types of care within the same institution.

Table 6.1: Summary of research contributions Source: Author's own

6.3.1 Theoretical contributions

This thesis makes a few theoretical contributions to the healthcare service and CE literature. First, it adds to the conceptual development of CE, addressing recent calls to increase our knowledge of this phenomenon (Edvardsson *et al.*, 2005; Gentile et al., 2007; Palmer, 2010; Maklan and Klaus, 2011; Chahal and Dutta, 2014).

- ***Identification and definition of the critical dimensions and attributes that constitute customer experience and development of a holistic conceptual model of CE***

To understand the aspects that may influence CE, prior work has predominantly considered service quality dimensions mainly around organization-driven stimuli, failing to recognize the distinct aspects that customers encounter directly or indirectly at touch points from a subjective CE. Through a content and narrative analysis of CE, 470 customer stories were revealed, and the distinct elements that occur during CE across different interactions were identified, categorised, classified, and defined in this research. Such a comprehensive understanding of holistic CE dimensions and attributes enables deeper, more complex insight into the distinct components that shape CE.

Drawing from prior CE propositions and findings, and from insights about dimensions and attributes elements resulting from a robust narrative literature review in Chapter 2, this research extends the current body of knowledge on CE by developing a holistic theoretical model of CE that 'pieces together' the dimensions, attributes, outcomes, and positive and negative significant events or incidents of CE in NHS England hospitals. Specifically, the holistic model proposes future research on customer engagement in the co-creation of service improvements. In addition to the core interactions, the model also includes classification of dimensions by relational (direct encounters or interactions), functional (indirect encounters or interactions), independent (unexpected encounters or interactions), and expected clinical outcomes.

Application of CIT-content analysis techniques to CE

CIT content analysis techniques have been applied in prior consumer research to identify positive and negative critical incidents (e.g., Nyer, 1997; Ruth et al., 2002). Scholars recognize the relevance of CIT content analysis for understanding customer behaviour as it offers a complete explanation of consumers' behavioural responses to emotions (Johnson

and Stewart, 2005). However, to date, no studies have used the technique to explain CE, which essentially reflects emotional responses. In this research, the CIT enabled a deeper understanding of how CE evaluations are influenced by a customer's direct and indirect interactions with the organization or staff and the subsequent consumer perceptions that result from the CE. Specifically, the application of the CIT content analysis technique provided a significant theoretical contribution to the CE literature by revealing that appraisals of significant events and stimuli (sum of interactions) in the environment (context and hospitals service encounters) cause specific emotional reactions (customer experience) which, in turn, affect subsequent consumer service evaluation intentions.

- ***Examination of CE studies across different healthcare service contexts***

Nowadays, consumers use multiple channels to search for, consume, and evaluate products/services (Verhoef, Neslin, and Vroomen, 2007). In recognition of this, several scholars have argued that the multichannel context of the encounter should be considered when examining customer experience (e.g. Puccinelli et al., 2009; Verhoef et al., 2009). However, empirical work investigating customer experience across different healthcare settings is sparse. This research contributes to the existing work on CE by examining the holistic model of CE empirically, separately for NHS England hospitals. Through such an examination, the researcher was able to provide insights into the CE process across different hospital sizes, NHS England hospital foundation trusts, and non-NHS foundation trusts. In addition, the holistic model of customer experience was developed using data from 78 NHS hospitals across England (e.g., small and large general hospitals, including specialist hospitals). The examination of the study data across different NHS hospitals and the variety of hospital episodes, e.g., outpatients, inpatients, emergency care, maternity, and service contexts and geographical locations, enabled a wide assessment of the contextual nature of CE, as discussed in Chapter 5, the discussion section.

6.3.2 Methodological contributions

- ***Investigation of CE through real customers'/patients' experience stories***

This research contributes to the work on CE by assessing individual patients' evaluations of their hospital experience through stories voluntarily posted on the NHS Choices feedback website. Customer evaluations of individual service (direct, indirect, independent, and

clinical) encounters, voluntarily posted during the occurrence or soon after, provided realistic, rich, in-depth insights into the distinct 'moment of truth' between the customer and any hospital department or service. This enables a rich understanding of the experience, including *'what happened?'*, '*what did you like or dislike?'*, *'where did it happened?'* and *'how did it happened?'*, and '*any advice?'*.

- ***A hybrid approach between netnography and CIT research methods***

This research was unique and innovative in that it employed a hybrid approach combining netnography and CIT qualitative analysis to capture and analyse online CE stories. Although social researchers have applied CIT for a few years now to investigate the critical incidents (positive and negative), this methodology is very novel to marketing and organizational scholars (Fisher and Todd, 2012). The application of this hybrid approach in the research enabled an investigation into the classification and frequency analysis of factors that influence positive and negative customer experiences in NHS hospitals, and into patterns surrounding consumers' experiences and reactions when offered unsolicited.

In addition to the theoretical and methodological contributions discussed above, the researcher's accepted paper, "Holistic conceptualization of customer experience in the NHS England hospitals context: A netnographic study", presented at the 2016 Academy of Marketing Conference, was independently assessed by two reviewers, who are subject specialists. Their feedback and acknowledgement of contributions received helped shape the final thesis. Below are reviewers' comments or quotes on the paper's contribution to set criteria:

- ***Criteria: Contribution to knowledge***

Reviewers' comments

> "An interesting piece of research development on customer experience. The author made a strong case of concept redefinition based on contextual factors; in this case, the NHS". (Reviewer 1)

> "The topic is interesting considering the importance of patient experience in healthcare service outcomes. The paper, at this stage, does make a convincing contribution to the services literature. The author is attuned with current studies and positions the paper well. For instance, comparing this paper to Ponsignon et al.

(2015), Healthcare experience quality: the author did a good job of clearly highlighting the theoretical contribution". (Reviewer 2)

- ***Criteria: Structure and presentation***

Reviewers' comments

"Good presentation". (Reviewer 1)

"The paper is well structured". (Reviewer 2)

- ***Criteria: Literature review***

Reviewers' comments

"Thorough and critical, evidence of concept development and methodology justification". (Reviewer 1)

"The literature review fails to acknowledge related recent studies that could help the author positions the paper well. A lot of studies have been done recently in the area of service experience, which could be helpful e.g. McColl-Kennedy et al (2015) Co-creating service experience practices in the Journal of Service Management. The authors also introduce 'social context' which need to be explained and its relevance to patient experience in healthcare services, these papers among others could be helpful - Akaka, Melissa Archpru and Jennifer D. Chandler (2011), "Roles as Resources: A Social Roles Perspective of Change in Value Networks," Marketing Theory; Osei-Frimpong, Kofi, Alan Wilson and Nana Owusu-Frimpong (2015), "Service Experiences and Dyadic Value Co-Creation in Healthcare Service Delivery: A Cit Approach," Journal of Service Theory and Practice". (Reviewer 2)

After this review, the researcher added to the final thesis the recent studies on co-creation as suggested above by reviewer 2.

- ***Criteria: Theory development***

Reviewers' comments

"Clear potential evidence of developing customer experience theory based on context (NHS)". (Reviewer 1)

"The paper has potential in theory development". (Reviewer 2)

- ***Criteria: Methodology***

Reviewers' comments:

> "The chosen methodology is appropriate". (Reviewer 1)

> "The only query the author should consider is the authenticity of data, and the filtering process. I would suggest consideration should be given to actual contact with the NHS customers to engage in a qualitative interview before a big data approach as indicated in this paper". (Reviewer 2)

The researcher has since provided in the final thesis a full justification for not engaging in qualitative interviews before the netnography data collection approach and included it as a limitation.

6.3.3 Implications for practice

- ***Leveraging customer/patient feedback to evaluate hospital patient experience***

This research provides NHS managers with an understanding of the distinct direct, indirect, and independent service interactions that occur along the patient/customer journey and the relative importance of each element in enhancing the customer experience within NHS hospitals. Accordingly, managers should be able to identify service interactions or encounters relevant to improving the hospital experience. To gain a complete end-to-end understanding of the patient/customer journey, managers will be able to draw from these insights and conduct 'service interactions mapping', mapping being a technique that is commonly used by practitioners to identify key 'moments of truth' between the customer and a company (Zomerdijk and Voss, 2010). Customer journey maps incorporate the view of (i) the customer journey process, (ii) healthcare ecosystems, and (iii) relevant elements at each service interaction point. Managers will be able to shift their attention from examining individual service/customer interactions to understanding the collective customer perspective across the continuum of care. Mapping key service interactions and identifying the distinct elements at each interaction will provide managers with deeper insight into interactions across the continuum of care.

The findings from this research emphasize that service interactions (direct and indirect) identification and measurement should be assessed from a customer's perspective. In other

words, NHS hospitals managers should view the patient experience using the outside-in approach. It is clear from this study's findings that NHS hospital customers are not exposed to the web of organizational processes that operate behind the scenes to deliver their experiences. They only view a series of interactions from the outside in. Therefore, hospitals should manage CE by understanding the customer's perspective. In doing so, managers should consider the identified customer interaction elements to gain a more holistic, complex understanding of CE throughout the continuum of care.

- ***Inform development of evidence-based policy that has potential to impact all NHS hospitals***

Overall, the research has evidenced a valuable research method and tool that NHS marketers/management could adopt to improve the CE. It provides a robust evidence base to inform the design and improvement of healthcare services that consistently deliver positive experiences. The study identifies what constitutes positive and negative healthcare experiences and provides insights into areas that patients and carers perceive as particularly problematic, including a lack of explanation, expertise, and a focus on patient needs. The researcher recommends that managers consider direct, indirect, and independent encounters separately because each is associated with specific challenges and redesign principles. Hence, as this research has been conducted in accordance with the research guidelines of NHS studies, the findings and conceptual framework can support NHS or NICE policy/framework efforts to improve patient experience.

- ***The classification framework can also be used as a diagnosis to produce a comparative analysis***

Moreover, the classification framework can serve as a diagnostic and benchmarking tool. NHS hospitals can evaluate customer experience performance against the framework's dimensions and attributes to assess whether existing designs are effective. The conceptual framework can also be used to produce a comparative analysis of experience within and across health institutions, such as comparing the performance of similar departments across different healthcare providers and the performance of different types of care within the same hospital. For example, a hospital could identify underdeveloped aspects of the CE and formulate redesign guidelines that directly affect collective customer perceptions. Managers can also identify problematic areas from the patient perspective and trigger improvements

in the NHS hospitals service delivery system. For example, further studies could compare NHS hospitals by trust size (small, medium, and large) and by FT/Non-FT status, by regional NHS Strategic Authorities (NHS Wales, NHS Scotland, etc.), and by NHS hospitals versus private hospitals.

The researcher also used his privileged member access to other prominent NHS experts belonging to the Patient Experience Network, UK; The Chartered Institute of Marketing's, NHS Advisory Group; and Dr Foster Intelligence's Patient Experience Advisory Board and asked for their views on the applicability of the study's conceptual CE classification and CE definition frameworks to NHS hospitals. The consensus was that both frameworks could be used as diagnosis and benchmarking tools in practice. A list of the experts is in the Appendix.

6.4 Limitations and directions for future research

This study is conceptual in nature, and, as with any exploratory study, it has several limitations. However, there are also opportunities to build on this thesis. The study entails some limitations which have been considered when interpreting the results. First, it is unclear whether the classification framework would apply to other healthcare contexts, such as dentistry or general practice. Second, the thesis explores what hospitals' collective customers perceive rather than what is done. Stories represent subjective and personal views of the hospitals' collective customers. According to Ponsignon et al. (2015), the stories can be challenged because they do not necessarily provide accurate or objective reflections on the care and treatment received. Third, the study findings are limited to NHS England hospitals, and the data is collected at a specific time of the year (August to December). Studying hospitals' collective customers at different times of the year, with different NHS Strategic Authorities and private hospitals, and in different regions (Wales, Scotland, Ireland) would increase the generalizability of the results. Fourth, as with Ponsignon et al.'s (2015) Patient Opinion website data, information on the collective characteristics of customers was not available in the NHS Choices database. Hence, the researcher recognizes that participants are unlikely to be representative of the overall NHS England hospital collective customer population. Fifth, the stories vary greatly in length and detail. Like the studies by Ponsignon et al. (2015), Mkono (2014), and Kozinets (2010), much of the stories' richness lies in negative feedback, as participants describe poor experiences in detail.

Directions for future research

In this thesis, the researcher attempted to demonstrate how netnography can be a useful technique for investigating and understanding the subjective realities and interpretive meanings of hospital customer experience as provided by participants on their own terms. However, there is much more scope for adopting netnography as a research methodology in healthcare studies. Indeed, netnography remains outside mainstream research designs in tourism. Increasing the deployment of online research methods is timely as web-based technologies become globally accessible and cheaper, creating an ever-expanding volume of potential netnographic data. More specifically, the continued growth of healthcare-related websites such as NHS Choices (www.nhs.uk), Patient Opinion (www.patientopinion.org.uk), TripAdvisor (www.tripadvisor.co.uk), and PatientsLikeMe (www.patientslikeme.com) confirms this trend. The customer experience narratives reported by participants were not solicited but self-reported, which could have resulted in fragmented accounts. Recent technological advances offer customers new channels and platforms to provide solicited and unsolicited qualitative feedback in textual, unstructured formats (Ordenes et al., 2014). Future studies may focus on collecting qualitative customer experience feedback from unstructured textual data, solicited and unsolicited, such as online reviews and social media conversations (e.g., Facebook).

In future, healthcare studies researchers could make more extensive use of online data as it is cheaper than interviews or focus groups, patient-empowering (as patients and carers determine the content of their text almost exclusively), and expeditious, especially in studying populations which might be difficult to reach physically, and it may also be used for ethical reasons. As more patients and carers join online communities and engage on social media, researchers have greater access to rich, self-interpretive hospital collective customer experience data. Netnography has sufficient merit to ensure that, in the future, it becomes firmly entrenched in healthcare research methodology as a virtual ethnographic technique. However, as with any technique that is still in its infancy, some grey areas remain regarding the adaptation of traditional ethnographic techniques and CIT analytical techniques to the cyberscape as a fieldwork site. These grey areas require further investigation and include the ethical protocols associated with netnography, the actual process of conducting netnography, sample sizes, and the degree and duration of immersion in the virtual field. Further, at this stage, netnography is understood, for the most part, as developed for market research. Rather than adopting mechanisms and protocols developed

for other disciplines, it is more desirable for the advancement of healthcare theory that healthcare researchers develop their own, tailor-made specifications responsive to the eccentricities of healthcare studies and the healthcare industry.

This research also highlights the need for the development of appropriate measurement tools that can help to manage the delivery of the customer experience, and show how the co-creation of value can enhance the customer experience in the NHS hospitals context. Some of these constraints point to fruitful avenues for further research. First, this research only included data from England. To improve the global generalizability of the holistic model of CE, future research should replicate the study in other NHS authorities in other countries outside the UK (i.e. NHS Scotland, NHS Wales and NHS Northern Ireland), Western countries, and even focus on non-Western economies (e.g. Burgess and Steenkamp, 2006). This may help to unearth cross-cultural or geographical consumer differences that are important to UK and global healthcare.

This research only considered factors that significantly influence positive and negative customer experiences. While a customer may have either positive or negative experiences with a company (Jüttner et al., 2013), measuring the negative or positive impact of customer experience was outside the scope of the research. Future research could examine whether there are asymmetric effects of positive and negative experiences on different outcome variables (e.g., recommendation intentions, loyalty outcomes, and satisfaction). Other research directions go beyond the identified limitations. One potential research direction is to further understand the effects of customer experience on other 'hard' outcome variables, such as patient referrals, clinical outcomes, efficiency savings, mortality rates, customer satisfaction, revenue, and recommendations, using actual clinical and financial transaction data and hospital records. While this research has extended the current knowledge on the link between customer experience and actual healthcare service quality, it would be interesting to determine whether customer experience also influences other hospital value metrics.

On a similar note, this research examined how different hedonic and utilitarian consumer motivation orientations moderate the relationship between CE and its attributes and dimensions. Future research may consider how other consumer factors, such as consumer/patient expertise (e.g. Van Ittersum et al., 2013), moderate this relationship.

Finally, due to the absence of a universally accepted scale for measuring customer experience, the researcher obtained scale items from prior studies to reflect the dimensions of customer experience (i.e. sensory, affective, cognitive, relational, and physical) as recommended by Verhoef et al. (2009) and Gentile et al. (2009). Although the development of a scale to measure customer experience was beyond the scope of this research, future research could focus on developing an alternative scale to measure customer experience in the NHS hospitals context.

6.5 THESIS CONCLUSISON

This research offers a robust understanding of the customer experience, one that will help NHS hospitals to effectively design, monitor, and assess real customer experience at individual service encounters. The research contributes to the customer experience literature and offers insights into netnography and CIT-based innovative methodologies for capturing and evaluating customer feedback. Looking ahead, as the use of customer review websites that enable consumers to post positive and negative stories about hospital experiences continues to grow, marketers will undoubtedly continue to embrace new technologies to capture real customer experience insights.

Customer experience continues to be much discussed by practitioners, but the empirical research base is comparatively slight (Verhoef et al., 2009; Lemke et al., 2010; Klaus and Maklan, 2011). The researcher has explored critical dimensions and attributes of customer experience in the context of NHS England hospitals. He found that, with the help of netnography and CIT techniques, customers can indeed articulate the constructs by which they evaluate the customer experience, if not asked an overly narrow question about service quality or “the value you get from us”.

CHAPTER 5: DBA REFLECTIVE DIARY

My lonely long-distance DBA journey!

To me, the professional reflective development module was a very important part of my DBA because it gave me a platform to reflect on the loneliness of my long-distance DBA journey. It came as a shock to my peers and me when we were told that Professional Reflective Development would be our first tutorial class. It did not make sense to us as we all assumed that the obvious modules, which were Research Methods and Literature Review, would come first. I remember very well, on the first day of tutorials, getting even more confused and doubting the reason for starting this module.

However, after six months, I started realizing the benefits of starting with the Professional Reflective Development module as I was able to connect it to several aspects within my DBA journey. There are a few multi-touchpoints I have had to go through to date in my DBA journey, which, on reflection, could make or break it. For this chapter, I shall walk you through my reflective journey right from the time I considered the DBA, through all steps taken and the challenges, including potential emotional, social, psychological and physical nightmares, met along the way.

Getting started with the lonely long-distance DBA journey

My main reason for or aim in doing a DBA and not a PhD at the beginning was the wish to make a significant contribution as a "researching professional", rather than becoming a PhD student, as they strive to become "professional researchers" (Bourner, Katz, & Watson, 2000, as quoted in Taylor, 2007). I became interested in my customer experience topic while working in marketing in the healthcare industry (NHS and private hospitals), and I wished to contribute to the current state of knowledge. I witnessed many hospitals struggling with this issue and turning to consultants for help.

The importance of this topic for me was further confirmed through my active involvement since 2007 in the CIM's NHS Advisory Group, the Patient Experience Network, and in my role at Dr Foster Intelligence, the publishers of the Dr Foster Hospital Guide and owners of the Patient Experience Intelligence board, and the first organization to introduce the patient experience tracker (PET) devices in NHS hospitals for measuring patient or customer experience and satisfaction.

I thought the DBA route, rather than a PhD, was the right one for me, as I have already established myself as a professional marketer and am at the pinnacle of my career in the commercial world. According to Taylor (2007), these two routes do not appear to be in competition but are rather distinctive and alternative to each other, as illustrated in Table 6.1.

Professional doctorate (DBA) *"Researching professional"*	**PhD** *"Professional Researchers"*
Requires substantial professional experience and appropriate professional qualification	No professional experience/professional qualifications required
Entry: Usually following Masters Degree	Entry: Following first degree
Training through taught program, with directed study	Research training through an apprenticeship model
Teaching team	Individual supervisors
Cohort of students	Learning setting: Supervisor to student (1:1)
Different mentors/supervisors for different elements of the program	Supervision in University setting in relation to research thesis, and supervisor as expert in discipline or subject or area of research
Broad focus on Mode 2 knowledge	Specialist focus on Mode 1 Knowledge
Focus on research affecting professional practice as well as contributing to knowledge	Focus on research, making a contribution to knowledge
Tends to be seen as higher study in terms of career change and development	Normally viewed as providing initial training for a career in academia
• Continuous assessment through module assessments • Assessment by outcome product: thesis • Examined by viva	• Assessment by outcome product: thesis • Examined by viva
Dissemination/Publication: Focused/Narrow	Dissemination/Publication: Wide

Table 5.1: Difference between "Researching Professionals" vs. "Professional Researcher" (based on Taylor, 2007)

Once I decided to continue in the higher education system and pursue a DBA, I had other decisions to make. First, I had to be accepted by a university to work on my chosen area of study.

Becoming a researching professional

In general, between my peers and me, very little was done in terms of induction into the higher-degree system of taking on the role of a research professional. Watson (1974) described the "ill-defined limbo" which he saw the world of the postgraduate as, and he spoke of the traumatic intellectual transition which had to be made, during which new students might question the whole point of their being in the university. One common misconception about research is that it's an 'ivory tower' activity far removed from reality and social contact with others. If I say I am doing research, people/colleagues often talk to me as though I had decided to spend a few years in solitary confinement from which, in due course, I will emerge with my new discoveries.

The two potential emotional and career nightmares that I have faced to date in my DBA journey are not to finish, which is practically to guarantee a years-long, if not lifelong, feeling of having flawed or somehow uncompleted life, where I am constantly explaining or rationalizing to others (e.g. work colleagues, friends, spouse, family) and to myself just why I didn't finish. The thought of the emotional energy expended in often decades-long apologizing and soul-searching is incalculably debilitating and humiliating. On the other hand, I have often heard my peers remark (indeed, sometimes said it myself), *"if only I could finish my thesis, my troubles would be over."* Finishing often scars the successful laureate as well.

Selecting my supervisor

This was probably the most important step that I had to take. In general, students do not select their supervisors; they are allocated by the department. However, I thought it was not impossible to influence the selection myself, and I attempted to do so. I considered certain basic information to be confident that my supervisor was an appropriate person to supervise me. I looked at key factors, whether my supervisor has an established research record in any customer service or healthcare area, and is continuing to contribute to the development of his or her discipline. The questions that I asked myself included the following: Have they published research papers recently? Do they hold research grants or contracts? Are they invited to speak at conferences in Britain and abroad? I was satisfied when I was eventually allocated with my first supervisor, Dr Lily Wang, and my second supervisor, Dr Richard Warr.

Another important question I asked myself was, how close a relationship do I want with my first supervisor? Research has shown (Phillips, 1979) that when a student who needs time to plan and to continue unhurriedly until satisfied that there is something interesting to impart is paired with a supervisor who constantly asks for worthwhile results, the student becomes irritated and feels that the required standards are unattainable. It seemed to me that 'rapport' and good communication between the supervisor and me should be the most important elements of supervision from the first supervision session. It cannot be stressed too strongly that discussion of this relationship should begin at the earliest opportunity, and tentative agreement on working together should be reached.

The DBA adrift

Obtaining a DBA is inevitably complex. On reflection, I now see that all my peers and I embarked on our research with the naïve view that, once we had identified our topics, we would follow a predictable path to their conclusions.

Eighteen months into my DBA journey, I began to feel adrift. When I asked my fellow students to use word association to describe their DBA stage so far, some combination of the following responses was typical: fear, agony, torture, guilt, no end in sight, indefinitely postponed gratification, "ruining my life", "I am drowning in it", anxiety, boredom, hate, despair, depression, humiliation, and powerlessness.

Upon reflection, the DBA situation parallels long-distance running. How do runners keep going, mile upon mile, in, say, a 26-mile marathon? Experienced runners, such as Mo Farah, note that when their feet and souls begin to drag along the way, they constantly remind themselves that there were well-thought-out reasons for wanting to finish the race before they began, and some even repeat these reasons to themselves right through the entire course of the run. I keep reflecting to myself that my firm intention is to become a full (the doctorate bestows full membership) professional in my thesis field, and that achieving this is an adequate long-range reward for the task confronting me, and I also give myself constant self-reminders that the DBA "run" is a long one.

Taking a new job before finishing

I have also realized that doing a DBA is an intellectually demanding enterprise, and this has been true at all stages of my assessment work. It is especially true for the RD1 writing stage. I now feel writing RD1 demanded the most concentrated effort of the whole process.

There are several reasons for this. The first is emotional: it is difficult to avoid feeling that this is a chore, after the 'real' work has been done. There are always ambivalent feelings about the study itself and a barely suppressed desire to run away from it altogether, now that the data are there for others to see.

For both these reasons, this was not the time to take a new job. I was made redundant at work and had to spend a few stressful two months preparing for interviews and coping with financial pressures. I lost interest in the DBA and focused on getting a job. After two months, I finally took a new senior global marketing role that was demanding at first. I had to make a mark in the first six months and travel across the world. Apart from the physical dislocation, which makes intellectual work difficult and therefore easily postponed, a new job required me to concentrate attention on a new range of issues. As a result, I lost almost six months of progress on my DBA work.

This new job created the 'weekend warrior' type of work style, where I tried to give my DBA work just a few hours at the weekend, because I wanted Saturday and Sunday to rest and recharge for Monday. At the same time, my spouse and children also wanted these hours shared with them.

Making the thesis a top priority in my life

I have also reflected on our tutors telling us, every time, that to be successful, we are going to have to rearrange our social and psychological priorities – and even our relationships – during the thesis course if we are to get on top of the thesis and drive it home to completion. Indeed, nearly all the successful friends with doctorates I have known have had to make the thesis an obsession. The idea that lovers, spouses, children, and social life in general are relegated to the back burner, virtually put "on hold" for much of the thesis course, is horrifying and often incomprehensible to many people. Yet the rigours of the research and writing are such that a candidate has no strength, stomach, or time for extensive quarrels, grand passions, or backbiting.

Major aspects of my loneliness DBA Process

Here, I reflect on two aspects of my loneliness during my long-distance DBA journey. First, I will discuss the psychological nature of my experiences, emphasising that they have had a significant emotional component in addition to the recognised intellectual one.

Psychological aspects

Enthusiasm

I began my research period full of enthusiasm for my new undertaking. I have noticed this changing over the time it has taken to complete assessments and RD1. Research has shown that the main reason initial enthusiasm diminishes is the time required to work on a single problem (Phillips, 1980).

During the years of my research, I have become more remote and detached. At first, I had to concentrate hard on what I was doing; it completely occupied my mind. In some ways, I have become less enthusiastic; at first, I was full of enthusiasm for work, and I thought it would be very important, but in the end, other things have given me much more satisfaction.

In general, my early enthusiasm led me to overly ambitious estimates of what I could accomplish in the first three years. As time went by and deadlines came closer, I felt the stress of time constraints and the monotony of focusing on a particular problem for an extended period.

Isolation

Generally, I have been disappointed by the amount of work I managed to get done during this period, and on reflection, I feel I should be much further ahead than I actually am. I didn’t feel that I got very far after the end of my second year. I think I could have done more. I am frustrated that I haven't made as much progress as I hoped, but I don’t know how I could have achieved more.

I am dissatisfied with the amount and quality of my interaction with my learning set's peers. I also feel that I had very little in common with the others in my cohort, apart from Konrad Krietman; in addition, I did not talk to anyone about my work. This resulted in a period of

isolation. The lack of intellectual stimulation and the exchange of ideas with peers eventually led to a loss of interest in my topic, which I thought was of no importance to anyone else. Once again, work slowed down almost to a standstill. On reflection, regardless of discipline, topic, or university, I was suffering from the effects of the social circumstances in which I was working rather than from the work itself.

The Thesis

Throughout the taught modules, I enjoyed the initial work focused on the literature review. I enjoyed reading and expanding my knowledge of current space management practices in the sector. I undertook the DBA for two reasons: initially to improve the consultative process for a significant rationalization and relocation project and secondly to develop personal skills and management expertise. The duration of the doctoral study has been far longer than the timescales established for the specific work-related project that prompted the initial idea, and as a result, the learning through the various stages of research has come after action was taken on the project. This was a recurring frustration throughout the research, particularly in the taught module focused on methods and methodology.

Overall, the DBA programme has been an extremely demanding process that has tested me academically, emotionally, and to some extent physically. The work through the taught stages was enjoyable because it developed relationships with the other students in the Cheltenham 3 cohort. However, the research phase became more difficult because I was pushing forward with a research strategy I had developed, given the uncertainties that come with such a new set of theories. The time when I did not know where the work was leading was difficult for me, and this nervousness did not diminish until I was well into the analysis section, when I could begin to see how the qualitative data I had gathered was forming a solution. Overall, my advice would be not to take the decision to pursue doctoral study lightly. If you do take such a decision, then it is a marathon, and the appropriate training to complete the race is long and arduous. As a researcher, I can conclude that the DBA has sharpened my thinking, views, and knowledge of my research topic on CE more than it was when I started it. Hence, I am now able to reflect on my journey and critically evaluate my potential for completing the DBA with greater accuracy.

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APPENDICES

Appendix – Node listing of coding reports “Liked”, “Disliked” and “Advice”

Total: 3 coding reports with 128 subcategories

Titles sorted alphabetically

1. **Advice (24 subcategories)**
   - A&E closing hours
   - Administrative supervision
   - Amenities
   - Anesthesia
   - Appointments
   - Blank (advice)
   - Communication
   - Do not change or close hospital
   - Emergency complaints procedures
   - Enforcing no smoking rules
   - Infection control
   - Layout
   - Matron
   - Miscarriage care
   - Noise
   - Parking
   - Patient-choice hospitals
   - Patients during treatment
   - Physiotherapy ('no hands')
   - Respiratory beds
   - Second birthing pool
   - Staff
   - Waiting area
   - Waiting times

2. **Disliked (6 subcategories)**
    - Blank (disliked)
    - Other (disliked) (3 subcategories)
        - Everything disliked (nothing liked)
        - Patient attitudes
        - Stressful
    - Policies - procedures (disliked) (14 subcategories)
        - Admission
        - Appointments
        - Communication issues (18 subcategories)
            - *Between staff*
            - *Discharge instructions - post-care*
            - *Dishonesty*
            - *Doctors and consultants*
            - *Erroneous information*
            - *Expected waiting times*
            - *Family*
            - *Hospital & GP & patient*
            - *Lack of shared decision making*
            - *No response*
            - *Norovirus - MRSA*
            - *Patient - during stay*
            - *Post-care info & follow-up*
            - *Pre-admission*
            - *Reception*
            - *Records - forms*
            - *Special communication issues*
            - *Tests and procedures*
        - Discharge
        - Lack of privacy
        - Management issues
        - Medicine & prescriptions
        - Other
        - Pain management issues
        - Physiotherapy & exercise sessions
        - Pre-admission
        - Reception
        - Visitor restrictions
        - Wait times
    - Premises - facilities (disliked) (15 subcategories)
        - Amenities
        - Appearance & cleanliness
        - Atmosphere
        - Bed management
        - Blood testing - phlebotomy
        - Food and beverages
        - Lack of funding
        - Lack of supplies equipment
        - Layout
        - Other
        - Parking & fees
        - Signage & clocks
        - Smoking outside main entrance
        - Waiting area
        - Wards - rooms
    - Staff (disliked) (4 subcategories)
        - Behaviors & interactions
        - Level of care
        - Level of competence
        - Understaffed or unavailable
    - Unsatisfactory comments (disliked)

3. **Liked (6 subcategories)**
    - Blank (liked)
    - Other (liked) (3 subcategories)
        - Emotional support - sense of safety
        - Everything liked (nothing disliked)
        - Leaving - getting out - going home
    - Policies - procedures (liked) (11 subcategories)
        - Admission
        - Appointments
        - Chaplain availability
        - Communication (11 subcategories)
            - *Chief executive*
            - *Doctors and consultants*
            - *Family*
            - *Honesty*
            - *Hospital - VAD Team - Thoratec*
            - *Leaflets & booklets*
            - *Patient - during stay*
            - *Phone*
            - *Post-care info & follow-up*
            - *Shared decision making*
            - *Tests and treatments*
        - Discharge process
        - Maternity ward processes policies
        - Pain management
        - Privacy
        - Triage system
        - Visitor policies
        - Wait time
    - Premises - facilities (liked) (10 subcategories)
        - Amenities
        - Appearance & cleanliness
        - Atmosphere
        - Bed management
        - Equipment (Da Vinci robot)
        - Food and beverages
        - Layout
        - Parking & fees
        - Radio request show
        - Signage - website info
    - Satisfactory comments (liked)
    - Staff (liked) (3 subcategories)
        - Behavior and attitudes
        - Care
        - Competence

Appendix – Frequency by FTs and Non FTs (Advice, Disliked & Liked)

NODE REPORTS (Titles alphabetical)			FT	FT	Non-FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	Documents (470)	% of 470	228	% of 228	242	% of 242	Col B-D-F=0
ADVICE							
A&E closing hours	1	<1%	0	0%	1	0%	0
Administrative supervision	1	<1%	0	0%	1	0%	0
Amenities	1	<1%	0	0%	1	0%	0
Anesthesia	1	<1%	0	0%	1	0%	0
Appointments	3	<1%	2	1%	1	0%	0
Blank (advice)	211	45%	108	47%	103	43%	0
Communication	2	<1%	0	0%	2	1%	0
Do not change or close hospital	2	<1%	0	0%	2	1%	0
Emergency complaints procedures	1	<1%	1	0%	0	0%	0
Enforcing no smoking rules	1	<1%	0	0%	1	0%	0
Infection control	2	<1%	0	0%	2	1%	0
Layout	1	<1%	1	0%	0	0%	0
Matron	1	<1%	1	0%	0	0%	0
Miscarriage care	1	<1%	0	0%	1	0%	0
Noise	1	<1%	0	0%	1	0%	0
Parking	3	<1%	1	0%	2	1%	0
Patient-choice hospitals	1	<1%	0	0%	1	0%	0
Patients during treatment	2	<1%	0	0%	2	1%	0
Physiotherapy ('no hands')	1	<1%	1	0%	0	0%	0
Respiratory beds	1	<1%	1	0%	0	0%	0
Second birthing pool	1	<1%	0	0%	1	0%	0
Staff	6	1%	3	1%	3	1%	0
Waiting area	1	<1%	0	0%	1	0%	0
Waiting times	6	1%	4	2%	2	1%	0

NODE REPORTS (Titles alphabetical)			FT	FT	Non-FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	228	% of 228	242	% of 242	**Col B-D-F=0**
DISLIKED							
Blank (disliked)	212	45%	102	45%	110	45%	0
Other (disliked)	88	19%	40	18%	48	20%	0
Everything disliked (nothing liked)	23	5%	9	4%	14	6%	0
Patient attitudes	2	<1 %	1	0%	1	0%	0
Stressful	75	16%	34	15%	41	17%	0
Policies - procedures (disliked)	176	37%	74	32%	102	42%	0
Admission	10	2%	7	3%	3	1%	0
Appointments	22	5%	12	5%	10	4%	0
Communication issues	119	25%	53	23%	66	27%	0
Between staff	*1*	*%*	5	2%	6	2%	0
Discharge instructions - post-care	*1*	*%*	4	2%	7	3%	0
Dishonesty		*1%*	2	1%	2	1%	0
Doctors and consultants	*3*	*1%*	28	12%	25	10%	0
Erroneous information	*4*	*%*	13	6%	11	5%	0
Expected waiting times	*2*	*%*	5	2%	7	3%	0
Family	*2*	*%*	5	2%	7	3%	0
Hospital & GP & patient		*%*	2	1%	5	2%	0
Lack of shared decision making		*%*	6	3%	0	0%	0
No response	*1*	*%*	2	1%	9	4%	0
Norovirus - MRSA		*%*	1	0%	2	1%	0
Patient - during stay	*7*	*%*	15	7%	22	9%	0
Post-care info & follow-up	*6*	*%*	6	3%	10	4%	0
Pre-admission		*%*	0	0%	5	2%	0
Reception		*%*	3	1%	2	1%	0
Records - forms	*6*	*%*	8	4%	8	3%	0
Special communication issues		*%*	2	1%	5	2%	0
Tests and procedures	*6*	*%*	16	7%	10	4%	0
Discharge	24	5%	8	4%	16	7%	0
Lack of privacy	15	3%	8	4%	7	3%	0
Management issues	8	2%	3	1%	5	2%	0
Medicine & prescriptions	19	4%	8	4%	11	5%	0
Other	6	1%	2	1%	4	2%	0
Pain management issues	27	6%	12	5%	15	6%	0
Physiotherapy & exercise sessions	4	<1 %	2	1%	2	1%	0

NODE REPORTS (Titles alphabetical)			FT	FT	Non-FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	228	% of 228	242	% of 242	**Col B-D-F=0**
DISLIKED							
Pre-admission	5	1%	0	0%	5	2%	0
Reception	5	1%	3	1%	2	1%	0
Visitor restrictions	10	2%	4	2%	6	2%	0
Wait times	65	14%	27	12%	38	16%	0
Premises - facilities (disliked)	100	21%	48	21%	52	21%	0
Amenities	7	1%	2	1%	5	2%	0
Appearance & cleanliness	29	6%	14	6%	15	6%	0
Atmosphere	17	4%	7	3%	10	4%	0
Bed management	4	<1 %	1	0%	3	1%	0
Blood testing – phlebotomy	4	<1 %	3	1%	1	0%	0
Food and beverages	20	4%	8	4%	12	5%	0
Lack of funding	5	1%	4	2%	1	0%	0
Lack of supplies equipment	8	2%	4	2%	4	2%	0
Layout	8	2%	3	1%	5	2%	0
Other	4	<1 %	3	1%	1	0%	0
Parking & fees	27	6%	14	6%	13	5%	0
Signage & clocks	11	2%	7	3%	4	2%	0
Smoking outside main entrance	2	<1 %	1	0%	1	0%	0
Waiting area	8	2%	6	3%	2	1%	0
Wards – rooms	8	2%	4	2%	4	2%	0
Staff (disliked)	148	31%	67	29%	81	33%	0
Behaviors & interactions	104	22%	48	21%	56	23%	0
Level of care	92	20%	43	19%	49	20%	0
Level of competence	67	14%	37	16%	30	12%	0
Understaffed or unavailable	24	5%	8	4%	16	7%	0
Unsatisfactory comments (disliked)	249	53%	114	50%	135	56%	0

NODE REPORTS (Titles alphabetical)			FT	FT	Non -FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	Documents (470)	% of 470	228	% of 228	242	% of 242	Col B-D-F=0
LIKED							
Blank (liked)	118	25%	53	23%	65	27%	0
Other (liked)	162	34%	85	37%	77	32%	0
Emotional support - sense of safety	102	22%	58	25%	44	18%	0
Everything liked (nothing disliked)	88	19%	46	20%	42	17%	0
Leaving - getting out - going home	5	1%	1	0%	4	2%	0
Policies - procedures (liked)	230	49%	116	51%	114	47%	0
Admission	18	4%	7	3%	11	5%	0
Appointments	23	5%	11	5%	12	5%	0
Chaplain availability	1	<1%	0	0%	1	0%	0
Communication	180	38%	95	42%	85	35%	0
Chief executive		*1%*	0	0%	1	0%	0
Doctors and consultants	*2*	*7%*	45	20%	37	15%	0
Family	*3*	*1%*	24	11%	29	12%	0
Honesty		*%*	3	1%	2	1%	0
Hospital - VAD Team - Thoratec		*1%*	0	0%	1	0%	0
Leaflets & booklets		*1%*	2	1%	0	0%	0
Patient - during stay	*10*	*3%*	57	25%	53	22%	0
Phone	*3*	*%*	7	3%	6	2%	0
Post-care info & follow-up	*6*	*%*	12	5%	14	6%	0
Shared decision making	*0*	*%*	14	6%	16	7%	0
Tests and treatments	*1*	*1%*	28	12%	23	10%	0
Discharge process	5	1%	3	1%	2	1%	0
Maternity ward processes policies	15	3%	7	3%	8	3%	0
Pain management	18	4%	10	4%	8	3%	0
Privacy	7	1%	4	2%	3	1%	0
Triage system	1	<1%	1	0%	0	0%	0
Visitor policies	3	1%	2	1%	1	0%	0
Wait time	70	15%	34	15%	36	15%	0
Premises - facilities (liked)	75	16%	32	14%	43	18%	0
Amenities	4	<1%	2	1%	2	1%	0
Appearance & cleanliness	48	10%	21	9%	27	11%	0
Atmosphere	18	4%	7	3%	11	5%	0
Bed management	4	<1%	1	0%	3	1%	0
Equipment (Da Vinci robot)	1	<1%	0	0%	1	0%	0
Food and beverages	18	4%	12	5%	6	2%	0
Layout	5	1%	3	1%	2	1%	0
Parking & fees	1	<1%	1	0%	0	0%	0
Radio request show	1	<1%	0	0%	1	0%	0

NODE REPORTS (Titles alphabetical)			FT	FT	Non -FT	Non-FT	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	228	% of 228	242	% of 242	**Col B-D-F=0**
LIKED							
Signage - website info	4	<1%	3	1%	1	0%	0
Satisfactory comments (liked)	363	77%	187	82%	176	73%	0
Staff (liked)	352	75%	179	79%	173	71%	0
Behavior and attitudes	287	61%	147	64%	140	58%	0
Care	264	56%	137	60%	127	52%	0
Competence	200	43%	115	50%	85	35%	0

Appendix - Frequency by NHS England hospital size (Liked, Disliked & Advice)

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
ADVICE											
A&E closing hours	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Administrative supervision	1	<1%	0	0%	1	1%	0	0%	0	0%	0
Amenities	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Anesthesia	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Appointments	3	<1%	0	0%	3	2%	0	0%	0	0%	0
Blank (advice)	211	45%	47	40%	73	49%	76	43%	15	58%	0
Communication	2	<1%	0	0%	1	1%	1	1%	0	0%	0
Do not change or close hospital	2	<1%	0	0%	2	1%	0	0%	0	0%	0
Emergency complaints procedures	1	<1%	1	1%	0	0%	0	0%	0	0%	0
Enforcing no smoking rules	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Infection control	2	<1%	0	0%	1	1%	1	1%	0	0%	0
Layout	1	<1%	0	0%	1	1%	0	0%	0	0%	0
Matron	1	<1%	0	0%	1	1%	0	0%	0	0%	0
Miscarriage care	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Noise	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Parking	3	<1%	0	0%	1	1%	2	1%	0	0%	0
Patient-choice hospitals	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Patients during treatment	2	<1%	0	0%	0	0%	2	1%	0	0%	0
Physiotherapy ('no hands')	1	<1%	1	1%	0	0%	0	0%	0	0%	0
Respiratory beds	1	<1%	0	0%	0	0%	0	0%	1	4%	0
Second birthing pool	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Staff	6	1%	1	1%	2	1%	3	2%	0	0%	0
Waiting area	1	<1%	0	0%	1	1%	0	0%	0	0%	0
Waiting times	6	1%	0	0%	3	2%	2	1%	1	4%	0

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
DISLIKED											
Blank (disliked)	212	45%	51	43%	54	36 %	92	52%	15	58 %	0
Other (disliked)	88	19%	26	22%	27	18 %	33	19%	2	8%	0
Everything disliked (nothing liked)	23	5%	9	8%	3	2%	10	6%	1	4%	0
Patient attitudes	2	<1 %	2	2%	0	0%	0	0%	0	0%	0
Stressful	75	16%	18	15%	27	18 %	29	16%	1	4%	0
Policies - procedures (disliked)	176	37%	46	39%	59	40 %	67	38%	4	15 %	0
Admission	10	2%	4	3%	3	2%	2	1%	1	4%	0
Appointments	22	5%	7	6%	7	5%	7	4%	1	4%	0
Communication Issues	119	25%	32	27%	44	30 %	40	22%	3	12 %	0
Between staff	*11*	*2%*	4	3%	3	2%	4	2%	0	0%	0
Discharge Instruction -ns - post-care	*11*	*2%*	4	3%	6	4%	1	1%	0	0%	0
Dishonesty	*4*	*<1 %*	1	1%	1	1%	2	1%	0	0%	0
Doctors and consultants	*53*	*11%*	12	10%	21	14 %	19	11%	1	4%	0
Erroneous Information	*24*	*5%*	7	6%	7	5%	10	6%	0	0%	0
Expected waiting times	*12*	*3%*	5	4%	4	3%	3	2%	0	0%	0
Family	*12*	*3%*	5	4%	4	3%	3	2%	0	0%	0
Hospital & GP & patient	*7*	*1%*	1	1%	3	2%	3	2%	0	0%	0
Lack of shared decision making	*6*	*1%*	1	1%	0	0%	3	2%	2	8%	0
No response	*11*	*2%*	5	4%	3	2%	3	2%	0	0%	0
Norovirus – MRSA	*3*	*1%*	1	1%	2	1%	0	0%	0	0%	0
Patient – during stay	*37*	*8%*	9	8%	11	7%	17	10%	0	0%	0
Post-care info & follow-up	*16*	*3%*	5	4%	8	5%	3	2%	0	0%	0
Pre-admission	*5*	*1%*	0	0%	3	2%	2	1%	0	0%	0
Reception	*5*	*1%*	2	2%	1	1%	2	1%	0	0%	0
Records – forms	*16*	*3%*	6	5%	6	4%	4	2%	0	0%	0
Special	*7*	*1%*	3	3%	3	2%	1	1%	0	0%	0

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
DISLIKED											
Communication issues											
Tests and procedures	*26*	*6%*	6	5%	12	8%	7	4%	1	4%	0
Discharge	24	5%	8	7%	9	6%	7	4%	0	0%	0
Lack of privacy	15	3%	6	5%	4	3%	5	3%	0	0%	0
Management issues	8	2%	3	3%	2	1%	3	2%	0	0%	0
Medicine & prescriptions	19	4%	6	5%	4	3%	8	4%	1	4%	0
Other	6	1%	2	2%	2	1%	2	1%	0	0%	0
Pain management issues	27	6%	6	5%	11	7%	9	5%	1	4%	0
Physiotherapy & exercise sessions	4	<1 %	0	0%	3	2%	1	1%	0	0%	0
Pre-admission	5	1%	0	0%	3	2%	2	1%	0	0%	0
Reception	5	1%	2	2%	1	1%	2	1%	0	0%	0
Visitor restrictions	10	2%	2	2%	4	3%	4	2%	0	0%	0
Wait times	65	14%	22	19%	18	12 %	23	13%	2	8%	0
Premises - facilities (disliked)	100	21%	26	22%	30	20 %	38	21%	6	23 %	0
Amenities	7	1%	0	0%	1	1%	6	3%	0	0%	0
Appearance & cleanliness	29	6%	8	7%	6	4%	13	7%	2	8%	0
Atmosphere	17	4%	3	3%	1	1%	11	6%	2	8%	0
Bed management	4	<1 %	1	1%	2	1%	1	1%	0	0%	0
Blood testing – phlebotomy	4	<1 %	3	3%	1	1%	0	0%	0	0%	0
Food and beverages	20	4%	5	4%	5	3%	9	5%	1	4%	0
Lack of funding	5	1%	1	1%	2	1%	2	1%	0	0%	0
Lack of supplies equipment	8	2%	3	3%	1	1%	3	2%	1	4%	0
Layout	8	2%	2	2%	2	1%	4	2%	0	0%	0
Other	4	<1 %	2	2%	2	1%	0	0%	0	0%	0
Parking & fees	27	6%	6	5%	11	7%	9	5%	1	4%	0
Signage & clocks	11	2%	4	3%	2	1%	4	2%	1	4%	0
Smoking outside main entrance	2	<1 %	1	1%	0	0%	1	1%	0	0%	0
Waiting area	8	2%	3	3%	1	1%	3	2%	1	4%	0
Wards - rooms	8	2%	0	0%	3	2%	3	2%	2	8%	0
Staff (disliked)	148	31%	38	32%	45	30 %	61	34%	4	15 %	0
Behaviors & interactions	104	22%	29	25%	33	22 %	39	22%	3	12 %	0

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
DISLIKED											
Level of care	92	20%	21	18%	31	21 %	36	20%	4	15 %	0
Level of competence	67	14%	20	17%	17	11 %	29	16%	1	4%	0
Understaffed or unavailable	24	5%	7	6%	7	5%	9	5%	1	4%	0
Unsatisfactory comments (disliked)	249	53%	65	55%	76	51 %	97	54%	11	42 %	0

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
LIKED											
Blank (liked)	118	25%	28	24%	24	16 %	59	33%	7	27 %	0
Other (liked)	162	34%	37	31%	57	39 %	62	35%	6	23 %	0
Emotional support - sense of safety	102	22%	24	20%	35	24 %	39	22%	4	15 %	0
Everything liked (nothing disliked)	88	19%	24	20%	32	22 %	29	16%	3	12 %	0
Leaving - getting out - going home	5	1%	0	0%	4	3%	1	1%	0	0%	0
Policies - procedures (liked)	230	49%	57	48%	78	53 %	81	46%	14	54 %	0
Admission	18	4%	3	3%	11	7%	3	2%	1	4%	0
Appointments	23	5%	6	5%	8	5%	7	4%	2	8%	0
Chaplain Availability	1	<1 %	0	0%	1	1%	0	0%	0	0%	0
Communication	180	38%	48	41%	61	41 %	62	35%	9	35 %	0
Chief executive	*1*	*<1 %*	0	0%	0	0%	1	1%	0	0%	0
Doctors and consultants	*82*	*17%*	23	19%	24	16 %	27	15%	8	31 %	0
Family	*53*	*11%*	15	13%	17	11 %	20	11%	1	4%	0
Honesty	*5*	*1%*	5	4%	0	0%	0	0%	0	0%	0
Hospital – VAD Team – Thoratec	*1*	*<1 %*	0	0%	0	0%	1	1%	0	0%	0
Leaflets & booklets	*2*	*<1 %*	0	0%	0	0%	2	1%	0	0%	0
Patient – during stay	*110*	*23%*	29	25%	40	27 %	36	20%	5	19 %	0
Phone	*13*	*3%*	5	4%	3	2%	4	2%	1	4%	0
Post-care info &	*26*	*6%*	1	1%	11	7%	13	7%	1	4%	0

NODE REPORTS (Titles alphabetical)			Large	Large	Medium	Medium	Small	Small	Specialist	Specialist	Check #Docs
ARCHIVE DATA RESPONSES	**Documents (470)**	**% of 470**	**118**	**% of 118**	**148**	**% of 148**	**178**	**% of 178**	**26**	**% of 26**	**Col B-D-F-H-J=0**
DISLIKED											
follow-up											
Shared decision making	*30*	*6%*	8	7%	12	8%	6	3%	4	15%	0
Tests and treatments	*51*	*11%*	17	14%	19	13%	15	8%	0	0%	0
Discharge process	5	1%	0	0%	2	1%	3	2%	0	0%	0
Maternity ward processes policies	15	3%	2	2%	3	2%	7	4%	3	12%	0
Pain management	18	4%	3	3%	7	5%	6	3%	2	8%	0
Privacy	7	1%	2	2%	1	1%	4	2%	0	0%	0
Triage system	1	<1%	1	1%	0	0%	0	0%	0	0%	0
Visitor policies	3	1%	0	0%	1	1%	1	1%	1	4%	0
Wait time	70	15%	20	17%	23	16%	24	13%	3	12%	0
Premises - facilities (liked)	75	16%	17	14%	27	18%	27	15%	4	15%	0
Amenities	4	<1%	0	0%	0	0%	3	2%	1	4%	0
Appearance & Cleanliness	48	10%	11	9%	15	10%	20	11%	2	8%	0
Atmosphere	18	4%	3	3%	8	5%	6	3%	1	4%	0
Bed management	4	<1%	0	0%	4	3%	0	0%	0	0%	0
Equipment (Da Vinci robot)	1	<1%	1	1%	0	0%	0	0%	0	0%	0
Food and beverages	18	4%	6	5%	5	3%	6	3%	1	4%	0
Layout	5	1%	1	1%	2	1%	1	1%	1	4%	0
Parking & fees	1	<1%	1	1%	0	0%	0	0%	0	0%	0
Radio request show	1	<1%	0	0%	0	0%	1	1%	0	0%	0
Signage - website info	4	<1%	2	2%	1	1%	1	1%	0	0%	0
Satisfactory comments (liked)	363	77%	93	79%	119	80%	128	72%	23	88%	0
Staff (liked)	352	75%	91	77%	113	76%	126	71%	22	85%	0
Behavior and attitudes	287	61%	76	64%	98	66%	97	54%	16	62%	0
Care	264	56%	70	59%	83	56%	93	52%	18	69%	0
Competence	200	43%	50	42%	67	45%	66	37%	17	65%	0

Appendix – List of industry experts

- Stephen Winterson, Director of Marketing and Communications, Countess of Chester Hospital NHS Foundation Trust
- Irwin Wilson, Associate Director for Contracts and Marketing, Gloucestershire Hospitals NHS Foundation Trust
- Ginette Camps-Walsh, Chairman of The Chartered Institute of Marketing's Medical Marketing Group, Managing Director Medical Marketing Consultants Ltd. Board Member of 2020 Health
- Dr Jocelyn Cornwell, Director, Point of Care Programme, The King's Fund
- Dr Ade Adeagbo, Chair, NHS Alliance Non-Executive Directors' Network, and Non-Executive Director, NHS Greenwich
- Jo Cubbon, Chief Executive, Taunton and Somerset NHS Foundation Trust
- Simon Roberts, Head of Business Development and Marketing, Papworth Hospital's NHS Foundation Trus
- Richard Driscoll,C hief Executive, Crohn's and Colitis UK

- Claire Lilley, Senior Policy Adviser, Which? Ann Lloyd, Commissioner for London, Appointments Commission
- Louise Locock, Deputy Research Director, Health Experiences Research Group (Healthtalkonline), University of Oxford
- Neil Bacon, Founder, iWantGreatCare
- Jessica Bush, Head of Patient and Public Involvement, King's College Hospital NHS Foundation Trust
- Professor Hilary Chapman, Chief Nurse and Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust, and Member, National Quality Board
- Anne Marie Laverty, Director of Patient Experience, Northumbria Healthcare NHS Foundation Trust
- Sir Stephen Moss, Chair, Mid Staffordshire NHS Foundation Trust
- Antony Sumara, Chief Executive, Mid Staffordshire NHS Foundation Trust Jane Walters, Director of Corporate Affairs, King's College Hospital NHS Foundation Trust