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Therapy on Stroke Units An Ethnographic Study

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THERAPY ON STROKE UNITS:
AN ETHNOGRAPHIC STUDY

Thesis presented for the degree of

Doctor of Philosophy

By

Elizabeth Rose Taylor

King's College London

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Abstract

Background: Guidelines and audit have been widely adopted as quality improvement strategies in healthcare. A recent stroke guideline states that 45 minutes of each relevant therapy, 5 days per week, should be provided to patients deemed appropriate. National audit data suggest variation across teams in the proportion of patients deemed appropriate, and the quantity and frequency of therapy provided. Reasons for these variations are unknown.

Aim: To investigate the ways in which policy, professional judgement and patient need influence the delivery of therapies in stroke units (SUs) in the era of the 45 minute guideline.

Method: An ethnographic study, including participant observation and interviews, was conducted in three SUs.

Results: Drawing on theoretical concepts of audit society and street level bureaucracy, the study found that the 45 minute guideline was limited in its ability to influence delivery of therapies. The attempt to standardise therapy time was undermined by variation in the roles and remits of SUs and therapists, and varied understandings of 'what counts' as therapy. Thus they had different approaches to assessing therapy needs, and adopted different audit reporting practices. In line with the claims of street level bureaucracy, therapists developed routines of practice to simplify and manage their caseloads. In one example, the audit had become a way of categorising patients' need for therapy and justifying resource allocation. The thesis identifies the role of 'Street Level Leaders' in guiding therapists' attitudes and practices. The thesis provides empirical data to support the theoretical concept of audit society, showing how changes to therapy standards and practice took place in a wider economic and social context.

Conclusions: The 45 minute guideline was one of many factors influencing delivery of therapy and was diversely interpreted and implemented. The study's findings suggest that, in the context of the quasi-marketisation of healthcare, audit may become a tool of commissioner-centred, rather than patient-centred care. Ongoing engagement between strategic leaders, patients and clinicians is needed, to ensure that quality of care does not become secondary to 'playing the numbers game'.

Table of Contents

ABSTRACT	2
TABLE OF CONTENTS	3
TABLE OF FIGURES	9
TABLE OF TABLES	10
ACKNOWLEDGEMENTS	11
ABBREVIATIONS	12
CHAPTER 1 INTRODUCTION	13
1.1 INTRODUCTION	13
1.2 STROKE: DEFINITION, PREVALENCE AND CONSEQUENCES	13
1.3 AUDITING STROKE REHABILITATION	15
1.4 UNANSWERED QUESTIONS	16
1.5 RESEARCH QUESTION, AIM AND OBJECTIVES	17
1.6 THESIS STRUCTURE.....	18
CHAPTER 2 BACKGROUND TO THE THERAPY IMPROVEMENT STRATEGY	20
2.1 INTRODUCTION	20
2.2 STROKE SERVICE IMPROVEMENT IN THE UK.....	20
2.3 THE USE OF IMPROVEMENT STRATEGIES IN STROKE CARE	21
2.4 DEVELOPMENT OF AN IMPROVEMENT STRATEGY FOR STROKE REHABILITATION.....	22
2.5 DEFINING REHABILITATION AND THE ROLE OF THERAPISTS.	25
2.6 THERAPY INTENSITY: THE EVIDENCE	28
2.6.1 Attempts to measure therapy dose-response:.....	28
2.6.2 Patients' activity levels and time spent in therapy	32
2.7 VARIATION IN THERAPY INTENSITY REPORTED IN SSNAP DATA	35
2.8 JUDGING WHETHER A PATIENT REQUIRES THERAPY	40
2.9 CHAPTER SUMMARY.....	44
CHAPTER 3 THE CONTEXT OF QUALITY IMPROVEMENT IN THE NHS	46

3.1 INTRODUCTION	46
3.2 THE CONTEXT OF QUALITY MEASUREMENT IN THE NHS	46
3.3 QUALITY MEASUREMENT IN THE NHS: CHALLENGES AND PITFALLS	51
3.3.1 Measurement and misrepresentation	51
3.3.2 Unintended consequences	53
3.4 INDUSTRIALISATION OF HEALTHCARE AND THE RISE OF EVIDENCE BASED STANDARDS	57
3.5 CHAPTER SUMMARY	62
CHAPTER 4 THEORETICAL FRAMEWORK: THERAPISTS AS STREET-LEVEL	
BUREAUCRATS IN AUDIT SOCIETY	64
4.1 INTRODUCTION	64
4.2 SITUATING SSNAP AS AN EXAMPLE OF HIERARCHICAL OBSERVATION IN AUDIT SOCIETY	66
4.3 THERAPISTS AS STREET-LEVEL BUREAUCRATS	70
4.4 CHAPTER SUMMARY	75
CHAPTER 5 METHODOLOGY AND METHODS	77
5.1 INTRODUCTION	77
5.2 METHODOLOGY	77
5.2.1 Ontological and epistemological considerations.	78
5.2.2 Rationale for using the ethnographic approach	79
5.3 ETHNOGRAPHY – IMPORTANT CONSIDERATIONS	81
5.3.1 Use of Reflexivity	82
5.3.2 Impact of the researcher	84
5.3.3 Power asymmetry	85
5.3.4 Insider / outsider	86
5.3.5 Participant observation	87
5.4 METHODS	89
5.4.1 Preliminary contextual data gathering	90
5.4.2 Site selection	91
5.4.3 Interviews	93

5.4.4 How participant observations were undertaken and used	96
5.4.5 Ethics and Research and Development approval	98
5.4.6 Data analysis	99
CHAPTER 6 SETTINGS AND PARTICIPANTS	102
6.1 INTRODUCTION	102
6.2 OVERVIEW OF THE SETTINGS	102
6.3 INTERVIEW PARTICIPANTS	105
6.3.1 Staff Interviewees	105
6.3.2 Patient interviewees	107
6.4 INDIVIDUAL FIELDWORK SITES	110
6.4.1 Site A: Jade Ward	111
6.4.2 Site B: Olive Ward	115
6.4.3 Site C: Topaz Ward	118
6.5 PERIPHERAL SOURCES OF INFORMATION	120
6.5.1 Meeting the key strategic leaders for stroke quality improvement	120
6.5.2 Meeting the natives outside the field	121
THERAPY ON STROKE UNITS: OVERVIEW OF FINDINGS CHAPTERS	123
CHAPTER 7 : THE MYTH OF STANDARDISATION	124
7.1 INTRODUCTION	124
7.2 MODEL STROKE PATIENTS AND UTOPIAN SUS	124
7.2.1 They're not 'model stroke patients'	125
7.2.2 Contrasts in the 'casemix'	126
7.2.3 Differences in SU culture: 'Rehab was the ethos... we're just a stepping stone'	128
7.3 THE VARIED ENACTMENT OF THERAPY: TASK, PLACE AND PURPOSE	130
7.3.1 The varied scope of therapy	130
7.3.2 Therapy spaces	134
7.3.3 What are we? The therapists' identity crisis.	136
7.3.4 The purpose of therapy	137

7.4 AUDITING THERAPY	141
7.4.1 Therapists' interpretations of the rationale for the 45 minute guideline	141
7.4.2 Individuals interpreted the audit differently	142
7.4.3 Teams interpret the audit differently	143
7.5 'THERAPY APPROPRIATENESS'	144
7.5.1 Therapy appropriateness is not a concept	144
7.5.2 They stop needing therapy the Tuesday before Discharge	146
7.5.3 Changing attitudes	146
7.6 CHAPTER SUMMARY	147
CHAPTER 8 : ROUTINES OF PRACTICE	149
8.1 INTRODUCTION	149
8.2 PRIORITISING PATIENTS: 'WE'RE CONSTANTLY COMPROMISING'	150
8.2.1 We're constantly juggling	151
8.2.2 When pressure is increased, rehabilitation is not prioritised	152
8.2.3 Cutting corners	153
8.3 CATEGORISING, LABELLING, OBJECTIFYING	155
8.3.1 SSNAPing or not SSNAPing.....	156
8.3.2 Borough boundaries: Chesney or Chittleford	158
8.3.3 Diagnosis: Stroke patients and medical patients	159
8.3.4 Death and dying.....	160
8.4 THERAPY HAPPENS IN THERAPY SESSIONS.....	161
8.4.1 Competing for time and space.....	161
8.4.2 Uni-disciplinary working	163
8.5 "NOBODY ASKING ME": LACK OF PATIENT INVOLVEMENT	167
8.5.1 'It would have been good, being more involved'	168
8.5.2 Attending to the whole person.....	170
8.6 CHAPTER SUMMARY	172
CHAPTER 9 : THERAPY ON THE THRESHOLD OF AUDIT CULTURE	175

9.1 INTRODUCTION	175
9.2 PERCEIVED CHANGES IN SU THERAPY.....	176
9.2.1 Medical management has improved, but SUs are now less rehabilitative environments	176
9.2.2 Changing spaces.....	178
9.2.3 We've lost that loving feeling	180
9.3 CONTRACTS AND COMPETITION	181
9.3.1 'Beds' means money.....	181
9.3.2 Contracts and commissioners.....	182
9.3.3 Rivalry and Mistrust	184
9.4 MISREPRESENTING THERAPY PRACTICE.....	186
9.4.1 'It doesn't reflect our practice'	186
9.4.2 Counting what shouldn't be counted	188
9.4.3 Excluding patients from the audit	188
9.5 THE MIXED INFLUENCE OF THE 45 MINUTE GUIDELINE.....	190
9.5.1 Pragmatic internalisation: It's in the back of your mind, but it's just a guideline	190
9.5.2 A threat to clinical reasoning	192
9.5.3 Data-driven services	192
9.6 INFLUENCING 'THE QUALITY BENEATH'	197
9.6.1 Bottom-up versus top-down.....	197
9.6.2 Clinical leaders emphasise or filter policies	199
9.7 CHAPTER SUMMARY	202
CHAPTER 10 DISCUSSION AND CONCLUSIONS	204
10.1 INTRODUCTION	204
10.2 SUMMARY OF FINDINGS.....	206
10.3 THE PROBLEMATIC STANDARDISATION OF THERAPY TIME	208
10.4 STREET-LEVEL LEADERS: AT THE INTERFACE OF POLICY AND PEOPLE	214
10.5 SSNAP AS A TOOL OF COMMISSIONER-CENTRED CARE	218
10.6 STRENGTHS AND LIMITATIONS	223

10.7 RECOMMENDATIONS AND IMPLICATIONS FOR FUTURE PRACTICE AND RESEARCH	225
10.8 CONCLUSION	227
REFERENCES.....	228
APPENDIX A: SAMPLE PAGE OF PUBLICATION.....	253
APPENDIX B: INTERVIEW TOPIC GUIDES (STAFF AND PATIENT).....	254
APPENDIX C: FIELDNOTES FROM JADE WARD SSNAP MEETING	256

Table of Figures

Figure 1: Scatterplot showing the relationship between average (median) daily minutes of OT provided and the percentage of the caseload reported as requiring OT in each team.	36
Figure 2: Scatterplot showing the relationship between average (median) daily minutes of PT provided and the percentage of the caseload reported as requiring PT in each team.	37
Figure 3: Scatterplot showing the relationship between average (median) daily minutes of SLT provided and the percentage of the caseload reported as requiring SLT in each team.	37
Figure 4: The Stroke Pathway in London (Healthcare for London 2008)	92
Figure 5: Set up for an interview in a meeting room	94
Figure 6: Flow diagram showing stroke pathway for Chesney and Chittleford patients	112
Figure 7: Structure of Findings Chapters	123
Figure 8: Notes from a multi-disciplinary meeting on Jade Ward.	125
Figure 9: Extract from fieldnotes. Jade Ward 9.9.14	133
Figure 10 Gym, Topaz Ward 11am.....	134
Figure 11: Extract from fieldnotes 3.9.14, Jade Ward	162
Figure 12: Extract from reflective diary, July 2015.....	170
Figure 13: Extract from reflective log: January 9th 2015	171
Figure 14: Extract from email from therapist. February 2016	184

Table of Tables

Table 1: SSNAP results for each therapy intensity indicator.	38
Table 2: Relationships between therapy indicators.	39
Table 3: Characteristics of the fieldwork sites.....	103
Table 4: Staff Interview Participants	105
Table 5: Patient (and carer) interview participants at Site A.....	108
Table 6: Conceptual framework of humanisation (Todres et al 2009 p70).....	150

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Abbreviations

Abbreviation	Meaning	First Use
CQC	Care Quality Commission	21
DALY	Disability Adjusted Life Year	14
EBP	Evidence Based Practice	57
HASU	Hyper-acute Stroke Unit	86
ISWP	Intercollegiate Stroke Working Party	13
NHS	National Health Service	18
NICE	National Institute for Health and Clinical Excellence	13
NPM	New Public Management	65
OT	Occupational therapist / Occupational therapy	13
PT	Physiotherapist / Physiotherapy	13
R&D	Research and Development	98
RCP	Royal College of Physicians	13
RCT	Randomised Controlled Trial	24
SLB	Street-level bureaucrat	65
SLL	Street-level leader	215
SLT	Speech and language therapist / Speech and language therapy	13
SSNAP	Sentinel Stroke National Audit Programme	15
SU	Stroke Unit	15
TA	Therapy assistant	89
UK	United Kingdom	13
WHO	World Health Organisation	13

Chapter 1 Introduction

1.1 Introduction

Since 1995 the Stroke Programme at the Royal College of Physicians (RCP) has been driving radical service improvements across multiple areas of stroke care in the United Kingdom (UK) (Cloud et al 2013). Rehabilitation reduces mortality and long-term disability after a stroke (Department of Health (DoH) 2007), and increasing the intensity of therapy provided to stroke patients has become a target for improvement. 'The 45 minute guideline', which aimed to increase the amount of therapy offered to stroke patients, was set out in the National Clinical Guidelines for Stroke (Intercollegiate Stroke Working Party (ISWP) 2012) and incorporated into the NICE guidelines for Stroke Rehabilitation (National Institute for Health and Care Excellence (NICE) 2013), and applies to occupational therapists (OTs), physiotherapists (PTs) and speech and language therapists (SLTs). It attracted much debate and discussion when it was introduced, and many therapists declared that it was inappropriate and unachievable (Rooney 2013). Since then, national audit results have shown that there is variation in performance against the guideline across the UK. It is not known how the guideline is being interpreted or enacted by therapists, or whether the audit has influenced their practice.

This introductory chapter will briefly set the scene for the PhD study and explain why it was considered important to explore the delivery of inpatient stroke therapy in the context of the national improvement strategy. The chapter will begin with an overview of stroke including its prevalence and its consequences. Therapy intensity is considered to be a crucial factor influencing recovery and restoration of independence after a stroke, and with this in mind the 45 minute guideline and related audit will be explained. The chapter will end with the study aim and objectives and an outline of the thesis structure.

1.2 Stroke: definition, prevalence and consequences

A stroke is a sudden and potentially catastrophic brain event that can happen to anybody at any time. The World Health Organisation (WHO) criteria for the diagnosis of stroke is "rapidly developed clinical signs of focal (or global) disturbance of cerebral function lasting longer than 24

hours or leading to death, with no apparent cause other than of vascular origin. This definition includes most cases of subarachnoid haemorrhage, intracranial haemorrhage, and cerebral infarction.” (Aho et al 1980). This medical definition is useful for diagnosis, but a patient’s perspective may be better suited to conveying the impact of a stroke.

“It’s a very severe thing to happen to anyone
it’s not like getting a – y’know – having a broken arm or
something like that
which incapacitates you for a couple of months
put your arm in plaster
and normally just take the plaster off
and you get back to where you were before
. . . . you lead a normal life one day
And within a matter of minutes, overnight
it all comes to an end.”

(Ellis-Hill 2008 p7-8).

Because a stroke damages the brain it can lead to any combination of difficulties in movement, cognition, perception and behaviour. It therefore causes a greater range of disabilities than any other condition, and is the largest cause of complex disability in adults (Adamson et al 2004). It has been reported that globally, between 1990 and 2010, there was a 68% increase in the numbers of people having a first stroke, an 84% increase in stroke survivors, and a 12% increase in disability adjusted life years (DALYs) lost due to stroke (Feigin et al 2014). Despite greater prevalence of stroke in high-income than in low and middle-income countries, resulting disability is lower in high income countries (as measured in Disability Adjusted Life Years) (Feigin et al 2014). The suggested explanation for this inverse association is the improved access to health care and rehabilitation in high income countries (Feigin et al 2014). In the United Kingdom in 2009 the treatment of stroke and loss of productivity combined are estimated to cost £8.9million annually (Saka et al 2009.)

1.3 Auditing stroke rehabilitation

Unquestionably, the hospital treatment of stroke patients in the UK has been transformed within a generation. Prior to the 1990s it was usual for stroke patients to be treated on general medical wards and there was no mandate for specialist services or rehabilitation. Now, stroke is a specialism that incorporates doctors, nurses and therapists among others. There is a proliferation of national guidelines covering multiple aspects of a patient's care. The protocol for establishing guidelines has been for a multi-disciplinary working party of professionals with expertise in stroke care to evaluate research evidence and arrive at a number of agreed recommendations.

Since the introduction of the UK's National Clinical Guidelines for Stroke in 2000 (ISWP 2000), monitoring of adherence to the guidelines has developed and increased. The Sentinel Stroke National Audit (SSNAP) programme was launched in December 2012, with the intention of benchmarking services nationally and regionally, monitoring progress, empowering clinicians to lobby for change when needed, and enabling patients to ask questions about the care available to them (SSNAP 2016).

The SSNAP programme aims to collect a dataset for each patient regarding their care from presentation at hospital through to 6 month follow up. Since the publication of its first pilot report in 2013, SSNAP has made a vast quantity of numerical audit data publically available. Data have been analysed, published and reported to clinicians to drive improvements in stroke care. 'Therapy intensity' is one of several processes of care used as a performance indicator. Others include the time taken to be scanned after a suspected stroke and the time taken to be admitted to a stroke unit (SU).

The data collection for the 'therapy intensity' aspect of the audit involves each hospital stroke team documenting each patient and whether he/she was considered to require OT/PT/SLT at any point during admission. There is no specification regarding who is responsible for making this decision, and it is up to individual teams to decide their processes for collecting data to be submitted to SSNAP. SSNAP publishes each teams' self-reported data for the median number of minutes of each therapy provided, and the median percentage of days as an inpatient on which

each therapy was delivered. Each team is given an audit score, which is a percentage intended to represent their performance for therapy intensity. It is based on the quality standard that 45 minutes of therapy should be provided to stroke patients, 5 days per week, and incorporates a benchmark that 80% of patients will require OT, 85% will require PT, and 50% will require SLT. The stated rationale for these benchmarks is that they have been guided by previous audit data. The audit score represents the number of minutes provided, proportion of days on which therapy was provided and proportion of patients considered to require therapy in each team. Further information about how this is calculated is available on the SSNAP website (SSNAP 2016).

Analysis of various components of the audit data has suggested that there is an association between certain audited structures (including stroke unit staffing), processes (including nutrition screen and formal swallow assessment within 24 hours of admission), and outcomes (measured as mortality rates) (Bray et al 2013). Therapy intensity is not one of the processes that has been analysed in this way. Furthermore, it is acknowledged that there is only limited evidence for the validity of process measures of quality in stroke care (Bray et al 2013; Parker et al 2012). Audit reports summarise national averages and present team results, but do not provide information about variation amongst teams or relationships within the data. SSNAP auditors have encouraged therapists to use the publically available data to highlight where there is a need for increased therapy and to consider how this could be achieved (SSNAP 2016). Audit data for therapy intensity appear to show considerable variation across sites nationally. There is variation in the reported proportion of the caseload considered to require therapy as well as the reported quantity and frequency of therapy provided. Although there have been steady improvements since its inception, many services are still measured as not meeting the 45 minute guideline (see p35)

1.4 Unanswered questions

The audit data appear to highlight that there is a problem. It may be that the audit is revealing an issue of inadequate and inequitable provision of therapy for stroke patients across different services, or there may be issues with the validity and reliability of the audit for therapy intensity. Despite the proliferation of data generated through the audit, it does not have explanatory power.

It is not capable of answering questions about how the national policy is being interpreted or implemented in practice. Audit is not merely a measurement tool, but is also intended to drive change. However, it is not capable of revealing to what extent and by which mechanisms it changes attitudes or practice, or whether it has unforeseen consequences.

There is a need to explore the extent to which the improvement strategy for stroke therapy intensity has influenced the way therapists plan, prioritise or deliver therapy to patients; the extent to which the audit score is likely to reflect quality of therapy provision; and unforeseen or unintended consequences of its implementation. Ethnography is well suited as a method for investigating these questions, as it enables the investigator to explore what is really going on 'on the ground'. The assumption behind this study is that observation of therapists at work is the best way to explore how they use their time and prioritise the needs of their patients. Asking them open ended questions about how they interpret the guideline, whether it has changed their practice and how they record and report information for the audit is crucial if we are to understand variation in audit practices. Participant observation allows comparisons to be made between what participants say in interviews and what they do in practice. Ethnographic research utilises a combination of participation observation and interviews to elicit descriptive information about a given group or setting, and is therefore considered an appropriate method for examining therapy provision on stroke units (SUs).

1.5 Research Question, Aim and Objectives

Research Question:

How is stroke unit therapy interpreted and enacted in the era of the 45 minute guideline?

Aim:

To investigate how factors such as policy, patient need and professional judgement influence the delivery of therapies in the inpatient stroke setting.

Objectives:

- i) To synthesise evidence from existing qualitative studies regarding provision of inpatient stroke therapy.
- ii) To explore the evidence base, background and rationale for policy regarding therapy intensity (e.g. the 45 minute guideline).
- iii) To conduct statistical analysis of the SSNAP data for therapy intensity, in order to explore variation amongst teams and potential relationships between indicators.
- iv) To conduct ethnographic fieldwork in three inpatient stroke settings, to observe and understand how the national 45 minute guideline and SSNAP audit are interpreted by therapists, and the extent to which they influence clinical decision making and practice.
- v) To conduct interviews in order to understand the concept of need for therapy, and priorities, expectations and experiences from the perspectives of patients, therapists and other key staff, and to compare this with observed practice regarding therapy allocation.

1.6 Thesis structure

Chapter 2 – Background to the improvement strategy. In this chapter I will present and discuss evidence relating to the development of stroke services and the role of stroke rehabilitation. I will discuss the concept of therapy.

Chapter 3 – The context of quality improvement in the NHS. Here I will critically review the wider context of quality improvement in the National Health Service (NHS). An increase in target setting and performance measurement will be situated within the context of industrialisation of healthcare delivery and the rise of evidence based practice and guidelines.

Chapter 4 – Theoretical Framework. I will explain the theoretical perspective of this study, drawing on authors including Lipsky and Power to position therapists as street-level bureaucrats in an audit society.

Chapter 5 – Methodology and Methods. In the first part of this chapter I will present ontological and epistemological considerations, and the rationale for using an ethnographic approach for this study. In the second part I will explain and discuss the methods used for data collection and analysis.

Chapter 6 – Setting the scene. This chapter will provide descriptive information about each site in turn, as well as information about staff and patient participants.

Chapter 7 – The myth of standardisation. In the first of three empirical findings chapters I will discuss different levels of variation observed across the three fieldwork sites, and suggest that the ideal of standardisation is undermined by, among other things, a muddled sense of purpose amongst therapists.

Chapter 8 – Routines of practice. In this chapter I will use Lipsky's notion of routines of practice to show that therapists developed ways to simplify and manage their caseloads. Therapists felt that they were constantly compromising and having to prioritise between patients and tasks. In one SU, the SSNAP audit had become a new way of categorising patients. I draw on Humanising Framework to juxtapose these routines of practice with the features of good quality care that patients identified as important.

Chapter 9 – Therapy on the threshold of audit culture. In the final findings chapter I will identify changes perceived by participants in the nature of SU rehabilitation over recent years. I will situate these changes within a wider context of changes in healthcare. I will show that in a context of competition and short-term commissioning, the audit has engendered feelings of rivalry between SUs. Having noted that therapists did not believe their audit scores reflected the quality of their services, I will discuss my observations regarding top-down and bottom-up mechanisms for change on the SUs. I will note that therapists' attitudes and prioritisation of policies was shaped by certain influential clinical leaders.

Chapter 10 – Discussion and Conclusions. I will summarise findings and interpret them with reference to existing literature and theory. I will focus on the problematic standardisation of therapy time; street-level leaders at the interface of policy and people; and SSNAP as a tool of commissioner-centred care. Strengths, limitations and implications of the study will be presented.

A note on the writing style:

In the background chapters, the focus is other people's work, and I therefore follow the convention of using the third person. In Chapter 5: Methodology and Methods, I begin writing in the first person, and continue to use this style throughout the rest of the thesis. This is in order to demonstrate reflexivity, to openly position myself as the researcher and to acknowledge the subjectivity of my decisions and observations.

Chapter 2 Background to the therapy improvement strategy

2.1 Introduction

This chapter will explain the 45 minute therapy intensity guideline and situate it within the specific context of stroke service improvement. It will begin with a brief history of stroke service improvement in the UK and demonstrate that the development of an improvement strategy for stroke therapy was part of a broader programme. Definitions of therapy and rehabilitation will be presented and discussed. The evidence relevant to the 45 minute guideline will be presented and discussed. In order to formally establish levels of variation in the SSNAP audit results for therapy intensity, statistical analysis of the publically available data was carried out. Results of this analysis will be presented. The challenge of determining need for therapy will be presented and related to literature regarding 'rehabilitation potential' and motivation. As part of the exploration of this topic, a narrative review of factors influencing the delivery of inpatient stroke therapy was conducted and published in a peer reviewed journal (included as Appendix A). The concept of determining patients' needs will be situated within the context of questions of distributive justice and health inequalities, and posed as a potential focus of quality improvement.

2.2 Stroke service improvement in the UK

Hoffman's 1974 paper, 'Nothing can be done', drew attention to the prevailing attitude of its time, when health professionals considered stroke patients with pessimism and referred to them as 'frustrating', 'depressing' or 'vegetables' (Hoffman 1974 p52). Stroke treatment focussed on reducing mortality rates, and less attention was paid to the fate of those who survived. Patients were typically left in bed on general medical wards, no longer requiring active medical treatment and not considered to have potential for recovery. An emerging interest in the management of stroke patients gathered momentum over the following decades, with the benefits of rehabilitation being debated and investigated (Dobkin 1989; Reding et al 1989; Smith et al 1981).

By the end of the 1990s stroke rehabilitation was a hot topic, with a growing evidence base marking a drive towards service improvement (Lewinter & Mikkelsen 1995, Smith et al 1981, Stroke Unit Trialists' Collaboration 1997). Randomised controlled trials demonstrated that multi-disciplinary care on SUs improved outcomes, and stroke unit rehabilitation was therefore

recommended as part of a drive to improve services (Kalra 1994a, 1994b, Kalra and Langhorne 2007; Lewinter & Mikkelsen 1995; Stroke Unit Trialists' Collaboration 1997, 2007). Specialist treatment provided on SUs and incorporating rehabilitation was agreed to be fundamental to recovery, as the focus of recovery broadened from a 'life or death' model to an interest in the restoration of lost function, independence and quality of life (Doolittle 1991; Ellul et al 1993; Kalra 1994b). Reorganisation of services, including the development of stroke unit rehabilitation, is considered to have led to significant improvements in mortality and morbidity from stroke in the United Kingdom (UK) (Kalra et al 1993; Kalra 1994a; Kalra & Langhorne 2007; NICE 2013; ISWP 2012).

Over the last two decades there has been a continuing increase in strategies for stroke prevention and care in the United Kingdom (Care Quality Commission (CQC) 2011; DoH 2007; ISWP 2008; NHS Improvement 2011; NICE 2010). The National Stroke Strategy (DoH 2007) was pivotal for many stroke services, as it represented a call to action based on evidence that the UK was providing inferior stroke services compared to neighbouring countries. The last decade in particular has heralded the introduction of evidence based policies and guidelines directing stroke care in the UK as well as other European countries, and UK services are now routinely audited against national standards (ISWP 2012; NICE 2010,).

2.3 The use of improvement strategies in stroke care

The adoption of standardised audits has made it possible to analyse audit data and identify patterns and trends over time. Analysis of national audit data for Germany, Poland, Sweden and the UK over a six year period between 2004 and 2009 found a general trend of improvement in quality of stroke care over time (Hillmann et al 2015). Various potential reasons contributing to these changes were suggested, including the introduction of policy and guidelines, the effect of the audits themselves in drawing attention to the quality indicators, and stroke service investment and reorganisation (Hillmann et al 2015). It was also noted that the improvements could reflect improved documentation within the audits as staff became more familiar with them (Hillmann et al 2015). A similar study by the European Implementation Score (EIS) Collaboration evaluated the use of different stroke care improvement strategies in European countries (di Carlo et al 2015).

The approach to evaluation was to give each country a score related to how many strategies were being used. Among other things these strategies included policy, guidelines, audit and performance indicators. The authors noted that it is challenging to analyse the relationship between use of improvement strategies and translation into better services and outcomes. Nevertheless, individual countries with more strategies such as policy and audit were also those with reduced stroke burden; therefore, it was considered reasonable to deduce that an association between the number of strategies used and the quality of a service (ibid).

This is in keeping with the pragmatic position on benchmarking and improving stroke services taken by Kalra et al (2011). They stated that guidelines should not be seen as a rule book and should be used with common sense and caution; that auditing structure and process is less problematic than auditing outcome; and that national audit is a powerful driver for change. Generalisations about the benefits of guidelines may be convincing in the bigger picture of temporal improvements in stroke care, but this should not prevent scrutiny of individual components of these guidelines and related performance measures. It is within the general context of the stroke improvement programme that the national strategic leaders in stroke care sought to create a specific performance indicator relating to therapy, and this will now be introduced.

2.4 Development of an improvement strategy for stroke rehabilitation

“Rehabilitation after stroke works. Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability.” National Stroke Strategy (DoH 2007).

Stroke rehabilitation is considered to be effective, and it is widely agreed that more is better (DoH 2007; Foley et al 2012; NICE 2013). The view that stroke patients should receive more rehabilitation therapy first became an official recommendation in the UK with the publication of the second edition of the National Clinical Guidelines for Stroke (ISWP 2004). The guidelines stated that patients should undergo as much therapy appropriate to their needs as they were willing and able to tolerate. It was acknowledged that there was debate and uncertainty about

the amount of therapy that should be provided, and whether there was a minimum threshold below which therapy would not be beneficial. The lack of relevant evidence was noted. The evidence that was cited (Bhogal et al 2003; Kwakkel et al 1997, 1999, 2002; Langhorne et al 1996; Langhorne et al 1996; Lincoln et al 1999; Partridge et al 2000; Slade et al 2002; Smith et al 1981) was said to be weakened by the fact that services offering more therapy usually had better organisation and expertise than the control group (ISWP 2004). Nevertheless, since these guidelines were published, national guidelines regarding stroke rehabilitation intensity have been developed in many countries. Some recommend increased therapy intensity without further specification, while others stipulate a required daily minimum of either 45 minutes or an hour (Duncan et al 2005; European Stroke Organisation (ESO) 2008; ISWP 2012; National Stroke Foundation 2010; Scottish Intercollegiate Guidelines Network (SIGN) 2010). The claims that rehabilitation is effective and that more is better are broadly uncontested, but the specifics regarding how therapy should be provided and the required intensity remain unclear (Foley et al 2012; NICE 2013). In the UK, the most recent edition of the guidelines gives the following recommendation:

“Patients with stroke should be offered a minimum of 45 minutes of each appropriate therapy that is required, for a minimum of 5 days per week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it” (ISWP 2012).

This recommendation is repeated as a quality indicator in the stroke rehabilitation quality standards commissioned by the National Institute for Health and Clinical Excellence (NICE 2013). The recommendation of a specific intensity of therapy treatment is one among many stroke standards, yet it has proved to be particularly controversial, and national audits suggest that it is not being met (SSNAP 2016). In order to address the aversion to the guideline expressed by many therapists, a consensus meeting was held by the Intercollegiate Working Party for Stroke and the Stroke Research Network (ISWP/SRN 2012). Despite presenting evidence for specific interventions from clinical trials and promoting the message that ‘more is better’, many therapists protested against the guideline. Non-research evidence suggests that some critics opposed the recommendation on the grounds of being unachievable due to resource issues (Rooney 2013).

Others questioned the desirability of the recommendation, criticising the rationale and evidence base (Foley et al 2012). Foley et al (2012) examined six clinical practice guidelines, including the 3rd edition of the UK guideline (ISWP 2008), and compared the recommendations made regarding daily provision of inpatient stroke rehabilitation. All the studies that were cited to support intensity recommendations were then reviewed in detail. The authors found that few of the studies cited were clinically applicable to the issue of inpatient therapy intensity (Foley et al 2012). Of the five studies cited in the UK guideline, Smith et al (1981) was excluded due to investigating additional outpatient treatment following discharge, which is not pertinent to the question of therapy intensity on SUs, and Bhogal et al (2003) was excluded as it focussed on aphasia recovery. Only five of the examined studies tested intensity of therapy as the only variable that differed between groups, and of these, only one study found a significant improvement in the primary outcome reported. Overall, the authors concluded that the evidence does not support specific recommendations regarding intensity.

The most recent edition of the UK guideline cites 'consensus' as the primary source for the intensity recommendation, suggesting that it was developed through consultation and discussion amongst the members of the intercollegiate stroke working party in the absence of strong or consistent supporting evidence (ISWP 2012). The earlier 2010 NICE guidelines are also cited, but this appears to be somewhat circular as many of the same experts were involved in the development of both guidelines. Basing guidelines on consensus has been criticised, as the opinion of individual members of a group is not proof of the benefits of a treatment (Timmermans and Berg 2010; Woolf et al 1996). It has also been argued that despite the benefits of clinical practice guidelines, they are often based on randomised controlled trials (RCTs) that do not reflect real life scenarios, and can be influenced by the bias of the expert panels who devise them (Sullivan 2010). A member of both the NICE and RCP guidelines has suggested that the '45 minute' recommendation was proposed as a pragmatic measure and an aspirational target for services in the absence of clear evidence regarding therapy intensity:

"We must be careful that the debate around the number, though important, does not OVERSHADOW the aspiration to provide MORE treatment." (Drummond 2012)

2.5 Defining rehabilitation and the role of therapists.

A multi-disciplinary team is seen as key to the success of SUs (Monaghan et al 2005; Strasser & Falconer 1997), and a recent overview of reviews found that for adults with stroke, multi-disciplinary team care significantly reduced death rate and led to improvements in independence and living at home one year after the stroke (Momsen et al 2012). Defining 'rehabilitation' or the roles of stroke therapists is problematic. Sometimes the terms 'therapy' and 'rehabilitation' are used interchangeably. Alternatively, rehabilitation can be used more broadly as an approach that should be adopted by professionals including nursing staff, whereas therapy is usually considered to be something provided by therapists (or therapy assistants). Whether patients and their relatives can provide 'therapy' or 'rehabilitation' is another question. Different definitions of 'rehabilitation' reflect contrasting positions regarding what rehabilitation is, as well as contrasting value judgements about what it ought to be.

A Stroke Association factsheet introduces therapists' roles as follows:

"A physiotherapist can help you to sit, stand or lie down, and develop exercises to help you move more easily and stop any weak limbs becoming stiff and painful...

A speech and language therapist can help with swallowing problems, suggest ways to help you communication using exercises, speech, reading and writing and explain to family and friends how they can help you communicate...

An occupational therapist can teach you how to get dressed, use the toilet and wash yourself, and give you advice on equipment..." (Stroke Association 2012)

The intention of the factsheet is to give people affected by stroke a simple introduction of what to expect from therapists; therefore, it may appear unreasonable to critique it. However, the wording of the factsheet represents a treatment-focussed approach which proliferates in stroke and has been criticised by various authors (Doolittle 1991; Whalley Hammell 2004, 2006; Mattingly 1991; Reynolds 2005; Williams & Wood 1988). An ethnographic study of patients with lacunar stroke published in 1991 concluded that,

“The hallmark of successful rehabilitation has been the restoration of lost function. This must not be the only focus ... People who have had a stroke do not define recovery in terms of the completion of discrete functional tasks. Recovery is marked by what matters to the person. Return to a life of meaningful values and activities is what counts.” (Doolittle 1991 p239).

Other authors around that time held that therapy should attend to the meaning of the stroke to the individual, their roles, relationships and potential creativity (Doolittle 1991; Kottke 1982; Lewinter & Mikkelsen 1995). In 2006, Whalley Hammell asserted a similar perspective:

“Rehabilitation is not about teaching exercises, mobility and self-care skills (although these might be useful for some people). Rather, rehabilitation is about enabling people to get on with their lives, to reconstruct their biographies and to attain a sense of continuity between their former and present selves” (Whalley Hammell 2006 p124).

There is a mismatch between this ideal and the assumptions about rehabilitation that dominate in much recent stroke evidence. It has been claimed that this conceptual gap should be attended to, as the meanings ascribed to rehabilitation will shape the way in which it is enacted.

“Through rehabilitation, involving engagement in physical, psychological and social processes, people can learn how to live a life that is not dominated by their disability. Described in these terms, rehabilitation belongs to the person, it is their process. Within research and clinical practice, rehabilitation is a term which seems to belong to the healthcare professional – professionals ‘provide’ rehabilitation, people are ‘rehabilitated.’ Exploration of discursive practices has shown that words construct as well as reflect accepted frameworks in the world” (Ellis-Hill et al 2008)

In something of a compromise position, it has been claimed that in the context of stroke rehabilitation it may initially be appropriate to focus on the physical dimensions of an impairment, but this should not be a substitute for striving to understand the individuals concerned within the context of their social and cultural lives, and intervening at a socio-political level when required

(Whalley Hammell 2006). The rehabilitation aims set out in the national clinical guidelines for stroke include maximising satisfaction with life as well as minimising activity limitations (ISWP 2012).

Inpatient stroke rehabilitation has been described as a 'black box', suggesting that its inputs and outputs are understood, but there is something mysterious about its inner workings or implementation (DeJong et al 2004; Bode et al 2004). It has been suggested that current challenges in stroke rehabilitation include improving our understanding of the processes of stroke rehabilitation, and that the "leading priority is to increase therapy input to make the best use of time that patients spend in rehabilitation settings" (Kalra & Walker 2009 p32). It is possible that rehabilitation and therapy are being interpreted and enacted differently by different therapists in differing settings; therefore, within this thesis it is important to be open to this possibility and avoid being constrained by pre-conceptions or rigid definitions. Occupational Therapists (OTs), Physiotherapists (PTs) and Speech and Language Therapists (SLTs) are the focus of the specific improvement strategy considered in this thesis. For the purposes of this thesis it will be assumed that each of the three therapies has different defining principles, but all share the aims of providing rehabilitation to maximise independence, reduce impairment and prevent further complications after a stroke (Dewey et al 2007). The NICE guidelines for Stroke Rehabilitation (NICE 2013) define stroke rehabilitation as:

"a multidimensional process, involving a multi-disciplinary team of people who work together towards goals for each patient, involve and educate the patient and family, have relevant knowledge and skills to help address most common problems faced by their patients." (NICE 2013 p14)

In keeping with this definition, the term 'rehabilitation' will be used to refer to an approach that may involve any or all members of the multi-disciplinary team. 'Therapy' will be used to refer to rehabilitation carried out by therapists, or prescribed and overseen by them. Further distinctions within 'therapy' are sometimes made, for example referring to 'face to face', 'active' or 'direct' therapy. Therapy work that takes place away from the patient may or may not be considered 'therapy'.

2.6 Therapy intensity: the evidence

There is some inconsistency regarding whether or not the 45 minute guideline is an 'evidence based guideline'. The RCP guidelines (ISWP 2012) state that it is 'consensus based'. The draft for the updated guidelines, due to be published in September 2016, recalls:

"For the 2012 edition, the available evidence was debated by the Working Party and subsequently by the NICE Quality Standards Development Group and a consensus reached that 45 minutes of active treatment with each relevant therapy each working day was a reasonable and achievable target."

(Draft ISWP 2016)

The first source cited for the guideline is 'consensus', but other supporting evidence is cited after this. The supporting evidence will be discussed in this section, as well as other relevant literature regarding therapy intensity. The first sub-section will focus on attempts to measure a dose-response for therapy. The second will discuss research regarding patients' activity levels or time spent in therapy while in hospital.

2.6.1 Attempts to measure therapy dose-response:

Many trials, observational studies and reviews have focussed on measuring the effects of PT and OT, often by comparing the association between therapy dose and response (Cooke et al 2010; Jette et al 2005; Kwakkel et al 1997, 2002, 2004; Langhorne et al 1996; Lincoln et al 1999; Lohse et al 2014; Nugent et al 1994; Partridge et al 2000; Peiris et al 2011; Scrivener et al 2012a, 2012b). These have presented mixed results, which could be due to a number of factors including: outcome measures used; differences in type of therapy provided and timing of intervention; patient characteristics; and whether there was enough contrast in the intensity of therapy provided to intervention and control groups to show an effect (Kwakkel et al 2004). Two reviews which found small summary effect sizes in favour of increased treatment time (Kwakkel et al 1997, Langhorne et al 1996) were confounded by heterogeneity of patient characteristics and differences in the organisational settings where rehabilitation was carried out (Kwakkel et al 2004). A further synthesis of studies exploring the effects of augmented exercise therapy found

that there was no ceiling effect for the benefits of therapy intensity, but that a minimum of 16 hours contrast between total amounts of therapy received by the intervention and control group was needed to show significant differences in Activities of Daily Living (ADL) scores (Kwakkel et al 2004). The studies included in the review varied in the amount of additional therapy that was provided, as well as the focus of therapy interventions (Kwakkel et al 2004). A meta-analysis investigating whether 'more is better' found that increased scheduled therapy time was associated with better outcomes (Lohse et al 2014). Authors noted that it would be preferable to analyse actual time spent in therapy rather than scheduled therapy, and that their analysis was not able to capture data regarding patients who were unable or unwilling to participate in the scheduled sessions.

The varying ability of patients to tolerate intensive therapy has been noted as a factor influencing drop-out rates in RCTs. An RCT conducted in China investigated whether additional early PT improved functional recovery in stroke patients (Peiris et al 2011). Provision of 45 minutes of PT, five times per week and commencing within one week of the stroke, was compared with no therapy. Modified Barthel Index showed significant improvements in those who remained in the PT groups, but this excluded 28 of the 78 group members who were unable to tolerate the intensity of 45 minutes per day and dropped out of the groups. It was suggested that cognitive disturbance, aphasia, double incontinence, site of lesion and sensory disturbance affected recovery.

The prevailing view that more therapy is always better has been challenged by the findings of A Very Early Rehabilitation Trial (AVERT 2015, Bernhardt et al 2016). The international trial, which included over 2000 stroke patients, randomised patients to receive the Very Early Mobilisation (VEM) protocol or usual care. 'Mobilisation' encompassed a range of interventions which were selected according to each patient's level (assessed out of 4 possible levels). For low arousal, dependent patients (level 1), mobilisation meant active sitting with assistance for 10-30 minutes. For patients assessed to be at level 4, mobilisation could mean standing and walking for at least 10 minutes, with no maximum. The VEM protocol was provided in addition to usual care for the intervention group. It commenced within 24 hours of stroke onset, compared to 48 hours for the usual care group. The intervention group patients had a higher frequency of out-of-bed sessions per day, and more median daily minutes out of bed per day. Outcome measures included

Modified Rankin Scale, days to achieve unassisted walking over 50 metres, proportion of patients able to walk unassisted by 3 months, dead, and serious adverse events. The study found that VEM reduced the odds of a favourable outcome at 3 months, suggesting that more is not always better. Findings indicated that short, frequent sessions were likely to be more beneficial. Authors noted that therapy intensity has been defined and interpreted in different ways in research studies, and that there should be a focus on frequency of sessions as well as duration. It was emphasised that issues such as timing, frequency and amount of therapy had been found to be more complex than previously realised. The draft 2016 RCP stroke guidelines state that new evidence has influenced changes to the therapy intensity recommendation:

“Evidence that has emerged since then [2012] has resulted in the need to qualify this target in early stroke rehabilitation. The large international AVERT trial... suggested that therapy in the first two weeks after stroke targeted at the recovery of mobilisation should be redesigned around multiple brief interventions lasting no more than a few minutes. Therapy targeted at other activities of daily living should be task-specific, progressive and practised frequently, and incorporated by the entire healthcare team into routine activities on the stroke unit every day of the week rather than confined to lengthy sessions separated by long periods of inactivity.” (ISWP 2016 p14)

The complexity involved in ascertaining the most appropriate intensity of therapy was also noted in a Cochrane review that attempted to examine the efficacy of speech and language therapy for treating aphasia caused by a stroke (Brady et al 2012). Authors found that although there was some evidence that some speech therapy input was more effective than none, further research was required to establish the optimum dose, frequency, duration and type of therapy provided. The review included the ACTNoW trial which recruited 170 stroke patients with communication impairments (Bowen et al 2012; Young et al 2012). This trial compared communication therapy provided by SLTs with non-specialist visitor contact for stroke patients over 13 weeks following the stroke, and received attention for subverting the ‘more therapy is better’ assumption (Bowen et al 2012). Authors concluded that the mostly impairment based therapy provided by SLTs had no added benefit over the provision of everyday communication in the first four months after a stroke. The primary outcome measured was the participants’ functional communication as

measured by an independent and blinded speech and language therapist using the Therapy Outcome Measure (TOMS). Secondary outcomes included participants' and carers' perceptions of their functional communication, wellbeing and quality of life. Authors suggested that SLTs should focus less on impairment focussed input and more on social participation including training with conversation partners and group work.

While Bowen et al (2012) recommended a more functional approach to communication therapy, other authors have suggested that there should be less focus on functional outcomes when evaluating the effects of therapy. In a synthesis of 14 studies regarding outcomes of stroke rehabilitation, authors concluded that although patients with severe stroke may not experience the same functional gains as those with moderate impairments, inpatient rehabilitation was beneficial to them in terms of reduced length of stay, decreased mortality and increased likelihood of being discharged home (Periera et al 2012). It was suggested that rather than focussing on improving function, more emphasis should be placed on discharge-planning, reduction of complications and family education. This implies that dose-response studies investigating remediation of impairments or functional improvements are only exploring a limited aspect of the potential effects of rehabilitation.

Seeking to prove associations between therapy dose and response could be argued to be a problematic aim from the outset. Rehabilitation is a complex process incorporating social, physical and psychological components, and the total number of potential interventions for any single patient is very large (Wade 2001). The Medical Research Council states that the conventional definition of a complex intervention is an intervention with several interacting components (Craig et al 2008). The components of occupational therapy that identify it as a complex intervention have been described (Creek et al 2005), and the broader concepts of 'therapy' and 'rehabilitation' inevitably encompass considerably more interacting components. Rehabilitation is multi-faceted in its delivery, and recovery can vary due to multiple factors including natural recovery, severity and location of stroke, the attitude of the individual, their social and physical environment and the therapy they receive. Therefore measuring the extent to which an intervention causes change could be considered futile. It has been argued that attempting to build an evidence base regarding content, duration, timing and intensity of therapy is reductionist,

and fails to attend to the influence of interactions that occur within the process of rehabilitation (Foley et al 2012; Wade 2001). Furthermore, trials of therapy may fail to demonstrate an effect, potentially leading to possible consequences such as withdrawal of services, due to erroneously examining one benefit of one component of a complex system and disregarding that component's benefit to the system as a whole (Wade 2001). However, studies measuring the effectiveness of individual rehabilitation interventions have contributed to the general impression (represented in national guidelines) of an association between intensity and benefit to the patient, and the appropriateness and feasibility of intensive therapy.

2.6.2 Patients' activity levels and time spent in therapy

Other quantitative evidence relating to therapy intensity prior to and since the introduction of the guidelines has focussed on exploring the extent to which SU patients engage in physical activity or physical rehabilitation interventions. The literature illustrates an ongoing concern that SU patients lack activity and interaction, and therefore do not maximise their potential for rehabilitation or recovery. An investigation into provision of stroke care in South London found that nearly 30% of patients with deficits did not receive OT or PT, and just over 40% did not receive SLT within three months of stroke onset (McKevitt et al 2005). Various observational studies have quantified the amount of time SU patients spend active or in therapy, concluding that rather than SUs functioning as rehabilitative environments, therapy sessions are isolated opportunities for activity, and that patients spend most of their time on SUs 'inactive and alone' (Ada et al 2006; Bernhardt et al 2004, 2007; Keith and Cowell 1987; King et al 2011; de Weerd et al 2000). It has been reported that there are variations in patients' activity levels in different SUs with similar levels of staffing (Bernhardt et al 2007, 2008). It has been noted that patients are not always available for therapy due to the need for medical investigations; however, an observational study found that this accounted for an average of 32 minutes for each patient per day (Bernhardt et al 2007). The same study reported that patients who had their family present more of the time received more therapy (Bernhardt et al 2007).

Several studies have compared therapy provision in different countries (Bernhardt et al 2008; Putman et al 2006, 2007; de Wit et al 2005, 2006, 2007). A study comparing five SUs in Melbourne, Australia and one in Trondheim, Norway, found that patients in Trondheim spent twice

as much time with therapists (Bernhardt et al 2008). Possible reasons for this were suggested, including restrictive manual handling policies in Australia, and differences in the staffing and the physical environments of the observed settings. Several papers were published from the Collaborative Evaluation of Rehabilitation in Stroke across Europe (CERISE) trial, which examined the provision and impact of therapy in four centres across Europe. The UK was found to perform badly when compared with SUs in Switzerland, Belgium and Germany, as patients spent less time in therapy, were less likely to receive OT and spent more time in their rooms despite better levels of staffing (de Wit et al 2005). UK patients were found to have more interaction with nurses and more visitors (de Wit et al 2005). OT and PT sessions were shorter in Germany, and it was suggested that human resources were used more efficiently there (de Witt et al 2006). A comparison of motor and functional recovery produced mixed results, using the following outcome measures: Rivermead Motor Assessment of Gross Function, Rivermead Motor Assessment of Leg / Trunk, Rivermead Motor Assessment of Arm, Barthel Index and Nottingham Extended Activities of Daily Living (de Witt et al 2007). Gross motor and functional recovery were reported to be better in Germany and Switzerland than in the UK, but the UK patients made better recovery in the area of self-care. This may suggest that UK patients, who also had a shorter length of stay, were learning to compensate and prioritising self-care in order to facilitate discharge from hospital, rather than remaining in hospital to focus on remediation of impairments. The study did not account for variables such as levels of motivation or different baseline levels which could be associated with different levels of potential for recovery.

Comparisons of therapy intensity and outcome in the four European centres must be considered in the context of the different admission criteria to SUs in each country, which were explored in an article by Putman et al (2007). This paper revealed the UK to be the only country with an open-door policy, admitting any patients onto the SU. Germany, Switzerland and Belgium were all found to have admission criteria based on factors such as age, cognitive impairment, insurance cover, and having a clear discharge destination with appropriate support planned at the time of referral. It seems reasonable to suggest that the finding that a lower proportion of UK SU patients receive intensive therapy is related to the fact that the UK is unique amongst these countries in accommodating patients regardless of such factors. The admission criteria difference may also explain why UK therapists have been found to spend more time in non-therapeutic administrative

tasks such as arranging suitable discharge destinations for patients (Putman et al 2006). A study exploring use of time by OTs and PTS in four different European SUs found that when 'patient related coordination activities' was not counted as therapeutic time, then UK therapists spent longer on non-therapeutic than therapeutic time. However, if data were analysed with patient related coordination activities included as therapeutic time, the difference disappeared (Putman et al 2006). The authors highlighted the need to consider organisational factors including routines (e.g. UK therapists do more administrative work and attend more meetings and ward rounds), perceived importance of different types of rehabilitation (e.g. cognitive training), staffing (management, rather than numbers of staff) and the physical environment (e.g. availability of spaces such as a pool or relaxation room), but no attention was paid to the case-mix in each country.

A Canadian study which found that patients were seen by therapists for an average of 75 minutes per day suggested that non-therapeutic tasks, including meetings, patient education classes and administrative tasks, may have been emphasised over therapeutic activities, which occurred 67-74% of the time (Foley et al 2012). It is clear that determining which aspects of therapists' roles are to be counted as 'therapeutic' time is not a straightforward issue. For example, the study chose not to include assessment, consultation, or educating patients as therapeutic tasks. Nonetheless, it has been argued that therapists are often not supported by their services to prioritise face to face patient contact over 'irrelevant paperwork and bureaucracy' (Drummond 2013).

Suggestions for increasing patients' participation in therapeutic activity have included giving patients treatment protocols that they can complete independently, running therapy groups, and structural reorganisation of the ward area (Ada et al 2006). Although groups have been suggested as a strategy to increase therapy activity (Ada et al 2006; Cooke 2012; van de Port et al 2012; de Weerd et al 2001), one study found that a group therapy programme did not increase motor activities performed by patients or time spent in therapy, although it might increase socialisation opportunities amongst patients (Thompson & McKinstry 2009). One Dutch study used a descriptive pre-post design to test an intervention aimed to increase activity levels (van de Port et al 2012). This involved providing increased group therapy, providing patients with a

therapy guide and educating nurses. Although activity levels increased following the intervention, the time patients spent alone was not reduced. It has also been noted that short term efforts at increasing activity are often not sustained due to turnover of staff, waning enthusiasm and practical difficulties such as finding somebody willing and available to take patients to groups (Ellul et al 1993).

This section has shown that although certain aspects of therapy and rehabilitation have been investigated and tested with specific cohorts of patients, there is no evidence directly justifying a minimum quantity of daily therapy for stroke patients in general. The term 'therapy' encompasses complex interventions provided by three different professions. New evidence suggesting that it is possible to provide too much therapy in certain situations (AVERT 2015, Bernhardt et al 2016) has challenged the previous assumption that more is better, and this is noted in the draft for the next RCP guideline, (ISWP 2016). Evidence suggests that stroke inpatients spend large proportions of their time inactive. Comparisons with other countries have found that UK patients are likely to spend less time in therapeutic activity, but there are confounding factors in attempts to compare services in different countries. The next section will focus on the variation in therapy delivery reported in the UK national audit.

2.7 Variation in therapy intensity reported in SSNAP data

SSNAP presents team level data on the proportion of the caseload considered to require each therapy and quantities of each therapy received. SSNAP uses national benchmarks for the proportion of patients considered to require therapy (80% for OT, 85% for PT, 50% for SLT) and rates each team's performance against these benchmarks. The SSNAP guidance notes state that these figures were derived using data from previous stroke audits (SSNAP 2016). In order to have a clear understanding of the background to the current study, statistical analysis of the publically available national data was completed with assistance from a statistician. This was initially completed using data from the October – December 2013 quarterly report, and was presented at the UK Stroke Forum (Taylor et al 2014). This was updated using data from the September – July 2014 report which included 19087 stroke unit patients managed by 202 UK teams. Therapy data were summarised using medians and Interquartile range (IQR). Pearson's

correlation was used to assess the strength of relationship between a) the percentage of patients considered to require therapy at any point in their inpatient stay; b) median number of daily minutes of therapy provided; c) proportion of days of the inpatient stay on which therapy was provided; and d) audit score. Data analysis showed that there was wide and unexplained variation in results for all key indicators. Averages presented in the following tables are for the time during the stroke unit admission during which patients were considered to require each therapy.

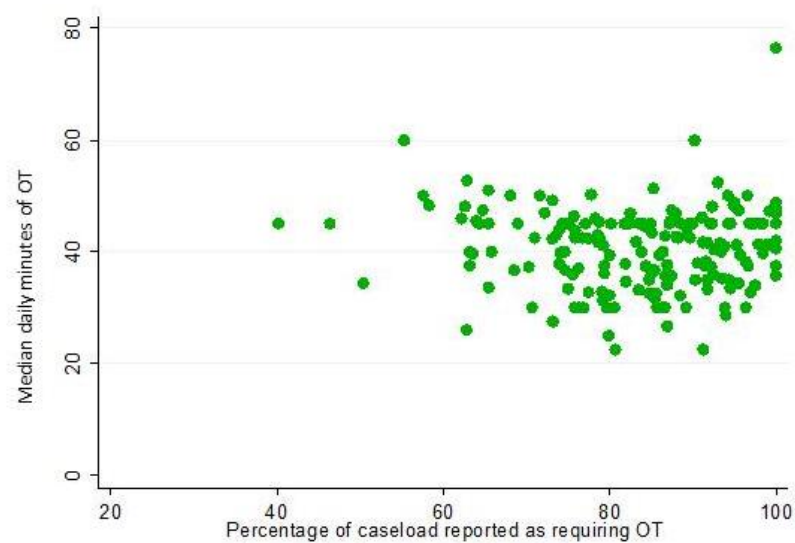


Figure 1: Scatterplot showing the relationship between average (median) daily minutes of OT provided and the percentage of the caseload reported as requiring OT in each team.

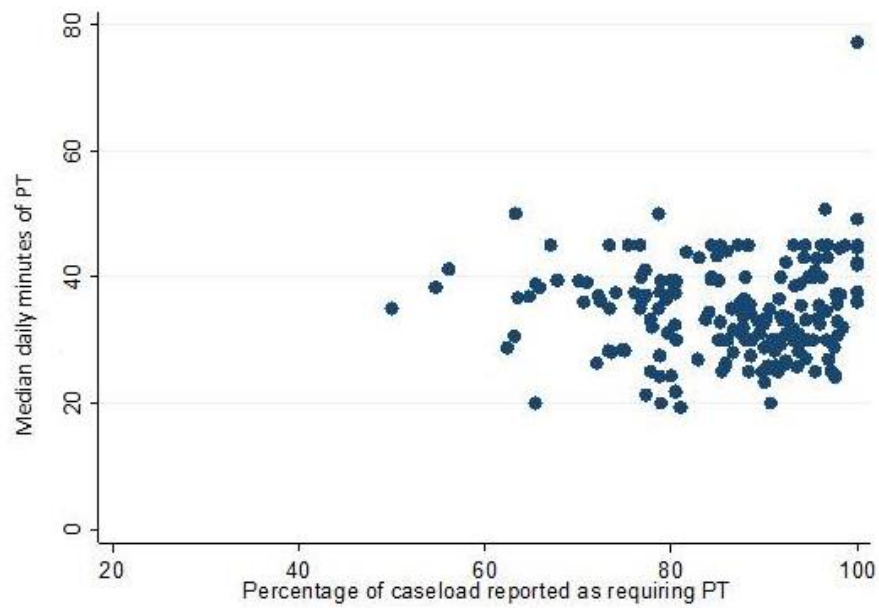


Figure 2: Scatterplot showing the relationship between average (median) daily minutes of PT provided and the percentage of the caseload reported as requiring PT in each team.

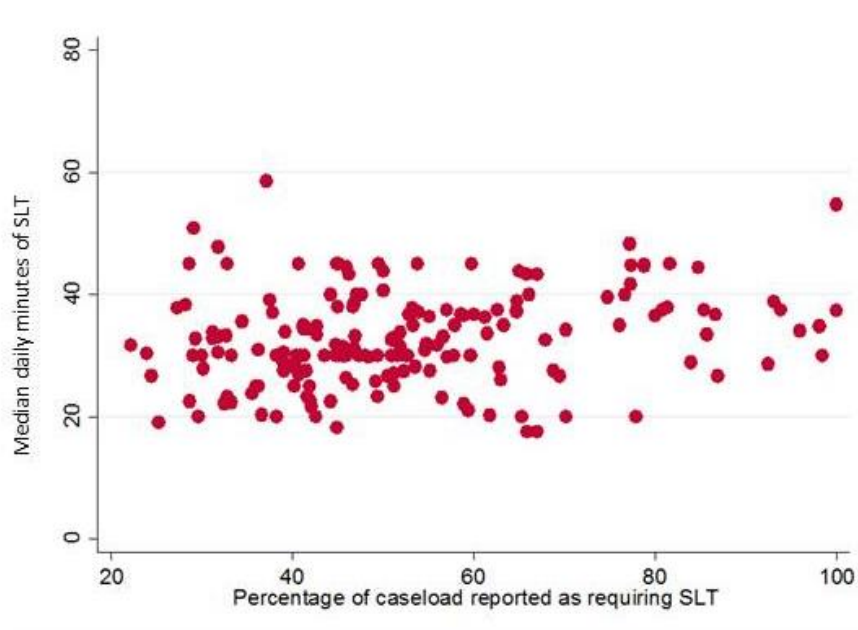


Figure 3: Scatterplot showing the relationship between average (median) daily minutes of SLT provided and the percentage of the caseload reported as requiring SLT in each team.

The national target of 45 minutes was not being met but on the days when therapies were provided, the median number of daily minutes exceeded 30 minutes for all therapies. The proportion of inpatient days on which therapy was received was low compared to the minimum target of 5 days per week, and this was reflected in the overall audit scores. This suggests that although session length may be increasing, there is a lack of intensity of therapy over the course of the inpatient stay. A focus on national averages should not obscure the wide and unexplained range of results amongst teams for all indicators, with variation in the reported need for therapy and in the quantity and frequency of delivery.

Table 1: SSNAP results for each therapy intensity indicator.

			Median	Interquartile range	Range
OT	A	% requiring OT	86.6	76.8-94.4	40.2-100
	B	Median OT minutes	42.3	36.3-45.0	22.5-76.5
	C	% days on which therapy was provided	54.7	45.4-63.5	19-100
	D	OT audit score %	72.2	56.1-91.8	22.5-155.8
PT	A	% requiring PT	89.9	80.4-95.6	50-100
	B	Median PT minutes	35.0	30.0-39.5	19.3-77.2
	C	% days on which therapy was provided	65.3	55.8-73.5	29.1-100
	D	PT audit score %	70.9	57.6-85.9	25.8-179.3
SLT	A	% requiring SLT	51.2	41.2-66.1	22.2-100
	B	Median SLT minutes	31.9	27.9-37.8	12.5-58.6
	C	% days on which therapy was provided	38.4	28.4-44.8	11-100
	D	SLT audit score %	36.4	24.6-60.0	7.1-136.1

Table 2: Relationships between therapy indicators.

	OT	PT	SLT
Is there a correlation between A (% requiring therapy) and B (minutes provided)?	No $r=0.077$ ($p=0.276$)	No $r=0.079$ ($p=0.263$)	Yes, there is a statistically significant correlation. $r=0.224$ ($p=0.013$)
Is there a correlation between A (% requiring therapy) and D (audit score)?	Yes $r=0.479$ ($p<0.001$)	Yes $r=0.417$ ($p<0.001$)	Yes $r=0.698$ ($p<0.001$)
Is there a correlation between B (median number of minutes on days therapy was provided) and C (% of days on which it was provided)?	Yes, there is a weak but statistically significant negative correlation. $r=-0.186$ ($p=0.008$).	No, the correlation is borderline statistically significant. $r=-0.135$ ($p=0.056$)	No, there is no correlation. $r=0.056$ ($p=0.433$)
Is there a correlation between A (% requiring therapy) and C (% of days on which it was provided)?	No $r=0.057$ ($p=0.425$)	No $r=-0.004$ ($p=0.955$)	No $r=0.073$ ($p=0.300$)

Analysis of audit data found no evidence of a relationship between the proportion of patients reported to require OT and PT and the quantity and intensity provided. Instead, variation in the identification of need and the quantity of therapy provided were unrelated and unexplained.

Teams that identified a higher proportion of the caseload as requiring therapy were likely to receive a higher audit score. Regarding intensity, a weak negative correlation was found with median daily OT minutes increasing as the proportion of days on which OT was provided decreased. There were signs of a similar trend for PT, but not for SLT.

The analysis highlighted that the SSNAP data for therapy raises questions for which it is unable to provide answers. It is not clear how decisions regarding therapy need (i.e. who requires therapy, and how much) are being made in each team; nor is it clear who is responsible for the decision. It is possible that therapy need is defined and delineated differently in different teams, but this requires investigation.

2.8 Judging whether a patient requires therapy

As discussed above, SSNAP publishes data on the proportion of the caseload considered to require therapy. This is sometimes referred to as being appropriate for therapy, and abbreviated to 'appropriateness'. In order to begin examining how this might be interpreted, a useful starting point would be to understand how SSNAP have explained their requirements regarding who should be reported as requiring therapy. Having done this, the concepts of rehabilitation potential and motivation will be considered, and it will be suggested that these concepts may be relevant to the question now posed by SSNAP regarding whether each patient required therapy. Factors influencing therapists' decisions regarding the type and quantity of therapy they provide will be summarised, with reference to a narrative review completed as part of the current PhD. It will be noted that individual patients and therapists may differ in their judgements about therapy needs. Determining therapy needs will be presented as a means of rationing resources, and factors influencing management of resources will be discussed. Potential in equity of allocation of therapy will be highlighted, and it will be noted that equity is a complex aspiration.

A guidance document accompanying the SSNAP audit acknowledged that there had been particular concerns about the therapy data and how it was gathered, and sought to clarify the answers to questions frequently asked by therapists (SSNAP 2016). The guidance stated that to determine whether a patient should be included in the audit, therapists should consider whether the patient required OT, PT or SLT at any point during their admission with the team. Patients assessed and not considered to require further therapy should not be included. Patients assessed and requiring further therapy should be considered appropriate, and for these patients the time taken to assess them should be included within the recorded therapy time. The guidance also advised that the date on which the patient was no longer considered to require therapy should also be logged. This could be different for each of the therapies, and should be the date on which the patient was no longer considered to have a deficit which should be treated by that therapy (SSNAP 2016).

No literature could be found that explored how therapists judge which patients to include in the audit. However; previous studies have explored therapists' use of the concepts of rehabilitation

potential and motivation, and these have relevance when considering factors influencing therapists' decisions regarding patients' therapy needs.

The presence or absence of 'rehabilitation potential' is commonly used to justify a decision about how much therapy a patient should receive. Reference to this concept as a decision making factor in therapy provision pre-dates the introduction of the 45 minute guideline. A focus group study used discussions of a clinical scenario to analyse the reasoning behind 'rehabilitation potential' decisions made by health care professionals (Burton et al 2015). The study found that decisions were made on a case by case basis, taking into account factors such as whether a patient could 'carry over' information or progress from one session to the next, and whether they were making functional improvements. It was noted that these decisions may not be reliable, and that therapists experienced an emotional burden of responsibility when deeming someone to have, or not have, rehabilitation potential. The decision carries significance because it is likely to influence the rationing of therapy resources and the intensity of rehabilitation offered. It can also influence the nature of therapy provided, in terms of a choice between active therapy and management. Authors noted that there is a lack of theoretical underpinning for the concept of rehabilitation potential, and suggested that a better understanding would be beneficial for those involved in shared decision making as well as patients and their carers. These findings relate to SSNAP's requirement for therapists to judge whether patients require therapy. It is feasible that this might be associated with a similar emotional burden of responsibility for therapists. It is also plausible that patients considered 'appropriate' for therapy will be those who would also be categorised as having rehabilitation potential. The current study offers an opportunity to investigate whether this is the case.

A patient's level of motivation is considered to influence the outcome of rehabilitation (and therefore, by definition, the appraisal of their rehabilitation potential) (Maclean et al 2002). This, too, is relevant to the question of determining the need for therapy, and judging who should be deemed to require therapy for the purposes of SSNAP data collection. One study concluded that the concept of motivation is embedded in therapists' assessments and reasoning, but therapists' judgements about patients' motivation were so inconsistent that the term should be dropped altogether (King & Barocloudh 1989, Maclean et al 2002). If motivation is a factor in therapists'

judgement regarding who requires therapy, then this inconsistency may explain some of the variation in proportions of the caseload considered appropriate for therapy. Therapists reported that patients' motivation could be influenced by various factors including their personality, their family, the rehabilitation environment and their condition (Maclean et al 2002). They felt able to influence motivation to a certain extent by chatting with patients and using this to help set relevant goals for rehabilitation.

As well as relating to the question of appropriateness for therapy, the concepts of motivation and rehabilitation potential relate to decisions regarding the intensity and nature of rehabilitation that is needed. In preparation for the current study, a narrative review of qualitative studies regarding inpatient stroke therapy was completed (Taylor et al 2015). Factors shaping the delivery of therapy were organised into six themes, one of which was 'Intensity, motivation and appropriateness for therapy.' This theme related to the current question of how therapists make judgements about what patients need. It was noted that the nature of therapy was multifaceted, and four studies found it incorporated imparting information and encouraging motivation (Eames et al 2010; Higgins et al 2005; Maclean et al 2000, 2002). This has a bearing on the question of whether a patient requires therapy, as the answer will depend on the interpretation of what 'therapy' is. Intensive rehabilitation was considered most suitable for patients with a borderline prognosis regarding whether they would be able to return to independent living, those who were younger, and those considered to be motivated (Galvin et al 2009a; Hubbard & Parsons 2007). Therapy provision for those with a clear prognosis would focus on facilitating discharge, as opposed to providing rehabilitation (Hubbard & Parsons 2007). Cognitive impairments, medical complications, social issues, fatigue and language / culture were considered to be potential barriers to rehabilitation (Galvin et al 2009a; Mold et al 2006). Consistent with the finding noted above from Burton et al's 2015 study, therapists made decisions about the type, intensity and duration of therapy each patient should receive on an individual and daily basis (Bayley et al 2012). Stage of recovery, availability of space and equipment were reported by therapists in a focus group to influence the type of therapy delivered (Bayley et al 2012).

Sometimes patients and therapists would differ in their opinions about appropriateness or need for therapy (Taylor et al 2015). Across the ten studies that explored patients', carers' or therapists'

views regarding allocation of therapy (Allen et al 2004; Bayley et al 2012; Daniels et al 2002; Galvin et al 2009a, 2009b; Higgins et al 2005; Hubbard & Parsons 2007; Maclean et al 2000, 2002; Mold et al 2006), there was no clear consensus regarding the preferred intensity of input. One study reported that in some instances patients felt they needed more inpatient physiotherapy, while PTs thought the appropriate setting for further rehabilitation was the community (Galvin et al 2009b). In another study the intensity of therapy was reported by patients to be overwhelming and overtiring, and it was noted that some would prefer the opportunity for recreation (Higgins et al 2005). There are differences in opinions amongst individual patients and therapists, as well as between therapists and patients, regarding patients' therapy needs. This raises questions about who is involved in making the decision required by SSNAP regarding whether therapy was required. It is notable that the concepts of patients' motivation and rehabilitation potential imply judgements made by professionals on behalf of patients regarding their needs, and appears to be at odds with rhetoric regarding patient choice.

Decisions about appropriateness and rehabilitation potential are most likely to arise in discussions about how therapy resources should be allocated. Factors influencing the allocation of resources are therefore also relevant. It has been noted that clinical decisions are based on availability of resources as well as clinical benefit (Allen et al 2004; Mold et al 2006; Taylor et al 2015). It has also been suggested that moral evaluations play a part in the management of resources (Mold et al 2006; Taylor et al 2015). Team decisions may be swayed by the extent to which an individual or their family are capable of 'working the system' (Mold et al 2006; Taylor et al 2015).

Such findings highlight the potential for inequity in allocation of therapy, whether in terms of the nature of therapy, the effort employed by therapists, or the quantity of therapy provided. In one study, although therapists reported believing that patients were equally deserving of encouragement, some also acknowledged feeling less likely to 'push' unmotivated older patients than people with more potential life years ahead of them (Maclean 2002). Equity in itself is a complex concept. Key principles need to be agreed, such as whether the focus should be equal access to health care, equal receipt of health care, or equalized health (Wagstaff and van Doorslaer 2000). Such questions are philosophical and political, and it is beyond the scope of this thesis to explore them in detail. However, it is useful to consider what kind of equity the

minute guideline may be trying to achieve. The guideline states that patients should be offered 45 minutes of therapy, whereas the audit asks how much therapy was delivered. The guideline is nuanced and allows the determination of appropriateness or need for therapy to be a clinical judgement, and the intricacies of what this means are left unquestioned. It has been noted that health care should be provided on the basis of clinical need, regardless of personal characteristics such as age, gender, ethnicity or disability, and that more attention should be paid to addressing equity as an aspect of quality (Marmot 2010; Raleigh and Foot 2010). The UK's quality agenda has been critiqued for failing to incorporate measurement of inequalities and equity, and there has been a call for an explicit focus on reducing inequalities (Raleigh and Foot 2010). The next section will focus more closely on the context of quality measurement in the NHS.

2.9 Chapter summary

Stroke can have a devastating personal impact on an individual, and the national and international burden of stroke are well documented. There have been vast and concrete improvements in stroke services over recent decades, and the pessimistic professional attitude attributed to pre-1990s stroke care has been replaced with a focus on the value of rehabilitation – whether it be to reduce impairments and disability, increase independence or enable adjustment and improve quality of life. The drive for improvement continues, and therapists have now been put in the spotlight and challenged to raise standards and reduce inequalities in access to services.

The first aspect of the improvement strategy is that national guidelines and quality indicators now include a target for therapists, based on the amount of time they spend delivering rehabilitation therapy. This target has been criticised for being undesirable and / or unachievable, and the evidence base for such a guideline has been called into question. Multiple quantitative studies have sought to investigate associations between the dose of a specific treatment and the outcome, but the interventions examined cannot be taken to represent the 'black box' of therapy, which is typically multi-modal and complex. Other studies have sought to measure the amount of time patients spend active or in therapy. These have been confounded by difficulties determining 'what counts' as therapy, and which aspects of therapists' roles should be demarcated as 'non-therapeutic'.

The second part of the improvement strategy is the inclusion of the therapy intensity target in the national audit of stroke services. Therapists have been encouraged to attend to the data which is published in quarterly public reports, and to use information to identify where there is a need for improvement. Analysis of the audit data showed that there is variation in the proportion of patients that each team considered to require therapy, as well as in the quantity of therapy being provided. There is no evidence of a relationship between these two indicators. SSNAP reports are providing unprecedented quantities of publically available data regarding healthcare interventions for stroke patients. The data suggest a general trend of improvement in the therapy indicators for which information is gathered. However, it is not clear how therapists are interpreting the quality standard or the audit questions, and it is possible that variation in the data represents variation in interpretations as well as, or rather than, variation in practice. Analysis of therapy data has highlighted a need to explore how therapists decide which patients require therapy. Existing evidence regarding therapists' decision making suggests that their judgements of patients' rehabilitation potential and motivation often influence allocation of their resources. There is a need to investigate patients' expectations and experiences of therapy in order to gain greater insight and direction for improving services. The use of the therapy intensity target and audit as a strategy for improvement warrants further investigation, including examination of how it has affected therapists' attitudes or practice and whether it is perceived to be influencing quality in stroke rehabilitation.

Chapter 3 The context of quality improvement in the NHS

3.1 Introduction

This chapter will explore the broader context of quality improvement in the NHS. Recent discourse regarding quality will be introduced, and critiques of targets and performance measurement as approaches to quality improvement will be presented. The adopting of evidence based practice and standardisation as markers of quality will be situated as part of an historical trend towards industrialisation of healthcare. Debates about whether this is beneficial or problematic will be reported, and it will be concluded that prevailing ideological perspectives relevant to the research topic should be analysed and questioned.

3.2 The Context of Quality Measurement in the NHS

“Measurement of quality to drive improvement is the sine qua non of a high-performing health care system, and the recent national focus on this area is likely to endure.” (Raleigh and Foot 2010 p 23)

The above quotation is taken from the King’s Fund paper ‘Getting the measure of quality: opportunities and challenges’ (Raleigh and Foot 2010). The paper, which focuses on acute healthcare, discusses key debates regarding quality measurement and draws on feedback from events hosted by the King’s Fund. It will be referred to several times in this chapter as it was a key source of evidence in the quality measurement debate.

The modern paradigm of quality measurement in healthcare is based on the Donabedian model of structure, process, and outcome (Donabedian 2005, Loeb 2004). Although there is a long history of performance measurement in healthcare, targets, audits and performance measurement have been more embedded in the language of the NHS since New Labour’s introduction of governance by targets in the late 1990s (Bevan & Hood 2006). In the previous chapter the changes in stroke management over the past three decades were described, and these same decades have also been characterised by a focus on quality measurement and improvement in the wider NHS. Some considered the new culture of performance measurement and targets to be beneficial (Ham 2009), whilst others criticised it as a system of micro-

management which served the paymasters rather than the public (O'Neill 2002). Accounting has become part of the infrastructure, often seen as the first step to improving quality of care (Pfleuger 2015).

The Darzi Report (Darzi 2008) sought to place quality at the heart of the NHS, shifting the focus of NHS improvement away from regulations and targets relating to activity volumes and waiting times, and instead seeking quality in safety, clinical effectiveness, and patients' experiences (Darzi 2008; Horton 2008; Raleigh and Foot 2010). Still, local and national standards and measures were seen as key to monitoring quality improvements, and the report stated that "we can only be sure to improve what we can actually measure." (Darzi 2008 p49).

The National Clinical Guidelines for Stroke and SSNAP are examples of a variety of national standards and national clinical audit projects introduced around this time to drive improvements in the NHS. In 2009 the National Clinical Audit Advisory Group suggested a new definition of clinical audit:

"Clinical audit is the assessment of the process (using evidence-based criteria) and/or the outcome of care (by comparison with others). Its aim is to stimulate and support national and local quality improvement interventions and, through re-auditing, to assess the impact of such interventions" (Black 2009 p2)

Timmermans and Berg (2010) suggested that professionals have a 'love-hate' relationship with standardisation and clinical guidelines. This is because they can perceive them to be a threat to their professional autonomy, whilst also seeing them as promoting uniform best practice and protecting the profession from 'quacks' and 'imposters' (Timmermans & Berg 2010 p 82). At face value, guidelines and audit both share the aims of raising standards, improving consistency and removing undesirable variation. It has been argued that national clinical audits have the potential to yield rich quality measurement data (Raleigh & Foot 2010). The publication of quality data is intended to drive improvements, but this is a broad aspiration that requires further scrutiny.

Studies have begun to scrutinise the use of audit. The effectiveness of audit and feedback as a strategy for improvement in healthcare has been explored (Boaz et al 2011, Ivers et al 2012). A review of systematic reviews of the effectiveness of interventions designed to increase the use of research in clinical practice considered four strategies: audit and feedback; computerised decision support; opinion leaders; and multifaceted interventions (Boaz et al 2011). Use of audit and feedback as a single intervention was found to be less effective than multifaceted interventions, such as a combination of guidelines, feedback and educational interventions. The authors noted a common limitation in the literature: a failure to be clear about whether the interventions being implemented were based on the best available evidence, or indeed on evidence at all. Authors urged for caution against a false assumption that all promoted changes in practice are evidence-based. The review concluded that complex interventions are required for implementation, with attention to context and purpose.

A Cochrane review investigating the effects of audit and feedback on professional practice and healthcare outcomes (Ivers et al 2012) was cautious about drawing firm conclusions due to the heterogeneity of studies and the non-specificity of terms such as 'verbal feedback'. There was a wide variety of results in terms of the effects of audit on patient outcome or professionals' behaviour, ranging from no effect to a substantial effect. Baseline performance was inversely associated with the effectiveness of audit and feedback. Overall, effects were small to moderate and depended on multiple factors including the design and delivery of the intervention. It was suggested that improvement strategies should be targeted at behaviours with better evidenced associations between processes and patient outcomes. For example, evidence from the review suggested that feedback may be more effective when baseline performance is low; when the source of feedback is a senior colleague; when it is provided more than one and both verbally and in writing; and when it includes measurable targets and an action plan. Authors acknowledged that there may be costs associated with providing feedback in these ways. Unlike Boaz et al (2011), Iver et al (2012) found that the effects of audit and feedback alone were similar to the effects of audit and feedback as the core part of multi-faceted interventions.

A review of evidence regarding the influence of performance measurement in stroke care on health policy or changes to the health system, found limited direct evidence of this, and called for

research into the association between performance measurement, health policy and changes to health systems (Cadilhac et al 2012). Another systematic review sought to synthesise evidence that publishing performance data improves quality of care (Fung et al 2008). Authors included 45 studies and found the evidence to be mixed, with some reports of negative unintended consequences and some evidence that publishing performance data stimulated improvement activity at hospital level. The studies included predominantly focussed on mortality rates and cardiac procedures, and the lack of evidence regarding the influence of public reporting on patient-centredness was noted.

In theory, performance measurement can drive improvements through different mechanisms (Berwick et al 2003; Hibbard 2008, Raleigh and Foot 2010). The 'selection' pathway relates to the fact that patients can choose between providers who will therefore be motivated to improve quality to attract patients and generate income. The 'change' pathway relates to the intrinsic motivation of professionals to improve quality. In the 'reputation' pathway publically comparing the performance of service providers drives them to change to improve their reputation and protect their public image. Evidence suggests that this is the most powerful of the drivers of improvement (Hibbard et al 2005; Raleigh & Foot 2010). Paradoxically, evidence from Fung et al (2008) suggests that patients do not consistently pay attention to information about quality of care (Hibbard 2008). Hibbard (2008) suggested that a reason for this may be that patients conceptualise quality of care differently from 'experts', although his findings on this topic highlight the contrasts between the UK model of healthcare and that of the United States where his study was based. Patients there were much more identifiable as consumers, as their definition of quality-of-care was found to include consideration of cost (Hibbard et al 2005).

Despite the ubiquity of standards and measures, serious quality issues have continued to go undetected in some NHS services. In 2013 the Francis Report presented an analysis of failings in Mid Staffordshire NHS Trust, publicising stories of suffering and poor care that had been masked by a 'culture of defensiveness'. Francis made 290 recommendations, centred on the need for more openness, transparency and candour. Regulation, fundamental standards and enhanced quality standards were seen as key to addressing the quality issues that had been identified.

Following publication of the Francis Report, several other reviews were commissioned by the government to explore how quality could be improved. The response set out in the Berwick Report (Berwick 2013) had a different tone. Berwick urged that quantitative targets should be used with caution and should never displace the primary goal of better care. The current system of regulation was criticised for being too complex. Berwick warned against transparency being seen as a threat and producing fear, and instead recommended a different approach to transparency that involves collaboration, shared learning and the involvement of patients and carers to monitor quality. Where the Francis report had been strong on enforcement of standards, Berwick's focus was on organisational culture. "In the end, culture will trump rules, standards and control strategies every single time" (Berwick 2013 p11).

These two reports revealed that there can be differences in the approach taken to improve quality. Others have noted that whilst quality improvement is by its nature a worthy aspiration, different perspectives regarding how it should be specified and measured may be held by those responsible for measuring it, and their various audiences (Raleigh & Foot 2010; Pfleuger 2015). Different domains of quality may compete for prioritisation, such as safety, patient-centredness, value for money, effectiveness and equity (Raleigh & Foot 2010). The therapy improvement strategy central to this thesis potentially relates to multiple different domains, including effectiveness and equity, but this is not made explicit in the guideline or audit. Effectiveness and equity are quite different aims. Interpreting the rationale for the 45 minute guideline as increased effectiveness could encourage therapists to focus on those patients they considered most likely to benefit from their input. Striving for equity might encourage them to give all patients the same amount of therapy, regardless of factors such as 'rehabilitation potential' and motivation discussed previously (see p40).

It has been argued that clarity of purpose is an important attribute for quality improvement, and performance measurement is less likely to be controversial if there is consensus about interpretations (Raleigh & Foot 2010). An example of this is distinguishing between 'measurement for judgement' and 'measurement for improvement' (Freeman 2002; Timmermans & Berg 2010 p206). I suggest that the SSNAP audit has characteristics from both of these

categories. In keeping with measurement for improvement it is not explicitly used for punishment or reward, but as with measurement for judgement it is for external and public use. According to Freeman (2002), measurement for judgement carries a higher risk of unintended consequences. The potential challenges and pitfalls of performance measurement will be explored in the next section.

3.3 Quality Measurement in the NHS: Challenges and pitfalls

Quality in health care is complex and its measurement is not straightforward. A good indicator should fundamentally have reliability and validity; be based on agreed, fully described definitions; and relevant and actionable for those using it (Mainz 2003a, 2003b; Raleigh & Foot 2010). Leaving aside discussion of whether the 45 minute guideline meets those criteria, there are broader issues to consider about the perils and potential unintended consequences of imposing standardisation and performance measurement, and these will be presented in the following sub-sections. The potential for measurement to misrepresent the aspect of care it seeks to reveal will be discussed. This will be followed by discussion of the potential for other unintended consequences of performance measurement.

3.3.1 Measurement and misrepresentation

This section will critique performance measurement by challenging the assumption that performance measures accurately portray reality. Different arguments will be presented that suggest that data from measures misrepresent reality, for example by simplifying it; defining it in according to a set agenda; or implying that an inspected part represents more than it actually does (e.g. a whole service).

Pfleuger's (2015) review of literature from the social science of accounting argues that activities designed to account for quality do not simply reveal information, but alter the reality they seek to inspect. The example of patient experience surveys is used to demonstrate that

“accounting for quality is transforming both the reality of quality and the patient that it sought out to uncover. Whether these transformations are good or bad, the point of this

illustration is that they are being brought about through the unacknowledged constitutive activities of accounting. As such, the assumption that measures, once deemed accurate, can be taken as undeniable reality is misleading.” (Pfleuger 2015 p6).

‘The patient’ and his or her ‘experience’ become constituted according to the agenda and design of the survey, data from which can be presented and analysed easily without the complications that asking patients open ending questions about their care would present. ‘The patient experience’ then becomes a manageable concept assumed to represent a concrete reality.

Another example of the potential for misrepresentation in quality measurement is synecdoche, meaning taking a part for a whole (Bevan & Hood 2006). Information yielded by a performance measure will always give an incomplete picture (Miller et al 2005). Whilst using a part to represent a whole may be efficient if the part that is cited is sufficiently meaningful, assuming a service is good because an aspect of it meets a target may be an erroneous leap. It has been argued that not everything that matters can be measured, and good performance on indicators may not equate to good care for individual patients (Raleigh & Foot 2010). A defender of performance measurement could argue that it must rely on certain measures as proxies for overall quality, as it would be impractical and undesirable to seek to measure everything.

It has been suggested that a performance measure can serve the metaphorical function of a tin opener or a dial, and that,

“Most measures are tin openers rather than dials: by opening up a can of worms they do not give answers but prompt investigation and inquiry, and by themselves provide an incomplete and inaccurate picture.” (Carter et al 1992 p49).

When this is acknowledged, data can be usefully discussed to explore areas for investigation or improvement, but there is a danger that data can be taken at face value without consideration of important contextual factors. The importance of attending to context when attempting to improve quality was discussed in a collection of essays published by the Health Foundation (Bate et al 2014). Not attending to contextual factors can be particularly damaging when using data to

compare services. Publication of league tables may be seen as promoting transparency and facilitating the various pathways of change described in the previous section. However, confounding factors or statistical uncertainties are likely to be lost in the headlines and the negative impact of poor performance on staff and organisations may be significant (Goldstein & Spiegelhalter 1996; Raleigh & Foot 2010,).

Measured performance may be misleading due to its failure to attend to confounding factors, but it may also be misleading due to the quality of data used. Data reporting may be carried out differently by different providers, and even from the same provider data quality may vary for different indicators (Raleigh & Foot 2010). In the case of the SSNAP audit of therapy intensity it is unclear whether variation is due to variation in data quality or variation in practice (or both). Since there is scope for different interpretation of key terms used in the SSNAP audit, this may influence the data quality.

3.3.2 Unintended consequences

There is evidence that performance measures bring unintended consequences, and that these can potentially outweigh their benefits (Fung et al 2008). It has been noted that 'high level metrics' have not prevented severe quality and safety failures such as the high profile cases in Morecambe Bay maternity unit and Stafford Hospital (Kirkup 2015; Martin et al 2015). Potential unintended consequences of performance measurement include the emotional impact on the people who are being measured; a focus on quantity and timing at the expense of what is valuable to the recipient of care; and 'hitting the target but missing the point', or 'gaming'.

Some authors have argued that the costs of performance measurement outweigh the resulting improvements in healthcare (Loeb 2004; Pflieger 2015; Seddon 2008). Loeb (2004) claimed that performance measurement can be a source of anxiety and frustration for those who are being measured and those who are measuring. Measurement adds costs to the system, and is surrounded by dispute or uncertainty about what to measure and how (Loeb 2004). In his work on systems thinking in the public sector Seddon (2008) criticises target setting and audit as 'a burgeoning and dysfunctional stranglehold of bureaucratic control' (Seddon 2008 p11). It could be argued that Seddon and other critics of 'target culture' critique one ideology based on a bias

towards another, without sufficient evidence to uphold their claims. Nevertheless, such critiques are presented here as this study seeks to provide empirical evidence that may uphold or refute them. Seddon claims that by tampering with the system, targets always make performance worse. It is wrong to assume that because a target has been met, a service has performed well, as the impact of the target is concealed. Furthermore, he argues, targets inevitably lead to a range of negative consequences.

“...in the face of evidence showing that targets produce perverse consequences, people who believe in targets simply assume they need to refine the targets or identify the ‘bad apples’ who prevent them from working. In fact, the right thing to do is drop the targets altogether.” (Seddon 2008 p9-10).

The unintended consequences of targets and audit that Seddon and others warn of include cheating (also known as ‘gaming’ – see below); placing the interests of the regime above individuals; focussing on quantity and timings instead of understanding what is of value to the person using the service; added cost; empty conformism and rote behaviour; diminished initiative and imagination; and a culture of roles and direction rather than flexibility, motivation and problem solving (Seddon 2008). The risk that organisations may solely focus their quality improvement efforts on the areas being measured has been labelled ‘target myopia’ (Berwick et al 2003; Bevan & Hood 2006; Goddard et al 2000; Pfleuger 2015).

A critique of clinical performance measurement raised concerns that not only do some performance measures have limited clinical benefit, but different measures can compete for priority in practice and thereby interfere with clinical decision making (Werner and Asch 2007). Measured activities may take precedent over unmeasured activities; and performance measurement may shift the priority from the patient’s expressed needs to the physician’s needs (Werner and Asch 2007). In fields outside healthcare such as business and education, many have warned that what is measured (such as stock values or examination results) becomes what is valued, rather than what is valued guiding what is measured. This is similar to the arguments in healthcare quality measurement literature. It is argued that quality improvement efforts can

displace quality, for example by controlling what is measured at the expense of aspects of care that are not measured (Pfleuger 2015).

Cases of this type of displacement of quality may be referred to as gaming. Gaming is a much discussed unintended consequence of performance measurement. It has been defined as “reactive subversion such as ‘hitting the target and missing the point’ or reducing performance where targets do not apply.” (Bevan & Hood 2006 p521). It has been suggested that gaming led to various false impressions of improvement caused by New Labour’s programme of ‘targets and terror’ in the 2000s (Bevan & Hood 2006). A frequently cited example of this was the subversion of a target intended to reduce waiting times to see general practitioners (Bevan & Hood 2006; Seddon 2008). In order to meet the target of seeing patients within 48 hours, patients were told they could not book appointments more than 48 hours in advance. This was revealed by a voter to the Prime Minister at the time, Tony Blair, to his apparent surprise during the 2005 general election campaign (ibid). Another example cited by critics of targets and performance measurement is a survey that found that the vast majority of New York cardiologists agreed or strongly agreed that the publication of mortality rates influenced their decisions about whether to perform angioplasty (Espeland & Sauder 2007; Narins et al 2005). It was suggested that they became less likely to perform surgery on patients who were at greater risk, but who might have benefitted from angioplasty. However, it could equally be argued that this is not an example of gaming, and that being more wary of mortality risk is not a negative consequence in cardiologists’ decision making.

The ‘gaming’ criticism of performance measurement relates to Goodhart’s Law (from the field of economics), that when a measure becomes a target it ceases to be a good measure because ‘any statistical regularity will tend to collapse once pressure is placed on it for control purposes’ (Goodhart 1984 p64, cited in Bevan & Hood 2006). Gaming could involve misreporting numbers; prioritising the aspect of care that is being measured at the expense of others; discounting patient preferences or need in a quest to chase the target; or employing strategies to achieve the target that do not represent a real improvement (Bevan & Hood 2006; Raleigh & Foot 2010; Werner and Asch 2007).

The terms 'gaming' and 'playing to the test' imply a calculated subversion of quality improvement targets. The term 'reactivity mechanisms' (Espeland & Sauder 2007; McGivern & Fisher 2012,) allows for the inclusion of unintentional and unintended changes that occur as a result of targets and performance measurement (Espeland & Sauder 2007, McGivern & Fischer 2012). The term 'reactivity' comes from sociology, and the methodological problem of a reactive measure which contaminates results by changing the very object of study (Espeland & Sauder 2007). Negative effects on practice can be related to clinicians internalising new norms that distort their professional values and priorities. The anxiety caused by rankings, surveillance and normalisation leads to the influence and effects of the measures being amplified, which in turn leads people to manipulate measures to give an impression of good performance (McGivern & Fischer 2012; Sauder & Espeland 2009). McGivern and Fischer (2012) found that regulatory transparency paradoxically led to clinicians hiding or avoiding practices that could be perceived as negative. Investigating psychological therapists' responses to certain regulating practices, they found that the importance of achieving scores on specific outcome measures changed the ways that therapists practiced. Therapist participants reported having become so focussed on their numerical score that it influenced their clinical decisions. For example, they would put more complicated clients on hold and focus on 'easy ones, which get my scores up' (McGivern and Fischer 2012 p294).

As well as leading to anxiety and a fear of blame, it has been claimed that having to be responsive to a ubiquitous array of targets and standards can lead to 'target fatigue' among managers and clinicians (Pfleuger 2015; Raleigh and Foot 2010; Wait 2004; Werner and Asch 2007). In an era of increasing suspicion and mistrust about healthcare systems, clinicians are subject to a range of different and inconsistent forms of central control (Ballatt and Campling 2011; O'Neill 2002). They may feel apathetic about the usefulness of measurement, and inspiration, innovation and a drive to improve may diminish (Pfleuger 2015; Raleigh and Foot 2010; Wait 2004; Werner and Asch 2007). It has been claimed that if the main criteria for quality assessment are cost efficiency or numbers processed, positive results could give a false impression of quality and could also mask a workforce that is burnt-out by 'target chasing' (Cole-King & Gilbert 2011). In this eventuality, workers may lose compassion for patients, overlook their needs, or find them a source

of additional stress and irritation (Cole-King & Gilbert 2011). A criticism of these claims is that they are speculative and not grounded in evidence.

In calling for a more values-based approach to improvement in the NHS, the Berwick report echoed the work of others who have argued that quality improvement should focus on efforts to nourish and promote compassion and kindness (Berwick 2013; Cole-King & Gilbert 2011; Ballatt & Campling 2011). Bureaucracy, time constraints, reward systems, routine and ritual have all been cited as impediments to compassionate care (Cole-King & Gilbert 2011; Frank 2010; Kelly 2007). Ballatt and Campling (2011) warn of the tensions faced by healthcare workers operating within a culture of targets, standardisation, regulation and inspection. They suggest this can be at odds with the kind of freedom needed to respond to patients' needs with kindness as person-centred individuals. They warn that "Standardisation risks reducing the choice, and depersonalising the work, of the clinician, just as emphasis is being put on choice and personalisation for the patient." (Ballatt & Campling 2011 p161) This is also associated with the so-called industrialisation of healthcare, the focus of the next section.

3.4 Industrialisation of healthcare and the rise of evidence based standards

This section will examine key changes in healthcare that have impacted on the way the role of the healthcare professional is constructed, perceived and enacted. These changes include incorporation of industrial models; the rise of evidence based practice (EBP); and the quest for standardisation. Much of the commentary on these changes has referred to medical practice, and the extent to which they also apply to the therapy professions will be considered. Critiques of the medicalisation of disability will also be considered where this relates to implications for therapy practice on stroke units.

There has been a gradual increase in the expectation that health practitioners should base their decisions on research evidence, and associated with this is the notion of standardised practice. Much of the focus has been on evidence based medicine, but this has broadened to EBP in other areas including therapy. In a review of post-war medical practice, Berg (1995) found that the

work of physicians had been reconceptualised from an art - involving intuition, common sense and informal judgements - to a science drawing on standardised and external schemes of logic (Berg 1995). Berg suggests that Western post-war attitudes, influenced in the wake of regimentation associated with Nazism and Communism, were hostile to the idea of government regulation. Many feared it would lead to an 'assembly line' approach to medical practice (Berg 1995). Nevertheless, the availability of an increasing number of treatment options, some of which carried significant risks to patients, led to the need for controls and consistent use of terminology (Ballet & Campling 2011; Berg 1995,). The need for standardisation has become increasingly accepted, and the value of clinical judgement has been questioned on the grounds that there is considerable disagreement among professionals who evaluate the same patients, and that professionals lack insight into the limitations of their judgements and decision making processes (Beckstead et al 2014).

Whilst some practitioners have strongly promoted EBP, others have seen it as a threat. It has been argued that EBP is an important phenomenon that should be subject to critique, and therefore social scientists should have a stronger voice in discourse surrounding the phenomenon of 'evidence based everything' (Mykhalovsky & Weir 2004). Lambert (2006) examined the history of EBP and criticisms of it. Limitations of EBP identified in critical literature were summarised in the paper as follows:

- 1) Incommensurate nature of population evidence and individual patient profiles
- 2) Bias towards individualised interventions
- 3) Exclusion of clinical skills from medical practice
- 4) Production of formulaic guidelines
- 5) Failure to consider patient views and narratives
- 6) Difficulties in disseminating & implementing evidence into practice

(Lambert 2006 p 2634)

Some have attempted to reconcile EBP and standardisation with individualised, patient-centred care and clinical judgement (Greenhalgh et al 2014; Sackett et al 1996; Sullivan 2010). Terms such as medical problem-solving and clinical reasoning entered the lexicon in the 1970s and

1980s, bridging the call for standardised evidence-based approaches with the desire for doctors to retain their individual judgement (Berg 1995). Haynes et al (2002) reconstructed the conceptual model of Evidence Based Medicine to position clinical expertise more centrally, as well as to draw attention to the individual clinical state and circumstances of each patient. Greenhalgh et al (2014) highlighted the unintended negative consequences of EBP – including the misappropriation of its ‘quality mark’ by vested interests; the unmanageable volume of evidence and clinical guidelines; inflexible, management driven care; guidelines that map poorly to multimorbidity; and statistically significant benefits demonstrated in research that may be less significant to individual patients. Rather than arguing against EBP, Greenhalgh has launched a campaign for an alternative approach to EBP that is individualised; refuses to let process dominate outcomes and is based on judgement not rules (Greenhalgh et al 2014). Napier et al suggested that

“...in clinical settings, a tendency to standardise human nature can be, paradoxically, driven by both an absence of awareness of the diversity with which wellbeing is contextualised and a commitment to express both patient needs and caregiver obligations in universally understandable terms.” (Napier et al 2014 p1607)

With specific reference to physiotherapy, it has been claimed that many therapists are in principle willing to meet the expectation that their practice is based on high quality research evidence, but that this poses a range of difficulties (Sullivan 2010). Evidence in guidelines can be out of date, inapplicable or incorrect (Sullivan 2010). The experts devising clinical guidelines may be biased by their own opinions and experiences, and there may be conflicts of interest (Shaneyfelt & Centor 2009; Sullivan 2010). It has been claimed that “in the world of evidence-based medicine, all too often context has been relegated to the lowly status of a constant or assumed to be ‘controlled for’ (a euphemism for disregarded).” (Bate 2014 p4). Evidence summarised from highly controlled research trials that seek to test the effectiveness of specific interventions, under standardised conditions and with a rigidly selected population may not reflect the individual preferences of patients or the complex, multi-faceted nature of rehabilitation (Sullivan 2010).

One proposed solution is for therapists to take responsibility to be well informed about relevant research evidence, consider this within the context of each patient's individual perspectives and realities, and with application of their clinical expertise (Sullivan 2010). A systematic review of OTs' attitudes, knowledge and implementation of EBP found that many OTs were ambivalent about EBP and likely to value personal experience and colleagues as important in decisions making rather than evidence such as systematic reviews of randomised controlled trials (Upton et al 2014). Some differences were found between OTs and other professional groups, for example Heiwe et al (2011) found that OTs read and critically appraised fewer articles than PTs and dieticians (Upton et al 2014). Therefore although the academic debates about EBP tend to follow common themes, there may be tendencies for different professional groups to be at different stages in terms of the perceived importance of evidence and standardisation. There may also be differences in attitudes based on a practitioner's level of seniority (Wiles & Barnard 2001).

EBP and standardisation are intertwined concepts, as there is an expectation that benchmarks and targets set up as 'standards' should be founded on research evidence. Some have seen EBP and standardisation as part of a reconceptualization of medicine that reflects patterns of industrialisation (Illife 2008).

"Medicine is changing from a craft concerned with the uniqueness of each encounter with an ill person to a mass-manufacturing industry preoccupied with the throughput of the sick." (Illife 2008 p3).

Illife proposed that the debates about targets (such as those outlined previously in this chapter) should be recognised as aspects of this broader transformation of enterprise. The concept of medicine as craft has parallels with discussion earlier in this chapter regarding the definition of therapy. Mattingly's concept of 'therapeutic emplotment' is used to represent the fact that the significant part of an OTs work may be hidden and interwoven throughout what could appear to be an uneventful therapeutic encounter (Mattingly 1994). The therapists she describes shift seamlessly between playing checkers and doing cross stitch with patients and engaging with them in intense and profound conversations with them about what motivated them to persevere

and live. Written in 1994, it could be argued that this more craft-like conceptualisation of therapy is already a relic in a new era of productivity and process.

Echoing Iliffe (2008), Ballett and Campling (2011) problematize the dynamics of industrialisation as being at tension with the motivation to be patient-centred, autonomous and, crucially, kind. The authors acknowledge the inevitability of industrialisation in healthcare, but warn that certain practices associated with standardisation and performance measurement pose threats to personalisation and patient choice. They suggest that a breakdown of trust between clinicians and patients will accompany the undermining of professional autonomy. They call for attention to be paid to how staff can be enabled to balance the need to attend responsively to their patients with the demands of accountability.

“Unless these process are understood, and the lessons applied both to the way regulation is constructed and managed and to how clinical staff are enabled to keep the patient in mind, the effects of regulation on a culture of kindness can be devastating.” (Ballett & Campling 2011 p162.)

The adoption of industrial processes into healthcare is not a recent phenomenon. ‘Taylorism’ and ‘Fordism’ were terms discussed by Gramsci (1992) to describe a new approach to labour management in factories. Production (e.g. of Ford motorcars) was standardised, and there was division of labour with each worker repeatedly doing their assigned task. The application of certain elements of Taylorism and Fordism in healthcare have been critiqued (Lundy 1996; Walby & Greenwell 1994; Willis 2000). In ‘Making cars and making healthcare: a critical review’, Winch and Henderson (2009) acknowledge that the adoption of industry models of practice such as the Toyota car companies ‘lean thinking’ are well intentioned. Health services in the UK and United States have both supported such models as means of improving processes and outcomes and reducing cost (Institute for Healthcare Improvement 2005; National Health Service Modernisation Agency 2004; Young et al 2004,). However, Winch and Henderson note that there is a lack of evidence regarding the effects of such an approach in healthcare. Models such as lean thinking involve distinguishing ‘value added’ from ‘non-value added’ steps in a procedure, and eliminating the wasteful ‘non-value added’ steps. The authors suggest that industrial models such as this

assume a narrow interpretation of 'quality' as cost neutral reduction in adverse effects. This neglects aspects of quality likely to be more important in healthcare than car manufacturing, such as the therapeutic relationship between a professional (such as a therapist) and patient. Using Hofstadter's terminology the authors suggest that this leads to a culture of 'unreflective instrumentalism' (Hofstadter 1963; Winch & Henderson 2009).

The gradual shifts in conceptualisation of healthcare described above incorporate the increasing sanctification of certain research evidence and standardised guidelines as the basis for clinical decisions, and the refashioning of therapeutic interventions from 'craft' or 'therapeutic emplotment' to industrialised process and lean thinking. As discussed above, these metamorphoses can be seen as positive developments towards quality improvement, or can be criticised for having negative unintended consequences. They can also be critiqued as an example of hegemonic discourse. Hegemony is the concept that ideas and values that come to be felt as 'common sense' are actually the norms and values of a dominant group (Gramsci 1992). This is closely aligned to theoretical imperialism, and crucial to both concepts is the notion that ideologies and beliefs do not prevail because they are inherently true but as a consequence of power (Foucault 1980; Gramsci 1992; Whalley Hammell 2011). This leads to a call to question, analyse and test dominant assumptions. For this reason it was considered important to select a theoretical framework for this thesis that challenged dominant discourses relevant to the research question. This will be presented in the following section.

3.5 Chapter Summary

A desire for improved quality in the NHS is, on the surface, uncontroversial. However, quality is complex and can be interpreted and prioritised in different ways. Quality measurement has been said to have power in itself to drive improvement, as it brings attention to the aspect of care under scrutiny. However, it can be problematic, it can be misleading and it can have unintended negative consequences. Increasingly, evidence based practice and standardisation have come to be seen as hallmarks of quality, but these can be viewed as part of a hegemonic shift that has potential consequences for the way health professionals work and the aspects of their work that

are valued. The following section will revisit some of these discussions in presenting the theoretical framework chosen for the thesis.

Chapter 4 Theoretical Framework: Therapists as Street-Level Bureaucrats in Audit Society

4.1 Introduction

The previous chapters set up the background for the 45 minute guideline, placed it within the context of broader NHS quality improvement drives, and introduced critiques of performance measurement in the NHS. The following section will explain the theoretical framework applied in the thesis and why it was selected.

The study seeks to investigate therapists in practice: how they work; how they prioritise; what influences them in their delivery of therapy. The research question could have been framed in more traditional terms of barriers and facilitators to policy implementation. In fact, an early construction of the aim was to explore barriers to the implementation of an evidence based guideline. Exploring the background literature I came to realise that such a question would rest on several assumptions: that the 45 minute guideline is an evidence based guideline; that it is not being implemented; and that it should be implemented. Rather than basing the study on assumptions which I considered to be unfounded, I sought to take a social sciences approach and explore what was influencing therapists at 'street-level'. Linked with the development of the evidence base regarding the effects of audit and feedback in healthcare (cf section 3.2), there has been a growing interest in implementation frameworks and embedded programme approaches to evaluation. Along with improvement science, implementation has emerged as new territory for investigation and knowledge. The expansion of this field in the years between Greenhalgh et al's 2004 literature review and their own review was noted by Moullin et al (2015). Greenhalgh et al (2004) had developed a conceptual model of diffusion in service organisations. Since then, as noted by Moullin et al, multiple models, theories and taxonomies have been developed in this area. Authors classified the 49 papers of their review according to four framework types: descriptive, prescriptive, explanatory or predictive (Moullin et al 2015). They found there was a lack of prescriptive and predictive frameworks, which they suggested may be indicative of the relative newness of the field.

An example of one embedded programme theory that now underpins much of the implementation literature is normalisation process theory (NPT) (May 2006). The NPT model can be used to analyse and explain factors that impede or promote the implementation of new clinical techniques, technologies or complex interventions. NPM can be used to frame the potential of an intervention to become 'normalised', using four constructs: interactional workability; relational integration; skill set workability and contextual integration.

The current study sought to understand the delivery of stroke unit therapy ethnographically, within the policy context of the 45 minute therapy guideline and the auditing of it. Another approach might have been to investigate the normalisation of the 45 minute guideline into practice, and to situate this within the field of implementation. However, having decided instead to take a broader focus, and unpick fundamental concepts such as stroke unit therapy, I chose not to use a structured, model-based theoretical approach. I was keen to have a toolbox of theoretical ideas that I could refer back to as I began to gather and interpret the data, and to allow the findings to evolve more organically through the process of theoretically informed analysis, rather than striving to fit findings into a pre-defined model.

Lipsky's theory of street-level bureaucracy (Lipsky 2010) was considered likely to have relevance to this exploration, as it concerns the implementation of policy in direct encounters between front line workers in public services and citizens. Lipsky broke new ground in the approach to policy implementation, seeking to understand it from the inside out.

"It began by asking not what street-level bureaucrats *should* do, but what they *did* and why. (Hupe & van Kooten 2015 p29).

Constructing therapists as street-level bureaucrats (SLBs) similarly turns a question of policy implementation its head, and seeks to unpick what therapists do, and why. Using Lipsky' theory supports the aim of investigating ways in which policy, patient need and professional judgement influence the delivery of therapy on SUs.

Lipsky claims that the use of discretion and autonomy by public service workers in complex interactions is inevitable. Use of Lipsky's practice based theory could help pose questions and frame interpretations about therapists at 'street-level'. However, I was also keen to consider theory that enabled a broader perspective, and prompted interpretations regarding the society in which therapy is being delivered. For this, I draw on Power's concept of the audit society. 'Audit society' suggests that audit and performance measurement should not just be seen as methods aimed at improving quality in the NHS, but are part of a bigger picture of audit culture within contemporary western society. Lipsky and Power have been used together as the theoretical framework for a recent study of Swedish student aid officials (Bruhn 2015), but to my knowledge they have not been used together to explore therapy practice. Referring to this literature and considering it during fieldwork and as part of data analysis is intended to frame the research question within a broader social context which should also be subject to critique. This theory and its applicability to the research topic will be explained, and relevant concepts from Foucault (who influenced audit society theory) will be discussed. This theoretical framework was a starting point for interpreting the study, but during the course of the study it became relevant to draw on other ideas to make sense of the data. These will be introduced in the findings chapters and discussion.

4.2 Situating SSNAP as an example of hierarchical observation in Audit Society

Various theorists have argued that there are problems with attempting to measure performance, particularly in the public sector, and that audit changes working practices (Lipsky 2010; Power 1997, 2000; Shore & Wright 2000). Some have also suggested that the development of an audit culture in the UK is a damaging new phenomenon, associated with specific power relationships and systems of surveillance (Power 1997; Shore & Wright 2000).

Shore and Wright (1999, 2000), claim that the emerging model of accountability is a disabling form of policing which treats people as commodities. They claim that this reduces professionals and their relationships to 'crude, quantifiable and inspectable templates', and that audit replaces trust and autonomy with scrutiny and mistrust. Accountability backfires, as individuals fear the consequences of admitting there are problems in a system in which failure is punished and

excellence rewarded. Shore and Wright, drawing on the work of Power (1994, 1997), Foucault (1991) and Rose (1992), argue that audit in the public sector is an instrument for new forms of power. Using the context of higher education as an example, they assert that audit culture undermines professionalism and disciplines academic freedom. Originating in aspirations to be accountable to the tax payer, it is argued that university quality assessment has involved policing and punishment, and has become divisive (Strathern 2000).

Power (1997) framed audit within the anthropological concept of rituals of verification. He noted the increasing use of the word 'audit' in the UK from the 1980s onwards, and sought to conduct a sociological investigation of the rise of monitoring, checking and reporting in multiple sectors of society (Power 2000). He conceptualised the subject of this work using the term 'audit society'. Three key causes of the audit explosion were identified. The first was the rise of New Public Management (NPM). This term refers to the public sector's adoption of certain private sector principles and practices in which inspections and audits became valued as tools for change, and national bodies such as the National Audit Office and the Audit Commission took prominence (Hood 1995; Power 2000). Shore and Wright (2000) have suggested use of the term 'neo-liberal governmentality'.

"By this, we refer to a wholesale shift in the role of government premised on using the norms of the free market as the organising principles not only of economic life, but of the activity of the state itself and, even more profoundly, on the conduct of individuals." (Shore & Wright 2000 p 61)

The second cause was that political demands for accountability in the public and private sector were made in the name of citizens as users or recipients of services. Thirdly, audit society arose from a rise in quality assurance programmes and a new style of regulation 'from below' (Power 2000). Power states that though audit society had its origins in the Thatcherite UK of the 1980s, it thrived under New Labour as regulation, audit and inspection became ever more central to the operation of the state.

The assumption behind the concept of audit society is that “many audit processes are not neutral acts of verification but actively shape the design and interpretation of ‘auditable performance’” (Power 2000 p114). Ultimately, Power claims that a large amount of audit activity has little to do with efficiency and value, and more to do with a loss of faith in the leadership of society. This then generates a desire to check, confess and purify organisational order.

The theory of audit culture draws on work by earlier theorists, including Weber and Foucault. Weber (1978) discussed the focus of modern culture on calculability and quantification, which he saw as key components of bureaucratic authority. Espeland and Sauder (2007) note that there is a crucial difference between using quantification to describe relations and make predictions, and using it to exercise power and judgement over these relations. The latter can be considered using Foucault’s terminology of governmentality, hierarchical observation and normalising judgement, described in *Discipline and Punish* (Foucault 1977, Rabinow 1984).

For Foucault, governmentality is a mode of power that does not act directly on others but acts upon their actions (Tremain 2005). By instilling new values and norms, external regulatory agencies seek to achieve a situation in which agents monitor their own actions and bring themselves into alignment with the political objectives (Shore & Wright 2000; Strathern 2000). In hierarchical observation people’s actions are made visible and comparable with others’, and this process assures the automatic functioning of power. By setting out expectations and then observing people’s behaviour, external norms become internalised. Normalising judgement is a related concept, and involves ranking people or institutions on a scale and publicising this to encourage comparison. Normalising judgement pervades our society, and Foucault gives examples such as league tables to demonstrate this. SSNAP reports could now be offered as another example. Although not commonly referred to as league tables, the SSNAP reports publically rate stroke teams, both on their performance against individual standards and by giving an overall grade.

Arguably, the concerns raised by scholars such as Power, Strathern, Shore and Wright and explained above echo Foucault’s claim that the modern approach to discipline aims to produce docile bodies: subjects that do not just do what is required of them but do it in precisely the way

that is desired. By dividing, classifying and ordering people and behaviour around a norm, society becomes more governable. Rather than power being held by a particular authority figure, Foucault sees it as being enacted through a web of social control. This is applicable to the question of this thesis. The 45 minute guideline has not been mandated by the state or a clearly identified authority figure, but has been reportedly co-constructed by a group or network of interested parties. Its main mechanism of power is audit, including the generation of comparisons between SUs, but it is not clear what the consequences of performance may be, or by whom they are to be administered. Therefore it appears reasonable to assume that the intention behind the 45 minute standard is to set a norm and encourage professionals to internalise it and change their behaviour by setting requirements of self-surveillance and surveillance of each other. By making audit data public and comparing results side by side, hierarchical observation and normalising judgement are mechanisms of control that take on a life and power of their own.

Critical work investigating the workings of these mechanisms of control in different aspects of society has been called for as an ethical imperative by Foucault and others (Tremain 2005). The 45 minute guideline was initially met with resistance by therapists, but if the improvement strategy is successfully enacted as a technique of governmentality then it will increasingly become rationalised as thinkable, applicable and acceptable by those who practise it and on whom it is practised (Tremain 2005). The timing of the current study offers a valuable opportunity to investigate whether this is the case, or whether resistance prevails amongst therapists on SUs.

It has been argued that the power relationship of audit is hierarchical and paternalistic, involving the scrutiniser and the observed (Foucault 1977, Shore & Wright 2000). The observed are not involved in discourse, but instead become objects of information. The focus is to produce a quantifiable score from certain performance indicators, in order to rank departments and institutions against each other. Foucault's claim that dull, routine bureaucratic processes can affect the lives of individuals is related to Shore and Wright's claim that the new audit culture leads to worker stress. It involves an administrative burden which creates work pressures; a 'pecking order' is created within teams, departments and organisations; and there is a sense of being under constant scrutiny. Shore and Wright suggest that this model is reductionist, punitive and

counterproductive. They propose that accountability should be based on different sorts of measures: qualitative, multiple, local and based on public dialogue.

The theory of audit culture is useful for framing the research question within in a broader societal context. It has been suggested that specific examples of the proliferation of quantitative performance measurement deserve closer scholarly attention, as they have the power to elicit broad and significant changes in the activities they monitor - and these changes may be intended or unintended (Espeland & Sauder 2007). Few empirical studies have investigated the influence of audit culture in healthcare settings. A study of the influence of audit on Swedish ambulance services presented ambiguous findings regarding the applicability of Power's theory to their context, which involved sporadic inspections that last only a couple of days (Waks 2009). The criticisms expressed in the audit culture literature are largely theoretical and conceptual rather than empirically based.

Foucault's governmentality highlights that mundane routines of discipline and control enacted by individuals are part of a broad contemporary approach to governing. As noted by Prior (2009) this theory is limited, as it does not offer insights into what happens in public services at the point where relations of power between officials and citizens are exercised (Prior 2009). A further criticism is that Foucault does not account for the potential for policies to be subverted or distorted in practice (Prior 2009). In a paper on reactivity and reactions to regulatory transparency, McGivern and Fischer (2012) stated the importance of understanding how clinicians experience regulation and its effects in practice. For this reason it is considered important that the theoretical perspective for this study should also attend to the enactment of practice for professionals such as therapists at 'street level'.

4.3 Therapists as Street-Level Bureaucrats

According to Lipsky's theory, street-level bureaucrats (SLBs) are public service workers such as social workers, policemen and teachers who put policy into action in direct encounters with citizens. Lipsky uses empirical examples from different public sectors to make the case that policy

is best understood in the context of these real life encounters rather than in the upper levels of administration.

Central to Lipsky's theory are two claims. The first is that a critical dimension of SLBs' work is the exercise of discretion. Rather than implementing policy by rote, they make decisions on a case by case basis in complex interactions. The second is that in order to manage their workload within the inevitable constraints of time, information and other resources, SLBs develop routines of practice. This involves simplifying their clients in order to categorise them and ration services accordingly. Decisions are made in the moment, and focussed entirely on the individual. They have immediacy in the moment they are made, but potentially have a significant impact on people's lives.

These decisions become self-fulfilling prophecies. To apply this to the question of therapy provision, an example would be that deciding whether somebody has potential to benefit from therapy is the same as deciding whether to invest therapy resources in that person. Assuming that therapy is generally effective, the person in whom therapy is invested will then be more likely to benefit, while the other person will remain the same or deteriorate. The outcome will therefore prove the assessor's prediction, that one person would benefit more than the other. Additionally, in dealing with human beings SLBs are aware that they must face the reactions to their decisions by the people affected by them. For these reasons, the reality of policy implementation is in stark contrast with the 'bureaucratic ideal of impersonal detachment' (Lipsky 2010 p9).

Lipsky does not focus on the health service, but his definition of SLBs can equally be applied in this field. His theory has been used to discuss medicine as street-level bureaucracy, due to the significance of professional discretion and healthcare rationing for medical professionals (Harrison 2015). Lipsky uses the terms 'clients' and 'clientele' which are more commonly used in the settings he describes than 'patients' which is common in the hospital setting. Therapists are not specifically considered by Lipsky, but would appear to fit the broad criteria of SLBs, and studies of resource allocation in stroke units have used this theoretical lense to consider decision making by the multi-disciplinary team (Allen et al 2002, 2004).

A defining feature of SLBs is that they work in situations too complex to fit to programmatic rules or guidelines. They use their discretion in response to the human dimension of a situation. Others have agreed with Lipsky that the human agency involved in officials' decision making is crucial, and that their situated judgements will be influenced by their past experiences, tacit knowledge, emotional response to the situation and their own interpretation of the formal guidelines they are expected to follow (Bevir 2007; Mayo et al 2007; Prior 2009; Wagenaar & Cook 2003; Yanow 2003). Their use of discretion, and the shortcuts and simplifications they develop as means of coping with the workload, are not sanctioned by their superiors. However, although these strategies may be perceived as illegitimate by managers, they are essential to the survival of the service as 'if everything receives priority, nothing does' (Lipsky 2010 p19).

The allocation of therapy is a question of distributive justice and equity and relevant to issues of health inequalities. Lipsky notes that there is a paradox between society's desire for services to commit to standards of fairness and equality, which can be demonstrated by rules and criteria, and each citizen's desire to be treated as an individual and with compassion. SLBs recognise that treating everyone alike is unfair, and a complex medley of factors will be considered in their decisions about need. SLBs' personal values and standards of deservingness will also influence their decisions. Rather than stating this as a criticism, Lipsky presents this as inevitable and notes that in this respect SLBs are like everyone. Additionally, the way they respond as individuals is affected by the fact that they typically work under stress, with high caseloads and administrative demands that reduce time for client interaction. There is also an element of stress experienced as a result of feeling under scrutiny from superiors whose negative evaluations could carry consequences – and in this way there are links with Foucault's work on surveillance and the audit culture literature discussed above.

Although personal factors are likely to have an influence, Lipsky also states that workers in different services may behave quite differently. He gives the example that a large team in a small city with a stable, homogenous population may be able to provide a full range of services, whereas a service in a large heterogeneous city may not be able to offer the same services.

Lipsky suggests that there will never be sufficient resources to meet demand. Although SLBs do ration their services, they must not appear to do so as society expects public services to increase efficiency rather than use additional resources. Rationing is often done in the guise of dividing caseloads into 'active' and 'inactive'. Increasing the workforce can mean that each worker has a smaller caseload, so the number of 'active' clients may increase, but not the amount of time spent with each one. This raises interesting questions when applied to the 45 minute guideline, for example whether the proportion of the caseload considered to need therapy (the 'appropriateness' question) will correspond with Lipsky's suggested 'active' caseload.

Lipsky focusses specifically on performance measures, and notes that it is very difficult to scrutinise quality in the work of SLBs. Measuring outcomes is problematic as there are too many variables to consider. It is not possible to know what would have happened in the absence of an intervention, or if an alternative decision had been made. Human beings are too complex to be summarised and simplified in metrics. Lipsky's claim that SLBs work is relatively free of scrutiny compared with many organisations can be challenged as outmoded as his original work was published in 1980, when New Public Management and the audit explosion were specks on the horizon. However, his analysis of the problematic nature of quality measurement has gained relevance. Taking an example from the police force, he notes that setting a target for the number of arrests that should be made per month and measuring this only yields information about how many arrests were made. It does not signal good or bad performance, or offer insights into the appropriateness or fairness of the police workers' actions (Lipsky 2010 p51). The easiest thing to quantify with the least intrusion is the use of workers' time; therefore, organisations tend to measure productivity rather than quality of performance. This clearly relates to the 45 minute guideline, which potentially draws focus to quantity of time spent with patients, rather than how this time is spent. It also raises questions about whether therapists may have been accustomed to having their use of time measured at an organisational level prior to the introduction of the national audit.

As stated above, a central claim for Lipsky is that SLBs will strive to retain their autonomy. This applies in the case of performance measurement, as he suggests that workers will retain independence and accommodate themselves to the measures. SLBs will in the first instance

resist the development of measures that they see as threats to their autonomy. Once imposed, they will alter their behaviour in response to the measures, but not necessarily in the way that was intended. This corresponds with arguments outlined earlier in the literature review about unintended consequences such as gaming, or hitting the target and missing the point. Although SLBs develop routines of practice to ration their services and meet performance targets, Lipsky states that “most SLBs can be taken at face value when they assert that they are doing what they think is the best that they can do... only that they are functioning effectively and properly under the constraints they encounter” (Lipsky 2010 p81-82)

SLBs, according to Lipsky, tend to work in jobs with conflicting and ambiguous goals. Idealised public service goals can be difficult to achieve and ambiguous, and there can be a conflict between the requirement to be client-centred on the one hand, and efficient mass processing of the workload to serve the goals of the organisation. Lipsky notes that there is often disagreement or ambiguity about the role expectations of SLBs, and the focus of their work is likely to be influenced by fellow workers. This relates to the discussion earlier in the literature review regarding definitions of rehabilitation, and the lack of consensus regarding the role of therapists noted in the narrative review completed as part of the PhD (Taylor et al 2015 – see Appendix A).

Some criticisms of Lipsky’s theory have been based on the extent to which he remains relevant in the contemporary era (Barnes & Prior 2009). It has been suggested that the increased proliferation of performance targets has led to the ‘death of discretion’, as front line workers are more tightly restricted in their choices and actions (Ellis 2007, Howe 1991; Taylor & Kelly 2006). Others have retorted that the impact of NPM on workers’ autonomy is exaggerated, and that Lipsky’s launching of the debate between top-down and bottom-up policy implementation remains pertinent in contemporary public services (Evans and Harris 2004; Halliday et al 2009; Hupe & van Kooten 2015). Evans (2011) claims that Lipsky’s characterisation is strikingly relevant, but he criticises Lipsky for homogenising people from different occupations and also for failing to attend to the role of managers in the complexity of policy implementation. Lipsky’s clear distinction between managers and workers is seen as at odds with a reality in which managers are often professionally aligned with front line workers. A further criticism is based on the claim that citizens have now become ‘key actors in the delivery of policy at street level’ (Barnes & Prior

2009 p3), and are not 'empty vessels' (Yanow 2003 p245). Citizens, it is claimed, respond to policies and engage with practitioners in deliberation about their desired outcomes and their own capacities for action (Prior 2009). The extent to which this is true for patients on SUs will be investigated in this thesis. Discussions regarding Lipsky's continuing relevance tend to focus on social services as the examples of potential street level bureaucracies. There is scope to investigate whether Lipsky's theory can usefully illuminate data regarding the delivery of SU therapy and the implementation of the 45 minute guideline.

4.4 Chapter Summary

Ethnographic research seeks to provide rich, in depth descriptions of a specific group of people in a specific setting. Unlike large scale quantitative research, it does not claim to provide generalisable information based in these small scale insights. Instead, theory is used to frame the research question, and to consider and interpret findings. In this study the theoretical framework draws on a practice based theory regarding the implementation of policy by public service workers. The study seeks to investigate similarities and differences between SU therapists and Lipsky's account of street level bureaucrats (SLBs). The use of Power's audit society theory situates therapists within the context of a contemporary 'explosion' of audit. This allows questions to be raised about whether the introduction of SSNAP can usefully be viewed as part of this explosion. Power sees the rise of audit and performance management as characteristics of New Public Management (NPM). The use of league tables in the education system is an example of this, and this also appears to be an example of Foucault's concepts of hierarchical observation and normative judgement. It is considered likely that these concepts may have relevance when considering the recent addition of SSNAP as a publically available rating system for stroke teams. The use of audit society and street-level bureaucracy as a theoretical framework to explore the implementation of policy by therapists is novel. This may be because therapy has not previously been measured in national audit. The timing of this study enables new insights to be sought regarding therapists as street-level bureaucrats in an audit society.

Chapter 5 Methodology and Methods

5.1 Introduction

The question this thesis seeks to explore is: how is stroke unit therapy interpreted and enacted in the era of the 45 minute guideline? An ethnographic approach was chosen to investigate this question, and this involved participant observation and semi-structured interviews with staff and patients in three different SUs. Fieldnotes and interview transcripts were analysed inductively alongside deductive use of theory to support and shape the analysis. This chapter begins by explaining the methodology of the study, including the ontological and epistemological stance and the rationale for using an ethnographic approach. The second section will focus on considerations for planning and carrying out an ethnographic study. This includes consideration of approaches to participant observation, the role of the ethnographer, the use of reflexivity, and evaluating quality in ethnographic research. The third section outlines the methods used. It explains the process of selecting sites, recruiting participants and collecting and analysing data.

This chapter interweaves a 'realist' account of methods, with a 'confessional account', in the first person, of the deliberations involved in selecting them (Hammersley & Atkinson 2007). This means that rather than flowing in chronological order, the narrative moves back and forth between what was planned and what took place. The aim of using this style is to give a transparent account of the rationale for choices that were made and issues that required consideration.

5.2 Methodology

As noted in Chapter 2 (see p28), quantitative studies have been used by proponents of the 45 minute target as justification for the broad notion that there is a 'dose response' to rehabilitation. Some such studies test a specific intervention to target a specific impairment, while others take the form of time and motion studies and report on the number of minutes spent by patients in activities such as standing or walking. Anecdotally, talk of 'the 45 minutes' amongst clinicians, policy-makers and academics is now used to refer both to the auditing of the target and to the target itself. Discourse surrounding the 45 minute target seems largely to sit within a positivist paradigm. Studies using stopwatches and observational charts to measure therapy empirically are an example of this. The stance of this thesis is that there is another way to consider and

interpret therapy delivery, and that a qualitative methodology that seeks knowledge beyond the numbers is best placed to investigate certain important questions relating to therapy provision. How are therapists interpreting the target, and the tick boxes that ask whether a patient required therapy and how much they received? What does it mean to be 'appropriate for therapy', and who decides? How do therapists prioritise amongst their patients and between their various work demands; and where do patients fit in to it all? Interpretive questions that investigate the 'what' 'why' or 'how' of a phenomenon, rather than 'how many' or 'how much', are best suited to a qualitative methodology (Britten 2011; Green & Thorogood 2004).

5.2.1 Ontological and epistemological considerations.

"Man is an animal suspended in webs of significance he himself has spun... I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning." (Geertz 1973 p5)

The philosophical assumptions of any study include ontological assumptions (about the nature of reality) and epistemological assumptions (about how reality can be known and the relationship between the knower and what is known) (Cresswell 2007). It is important to reflect on and acknowledge the philosophical assumptions of any study, as these will guide the inquiry (Cresswell 2007). It has been suggested that rather than needing to label oneself with a rigid ontological position, it is useful to consider the influence of different philosophical positions on the approach used to answer different questions (Barry 2002; O'Reilly 2009).

To consider how different ontological and epistemological positions might influence the study of therapy, I offer an example of a specific therapy intervention: acupuncture treatment for shoulder pain. It is possible to observe and record how many times a patient receives acupuncture treatment for shoulder pain; the position of the needle; and his /her pain rating on a numerical scale. A positivist epistemological approach to investigating the amount of acupuncture treatment required to treat shoulder pain might well use such empirical observations to draw conclusions and make claims about their application to the general population. This might be based on an ontological belief that acupuncture works by causing certain observable chemical compounds to be released into the body. An alternative ontological perspective might be that there are other

factors that should be considered, such as the way pain is socially constructed and the meaning ascribed to acupuncture therapy by the therapists and patient.

Social constructionism holds that in attempting to make sense of the world, we construct knowledge socially and through shared experience (Andrews 2012; Charmaz 2000, 2006). In the context of this thesis, it is considered appropriate to investigate the social context of the SU; and how therapists construct beliefs about their role, purpose and how best to serve the needs of their patients. The setting for the research question is complex, involving different actors (including different professional groups, patients and relatives) with different influences and experiences. Experiences of therapy will vary amongst these individuals, as will the meanings and values they ascribe to it. Furthermore, unlike the specific intervention example of acupuncture therapy for shoulder pain, 'therapy' is a broad concept which can be used to represent many different activities serving different aims (e.g. increasing independence, improving well-being, reducing risk, reducing impairment). In the guideline that is the focus of this study it also incorporates three different disciplines: OT, PT and SLT.

The ontological position for this study is that the application of any specific therapy intervention involves factors that are not objectively 'out there' in the world. The epistemological position is that attempts to quantify 'therapy' (which could involve any variety of interventions) in general terms will involve misleading over-simplification. Quantifying the amount of time spent in therapy will tell us little about what is being offered, what is being received or why it is or is not beneficial. Instead, in keeping with constructivist and constructionist paradigms, the most appropriate means of furthering understanding in this area is to seek and interpret participants' views and observe their behaviour, whilst being mindful of how the researcher's own background and perspective might shape this interpretation (Andrews 2012; Charmaz 2000, 2006; Cresswell 2007).

5.2.2 Rationale for using the ethnographic approach

The term 'ethnography' is derived from the Greek words *ethno* and *graphy*, and can broadly be defined as writing about people. An ethnography is an interpretative account, and its authority relies on systematically gathering and analysing data, integrating with participants in their natural setting, and using and developing theory (Madden 2010). An ethnographic account primarily

investigates what people do, how they understand and account for what they do, and the broader implications of this. Long term, multi-method data collection is a key feature of ethnographic research (Huby et al 2007). Ethnographic studies typically involve observation and interviews within particular settings, and seek to describe the perspectives and meanings constructed by people in their everyday settings (Grbich 1999). It has been noted that the terms 'therapy' and 'rehabilitation' lack clear definition, and a lack of consensus about their definitions may relate to variation in the way SU therapy is delivered (Taylor et al 2015). The complexity of the SU setting and the potential for multiple understandings or constructions of therapy delivery suit an ethnographic approach. Although systematic, the course of an ethnographic study is not pre-defined but evolves throughout its duration in an iterative-inductive process (O'Reilly 2009). This has been described as being free to 'muddle about' in the field, rather than having a pre-conceived hypothesis to prove or disprove (Grbich 1999; Wolcott 1979).

The rationale for using ethnography in this study was that use of detailed description to tell a story of what goes on in SU therapy would offer rich insights into how therapists interpret and enact their roles and make decisions regarding therapy delivery. Additionally, ethnography was considered suitable for investigating how a specific social rule (the 45 minute guideline) is variously understood and implemented. The use of extensive participant observation in addition to interviews gives an opportunity to compare what people do with what they say. If there are inconsistencies between the two, these can be explored in a non-threatening way as the participants gain trust in and familiarity with the researcher (Geertz 1983; Hammersley & Atkinson 2007; Lambert & McKeivitt 2002). This means that the interpretation neither rests solely on what participants report, nor on what the researcher documents having seen, nor even on a snapshot combination of the two. Instead, formal interviews, informal conversations and observations are ongoing, and contradictions and inconsistencies can be noted and explored.

The use of 'thick description' is a characteristic of ethnography, and aims to give context and meaning to the actions being observed (Geertz 1973). During fieldwork, as well as conducting formal interviews, the researcher inscribes observations, informal conversations and ideas in descriptive fieldnotes. Description and use of the first person are typical in ethnographic writing (Clifford & Marcus 1986).

Ethnography has its origins in the anthropological study of different and exotic cultures, but it now commonly takes place 'at home' rather than amongst distant tribes, and 'the field' can be multiple sites (Shuttleworth 2004). Its potential value in healthcare settings is increasingly acknowledged (Clarke 2009a, 2009b; Savage 2000), and Finkler et al (2008) claim that ethnographers should focus on hospital services for the following reasons. They describe hospitals as fascinating, complex spaces that are constantly changing and provide the setting for many of the most significant times in our lives. The development of increasingly complex specialist services is associated with their day to day realities becoming increasingly poorly understood. The authors suggest that ethnographic studies can enlighten citizens about negotiation of contemporary health services and enhance theoretical understanding of pressures inherent in contemporary hospitals. Others promote the nuanced understanding that ethnography can provide in healthcare settings due to the nature and range of methods used (Savage 2000). Lambert & McKeivitt (2002) emphasise the valuable contribution an anthropological approach can have in healthcare research, but promote the importance of relating findings to theoretical concepts. They suggest that an overemphasis on methods rather than theory is detrimental to much qualitative healthcare research.

5.3 Ethnography – important considerations

This section will seek to explain potential issues that should be considered when using an ethnographic approach. In studies such as RCTs, efforts are made to increase objectivity in order to reduce the risk of bias or unintended influence on the object of study. In ethnography, the ethnographer is embedded in the field, collecting data with flexibility and responsiveness. Relationships are formed with the participants over a period of time, and due to the interpretative ontological perspective there is not the same expectation of replicability that there would be in different approaches. In order to give credence to the findings, it is important for the ethnographer to be open and transparent about how the research was carried out. The position of the researcher vis-à-vis 'the other' being studied can be problematic for reasons relating to power dynamics; the extent to which participants will change their behaviour in the researcher's presence; and the researcher's ability to maintain an outsider's perspective. There is a need to

strike the right balance between insider and outsider in order to make 'the strange familiar and the familiar strange', and to avoid 'going native'. The ethnographic researcher's best tool for checking that he / she is well positioned in these respects is reflexivity, and this will be the starting point for this section. I will then discuss the need to consider the impact of the researcher on those being studied; power relations between the researcher and those being studied and the researcher's 'insider outsider' role. Finally, the term 'participant observation' will be explored, as it can be used to represent a spectrum of techniques with 'participant' at one extreme and 'observation' at the other.

In ethnographic writing it is usual to use the first person. This acknowledges the personal presence of the researcher, whereas use of the impersonal third person and passive tense could give a false impression of objectivity, failing to highlight the interaction between the researcher and the research. As this section will describe the reasoning behind decisions made about how I chose to position myself as the researcher, the first person will be used, and reflections and recollections will be interwoven. It should be noted that where I draw on examples from my experiences and thought processes, these are not intended as citations of evidence, but to give a full, open and reflexive account of the methodological considerations that took place.

5.3.1 Use of Reflexivity

Reflexivity is a process through which the researcher engages in "explicit self-aware meta-analysis" (Finlay 2002 p209). The reflexive researcher examines how their own characteristics, feelings and experiences, and intersubjective elements, influence the on-going research (Finlay 2002). The central position of reflexivity as 'methodological self-consciousness' in qualitative research emerged in response to criticisms of early ethnographies, largely for failing to attend to the issues raised above (Clifford & Marcus 1986; Finley 2002; Seale 1999). Reflexivity can be conceptualised and used in different ways depending on the researcher's aims (Finlay 2002). There is a danger that claiming that reflexivity has been used to increase transparency and trust in the validity of findings can represent a confusion of ontological perspectives. Such an approach seeks to justify the qualitative method in positivist terms, suggesting use of reflexivity has enabled a 'truer' account of an objective reality (Finlay 2002), which is at odds with interpretive perspectives (Denzin & Lincoln 1994). An alternative position acknowledges that each researcher

has their own interests, and that these should be explicitly stated in order to allow the reader to consider the questions that were not asked; the people who were not represented; and the distortions that may have occurred in analysis and writing up (Finlay 2002; Hertz 1997).

As an interpretive ethnographer I cannot claim to have represented the truth or reality, and I must acknowledge that a different person in my shoes might / would have conducted, analysed and presented the research differently. Different themes could have emerged, and the observations I found representative or meaningful might have been dismissed in favour of things to which I did not attend. How, then, can a study using this methodology claim any authority or be worthy of the participants' or readers' time and attention? In any study of any design, the study question, inclusion and exclusion criteria, sites and methods have been chosen for certain reasons. Decisions always have to be made and there is always human thinking to be done. Good use of reflexivity acknowledges this, and considers it. During the fieldwork, I used reflexivity to monitor myself and critique the way I was performing my role as participant observer. My use of reflexivity in writing up serves a different purpose: to expose the inner workings of the research. This is an attempt to demonstrate integrity, transparency and accountability.

Finlay (2002) constructed a typology of five variants of reflexivity: (i) introspection; (ii) intersubjective reflection; (iii) mutual collaboration; (iv) social critique and (v) discursive deconstruction. My use of reflexivity throughout my PhD included introspection, intersubjective reflection and mutual collaboration. Introspection was not always, as it is suggested it should be, 'a springboard for interpretations and more general insight' (Finlay 2002 p215). Sometimes it took the form of 'benign introspection' (Woolgar 1988 p22), and sometimes, reflecting on my feelings of awkwardness or frustration whilst sitting idly in a therapy office was a means of giving myself something to do and making myself feel better. Often it was not clear in advance which of my rambling, 'stream of consciousness' fieldnotes would later spark insights into the context in which those thoughts occurred, and which I would dismiss as cathartic off-loading. Sharing fieldnotes with my supervisors was a useful, if exposing, way to seek feedback as well as keeping them informed about the progress of the study.

Intersubjective reflection was particularly relevant for reviewing and adapting my role as participant observer, and this will be elaborated on later in this chapter. This overlaps with my use of mutual collaboration. Mutual collaboration recognises the capacity of research participants to also be reflexive and engage in reflexive dialogue during the research process. Examples of my use of this style of reflexivity varied in scale. In my intersubjective reflections, I debated the pros and cons of being open with participants about my preconceptions and emerging thoughts. I noted that the more I opened up to them, the more they opened up to me. In certain situations, such as multi-disciplinary team meetings, I sat quietly writing in a notebook, and comments such as 'careful, we are being monitored' were made. Conversely, when I had informal chats with therapists and patients, and shared my own reflexive thoughts with them, they discussed their own experiences and perspectives freely. The danger of this approach was that encouraging participants to question and reflect on their own attitudes and experiences would have an impact on their behaviour and 'contaminate' the findings. I soon found that my very presence had this effect, regardless of whether I engaged in conversations or remained silent. A more formal use of mutual collaboration took place in each site after I had completed the fieldwork and begun to analyse the data. I presented preliminary findings and emerging themes to the SU teams to offer therapists (and any other members of staff who attended) an opportunity to discuss the extent to which they felt their experiences were represented.

5.3.2 Impact of the researcher

It is impossible for ethnographic researchers to make themselves invisible, and therefore it is naïve to assume that being present in the field has no impact on the behaviour or attitude of participants (Mesman 2008, O'Reilly 2009). Furthermore, participants are not passive in the process of inquiry. It has been suggested that informants may influence the ethnographer in accordance with their own interests (Shuttleworth 2004). For research taking place in NHS settings, there is a requirement for participants to read and understand participant information sheets and have the opportunity to ask questions prior to consenting to participate. This is already likely to plant a seed of thought on a topic they may not have otherwise been considering, or to shine a spotlight on the way they work. One way of attempting to reduce the impact of the researcher's presence is for the researcher to spend sufficient time in the field for participants to become accustomed to his or her presence, stop putting on a front and revert to usual behaviour.

However, spending an extended length of time in the field carries a further risk. As the participants become accustomed to the researcher, the researcher becomes accustomed to the field, and may lose his / her perspective as an outsider and sense of novelty regarding observed practices. This is commonly referred to as 'going native' (Madden 2010). These considerations influenced the decision to aim to dedicate three months to completing fieldwork in each stroke unit. When I presented this plan to a group of researchers with clinical backgrounds they expressed that three months of intensive observation would be too burdensome for the therapists as well as self-defeating, as the setting would become too familiar. Jeffrey and Troman (2004) have discussed different 'ethnographic time modes'. With these in minds, and following discussion with other researchers who had experience of conducting ethnographic studies in healthcare settings, I concluded that a 'selective intermittent time mode' would be most appropriate to the project. This involves spending a long period of time doing the research (from 3 months to a year), but with a flexible approach to the frequency and timing of site visits. Three months in each site was considered as a frame for the period during which observations and interviews would be conducted. This time would also include writing up field notes, arranging and transcribing interviews, spending time scrutinising the data away from the hospital and organising emerging ideas. I would begin with a 'compressed time mode' – attending the sites for whole days and weeks, 'hanging around, soaking up every tiny detail' (Jeffrey & Troman 2004), but rather than fixing myself to being with therapists for all of their working hours, I planned to experiment with coming and going at different times and on different days. This would allow me to observe all parts of the working week, it would allow the staff to get to know me but for me to resist being absorbed into their world and would enable me to continue to observe with 'fresh eyes' over a longitudinal period.

5.3.3 Power asymmetry.

Many anthropologists have raised concerns about the asymmetrical power relations embedded in traditional ethnographic study (Clifford & Marcus 1986; Hume and Mulcock 2004; James et al 1997; Shuttleworth 2004). The fieldwork encounter can be seen as problematic in terms of power relations, as it allocates to the researcher a power to represent and interpret 'the other' (Clifford & Marcus 1986). The legitimacy and motives of 'outsiders' seeking to make ethnographic representations of a certain group has been debated (Bourne 1983; Oakley 1981; Shuttleworth

2004). Prior to conducting the study and during the fieldwork I wondered about my position as researcher, and whether my background as an occupational therapist working with stroke patients was an asset or an impediment. I discussed this with participants informally, and hoped that discussing it openly might help to break down barriers and reduce the power balance in itself.

5.3.4 Insider / outsider

The constant striving to balance the insider and outsider role is a key characteristic of ethnographic study, and is referred to as a relationship between the emic (insider) and the etic (outsider) points of view (Geertz 1983). Clifford and Marcus (1986) discuss the need for a delicate balance between recognising that the ethnographer's personal experiences of participation and empathy are central to the research process, and restraining them firmly by keeping an observational distance. My background almost certainly proved advantageous in building trust with the participants, giving me access to the emic, but a criticism could be that I was too close to the topic, and therefore at increased risk of 'going native' and losing the etic perspective. As a therapist, I would have pre-conceptions about the nature of therapy and how it should be delivered. I would also be accustomed to many of the routines and practices that a real outsider might be struck by and see as more significant. On the other hand, my background gave me a short cut. Rather than spending time 'learning the language' of jargon, acronyms and terminology, I could maintain my attention on broader aspects of what was going on.

Before commencing my PhD I worked in a community therapy team, and had not worked in a stroke unit since 2006. This was prior to the major re-organisation of stroke services that occurred in 2008 in London, alongside the introduction of Hyper Acute Stroke Units (HASUs) (Healthcare for London 2008). Therefore the stroke unit as a field was neither alien nor familiar. It was only when I started the fieldwork that I realised how little I understood of its workings. My year spent out of clinical practice had also provided me with enough distance to see things with an outsider's eyes. Ongoing reflexivity, documented in fieldnotes, would be invaluable in striving to synthesise the emic and the etic and maintain a dialogue between the two.

5.3.5 Participant observation

Prior to commencing fieldwork I anticipated that my position as a researcher in the field could be anything from awkward to problematic. I had enough experience of hospitals to have a foreboding image of therapists buzzing around a ward in a blur, and me standing in the middle wondering where to put my coat. When discussing my planned research with other therapists they asked questions like 'are you going to wear a uniform?', and I was aware that a seemingly mundane question of what to wear could be important in making a statement about my role in the setting. Should I introduce myself as an OT, a researcher or a student? Each identity could give a different impression and make a difference to the content or amount of information that staff and patients felt keen to disclose to me, although it was not clear exactly how. I was reassured to discover (through reading, talking to other ethnographers and attending a summer school) that these were not neurotic worries but serious considerations for any ethnographer. Mesman (2008) discusses some of the 'role boundary' issues she faced in her own ethnographic research. She concludes that the field is not a stable world with distinct boundaries.

"The dynamics within the local-interactional spaces create a complex process in which one gets entangled in multiple engagements, conflicting feelings of loyalty, and a multitude of positions. In practice, there is no stable order that fits our 'dichotomised' fears and expectations." (Mesman 2008)

This may be true once one is in the field, and the nature of ethnographic research allows for shifting and evolving to occur; however, I needed to give prior theoretical consideration in advance to decisions about how to frame my research, how to present myself and how to act in the field (O'Reilly 2009).

Participant observation can be seen as a continuum with full immersion at one extreme and detached observation at the other (O'Reilly 2009). The natural science notion of ensuring nothing is altered or contaminated by the researcher was not considered applicable to this study, and my very presence was bound to have an impact of some sort. I had also heard anecdotes from other researchers who had conducted ethnographic research in clinical settings, had striven to maintain a strict observational role and had found this had a negative impact on relationships with staff

participants. Adler and Adler (1987) describe three different types of membership role in fieldwork: peripheral, active and complete. Due to my professional background I reasoned that assuming an active or complete role would lead me to perform the role of an OT, losing my role as an observer. This would be unethical and probably illegal in a setting where I was not employed, and methodologically it would prevent me from viewing the delivery of therapy from an outsider's perspective. The participant observer should strive to balance a tension between making the strange familiar and the familiar strange (O'Reilly 2009; Schutz 1971; Sunstein & Chiseri-Strater 2011). As the therapy context was already somewhat familiar to me I considered it important to attempt to keep some distance in order to see it as 'strange'. I was aware that I might well be tempted to speak up, advise or comment on clinical situations, and that doing this would express a professional authority that might inhibit staff from speaking openly to me or explaining things from their own perspectives. I therefore chose the role of peripheral observer, but planned to be flexible and to try to make myself helpful in menial and non-professional ways. My approach to entering the field and introducing myself to the teams varied in each site, and will be presented when I introduce the settings in the following chapter.

Certain decisions needed to be made in the moment once fieldwork had begun. Tinney (2008) discussed dilemmas encountered in her ethnographic study of nursing homes, particularly related to her participant observer role. Officially she was in a 'non-care' volunteer role, but when faced with the needs of residents – such as adjusting their clothing, feeding them, or wiping their mouths – she made on the spot decisions. Following Lipson (1994), she noted that in the absence of other guidelines, the researcher must use 'gut feeling' to resolve ethical dilemmas in the moment. An example of this came about a month into my fieldwork in the first site. I started to notice that the therapists were used to my presence and beginning to ask for help in various ways. One of the OTs approached me because she was planning on doing a washing and dressing assessment with a patient the following morning. She confided in me that she was pregnant and had been feeling sick and faint in the mornings. She was worried about how she would cope in a hot bathroom with the patient in the shower, and she asked me to help her. I understood that she was perceiving me as a fellow-OT, and an available second pair of hands. My instant reaction was to agree to her request – I did not want her to put herself or her patient at risk in the bathroom, and I felt sympathetic towards her. But then I reflected on the fact that she would not have made

the same request of a researcher without a clinical background. I asked her if someone else could help, but she wanted to come in early (at 8am instead of 8.30am) to do the session and did not want to ask a colleague to do the same. She was not ready to tell her colleagues about her pregnancy, so would find it hard to explain her need for help. I asked if she could do it as a joint session with a nurse, to which she puffed the air and shook her head. I reminded myself that I was not on the SU as an OT but as a researcher. I felt that as a researcher, helping the man to have a shower would be an unjustified invasion of his privacy. Although I always explained to patients that I had a background as an OT, I did not want them to see me enacting this role as I felt it might make them less open in discussing their experiences of therapy with me. For these reasons, I declined to help with the session, and instead helped the OT come up with an alternative solution. This decision presented a risk of damaging my relationship with the OT, but in fact this was not the case. She was able to find a therapy assistant (TA) to help her, which we both considered to be more appropriate as the TA was able to continue working on relevant goals with the patient subsequently. I usually found dilemmas easiest to resolve by asking myself whether an action might influence the data, and usually if something was asked of me that I felt would not have a bearing on the study findings then I was happy to oblige. The above example was different as I reflected that having presented myself as a researcher, the patient might feel less comfortable with my presence in the shower than with a health professional (wearing a uniform) whom he saw as facilitating his recovery. In addition, due to this particular patient's communication difficulties, it was not possible to discuss this with him.

5.4 Methods

The methods of data gathering used in the study included preliminary informal interviews with 'key informants' (e.g. members of the working party involved in setting the 45 minute guideline) to gather contextual data; participant observations of therapy work conducted in three stroke units; and informal and formal interviews with therapists, therapy assistants, managers, patients and carers. Fieldnotes and reflections were written throughout the course of the study, and these were treated as data along with interview transcripts. A constructionist approach to thematic analysis was used to identify, analyse and report latent themes (Braun & Clarke 2006). Data

analysis was both inductive and deductive. Use of the theoretical frameworks described previously informed the data analysis.

5.4.1 Preliminary contextual data gathering

It has been suggested that the ethnographer should enter the field with 'foreshadowed problems' (Grbich 1999). This means having an awareness of key issues and debates, but not allowing one's view to be limited by pre-conceived ideas. Prior to the commencement of fieldwork I was familiar with therapists' perspectives on the 45 minute guideline and audit from first-hand experience, but I had not previously had an opportunity to hear the from the leaders who had been involved in establishing the 45 minute guideline or the SSNAP audit. I was keen to increase my understanding of the context surrounding the study so that I had a balanced understanding of relevant debates and controversies. For this reason, prior to conducting fieldwork in the SUs I arranged to meet or speak to several influential stroke professionals who had been involved in the Intercollegiate Stroke Working Party (ISWP) or the establishment of the SSNAP audit. I sought their perspectives on the rationale for the 45 minute guideline, and they all spoke individually of the controversy and resistance voiced by therapists against it. Representatives of the different therapy professions spoke of their unusual dual role representing their profession to the group and representing the policy making leadership to the members of their profession. Many referred to a meeting that had taken place in March 2012, in which the ICSWP presented the case for increasing therapy intensity with the intention of addressing the opposition that therapists had expressed (ISWP 2012). I was told that the guideline was very contentious and problematic, and therapists were defensive about being audited as they were not accustomed to this. During the course of the PhD and when conducting fieldwork I took opportunities to attend meetings and discussions that related to the topic. When people outside the world of stroke rehabilitation asked me what my PhD was about I tended to struggle to explain it, but when talking to people with a role in stroke rehabilitation I invariably found that all I need to say was '45 minutes' and they would start telling me about their experiences and opinions on the topic. I considered peripheral discussions such as this to enhance the depth of data informing the study, and wrote field notes regarding any experience that appeared relevant.

5.4.2 Site selection

Purposive sampling was used to select SUs with different characteristics (Ritchie & Lewis 2003). The initial intention was to purposively select three sites that represented a range of performance according to the SSNAP data. It soon became clear that this was not as straightforward as anticipated. The SSNAP audit reported on a range of data sets including separate data for the proportion of patients considered appropriate for each therapy (OT, PT and SLT) in each team; the quantity of each therapy received; and the proportion of days on which it was received. There was no correlation between the 'appropriateness' scores and the quantity of therapy received, and teams that scored well for one therapy might not score well for another. Furthermore, performance as measured by the audit was not stable, but could change dramatically from one quarterly report to another. Whilst conducting fieldwork at the first site, I was under the impression it was a team that performed well on the audit data as it had done so in the most recent results. However, a month after I had finished fieldwork there I heard from one of their therapists that there was trouble in the team because SSNAP had raised concerns about the data they had submitted for the most recent report. This cast a different light on the fieldwork I had already conducted there, as the most recent rating applied to the time when I had been conducting my observations.

Despite these complexities, I sought to select sites that would show contrast, either in audit results, team practices, geographical areas or patient demographics. I decided to begin fieldwork at the first site before selecting further sites, as I might discover what sort of contrast would be most useful to explore. Pragmatic considerations were also relevant. It proved difficult to establish contact with gatekeepers unless I had a connection on which to draw. As I had anticipated, my fieldwork at the first site raised issues I had not considered.

My early planning was based on prior knowledge of the London stroke model. Stroke care in London was reconfigured into a hub and spoke model in 2010. The London stroke pathway established in 2010 was for patients presenting with stroke symptoms to be taken directly to a hyperacute stroke unit (HASU) for assessment, then, within 72 hours, to be repatriated to their local stroke unit, their own home or a nursing home (Morris et al 2014). This reconfiguration was designed to enable people with acute stroke to benefit from rapid access to brain scans and

thrombolysis (Morris et al 2014). I had unthinkingly assumed uniformity in the definition of a stroke unit, but found that there was variation in characteristics such as an SU's position in the local stroke pathway, and whether they were commissioned to provide acute care or rehabilitation. I became keen to see whether therapy was delivered different on these differently defined wards.

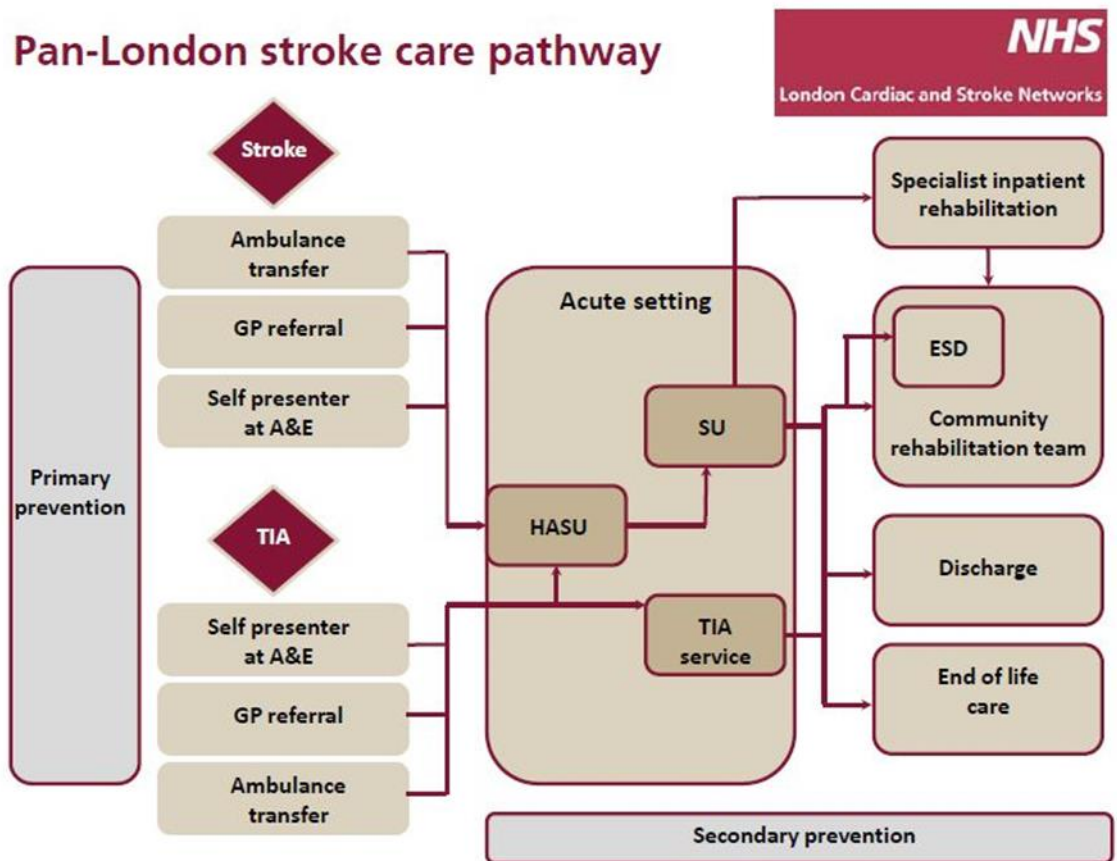


Figure 4: The Stroke Pathway in London (Healthcare for London 2008)

Additionally, I was keen to identify a site outside London. Therapists in the first site conveyed a clear sense that things were different outside London. Some therapists reported having worked elsewhere and found a difference in working practices and attitudes of therapy staff, whilst others recounted tales of colleagues who had left London to work elsewhere and complained about their new teams being less dynamic and less efficient. I became keen to identify a fieldwork site outside London, to explore these potential contrasts. The second site was seemed like an ideal site to offer contrast with the first, as its therapy SSNAP scores had drastically improved over time, it was located outside London and there were potential differences in the demographics of the staff and caseload.

The third site was located within London but contrasted with the others in scale, with a much smaller workforce and higher rate of admissions. Sampling was purposive but with an opportunistic element, as access to sites was always dependent on a willing and interested gatekeeper being identified.

The decision to use three sites for fieldwork was based on the need to balance rich, detailed data from each site with diversity from a range of sites, within the timescales afforded by the PhD programme.

5.4.3 Interviews

As with selection of study sites, sampling for interview participants was both purposive and opportunistic. There were certain key roles or characteristics I considered it important to include, but in addition it was important to be flexible and open to unanticipated opportunities.

The core sample I sought in each site included:

- staff from each of the three therapy professions (OT, PT and SLT), as well as therapy assistants (TAs) if used.
- staff with diversity in years of experience and seniority.
- patients with contrasting characteristics such as level of impairment / dependence; social situation; discharge destination; ethnicity; age.

Specific participants within this criteria were selected based on their availability and willingness to participate. In each site I sought the same core range of interview participants, but always with an openness to interviewing others who seemed to play a key role relevant to my enquiry, such as a consultant, nurse, manager or relative. Prior to inviting patients to be interviewed I confirmed with their therapists that they did not have any concerns about their suitability based on factors such as cognition or medical status.

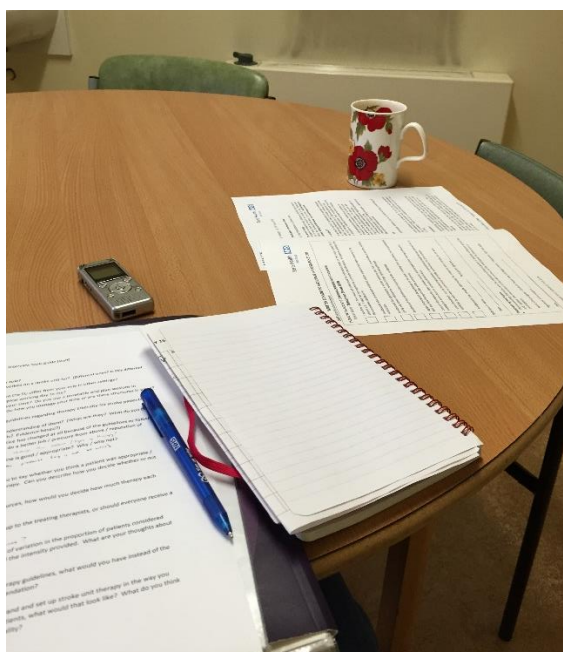


Figure 5: Set up for an interview in a meeting room

Interviews were semi-structured, with areas for discussion set out in advance in a topic guide (see Appendix B). In keeping with the guided interview structure outlined by Grbich (1999), the topic guides set out broad questions derived from theory, previous research and intuition regarding notions that required exploration (Grbich 1999). My approach to interviewing was consistent with that outlined by Britten (1995). Rather than strictly going through the questions in the topic guide, I aimed to be flexible and responsive to what was said by interviewees, allowing them to change the direction of the conversation and redirecting only when we had digressed too far or needed to be sure to cover important remaining questions. I aimed to ask open-ended questions in a neutral and sensitive manner. At times, participants would ask me questions or check whether their responses were correct, particularly when I asked them about the 45 minute guideline or SSNAP. In these situations I would either feign ignorance or explain I was interested in their perspective for the purposes of the interview but could discuss the question with them more after the interview. It has been noted that answering questions during an interview can reverse the researcher's earlier attempts at neutrality, but that if the interviewer does not answer questions this can lead the interviewee to become more closed in their answers (Britten 1995). Unlike interviews conducted in isolation, I had been carrying out participant observation with most of my interviewees prior to conducting the interviews. In general we had already established a certain level of rapport and trust, and we had usually had some conversation about my project. Therefore

I sometimes had questions in mind that followed from comments they had made or things they had done prior to the interview. I considered this an advantage of the method I was using, and found that being able to refer to my observations and probe further into elements of their practice added extra layers of depth to the data analysis.

All interviews were recorded on a dictaphone and transcribed. I transcribed seventeen interviews and others were transcribed professionally. I listened to the audio recordings of all the interviews with a critical ear in order to notice where I could improve my technique. I listened out for whether my level of directiveness was appropriate, whether I was leading participants with the wording of questions or my responses to their comments, whether I gave them enough time to make their points, and whether I picked up on cues to explore further (Britten 1995). Skinner (2012) discusses and gives examples of interview approaches, techniques and challenges. Skinner notes the importance of reflexive analysis of difficult and challenging moments in the ethnographic interview.

An interview I found particularly challenging was with a patient's wife, who I quickly understood had been keen to participate because she was concerned about her husband and wanted to ask questions about his condition. My intention to convey myself as a neutral researcher was challenged, and I had to make decisions in the moment about how to respond to her many questions. In interviews with therapists I felt comfortable taking control and re-directing the discussion when needed, but I felt a heightened need for sensitivity with this anxious and concerned relative, who was in the midst of an emotionally harrowing time. I also felt an ethical obligation of reciprocity. She had volunteered her time to be interviewed, and to ignore her questions would feel inappropriately aloof. On the other hand, it would be an abuse of my position to appear to answer on behalf of the multi-disciplinary team. Unlike the team, who seemed always to be busy and rushing, I was in a position to sit and hear her out for as long as she needed. My approach was to allow her time to ask whatever she wanted, and to answer any questions about myself or my general knowledge about stroke rehabilitation, but to advise her to consult the patient's team about specific questions. Her first questions were about me, how many years of experience I had as an OT and where I had worked. I felt obliged to answer these questions, but I felt uncomfortable with the role reversal. I usually began interviews with therapists with similar

questions, and this gave me a useful insight into how it felt for participants to be on the receiving end of my questions. The participant asked me fifteen questions before offering me the opportunity to ask her a question. After I had covered the questions I hoped to ask her, I asked if there was anything else she wanted to say. She noted she still had a lot of questions written down, so I agreed for her to go through them. I was pleased that I had allowed her the time to voice her questions and to listen to them, but without overstepping ethical or professional boundaries. The interview was not a comfortable experience and at the time I felt sure it had been disastrous. However, when listening to it and re-reading the transcript I noted that there was value in knowing what sort of things were playing on this woman's mind, and which of her questions seemed to be unanswered despite her various interactions with the team.

5.4.4 How participant observations were undertaken and used

In section 5.3.5 above I presented consideration of the use of participant observation and ethical dilemmas that could and did arise. In this section I will explain how the participant observations of therapy work were typically undertaken, and how this data informed the analysis. Participant observation often involves trial and error, and I used different approaches and reflected on these to guide me as I progressed through my fieldwork.

In the first fieldwork site, I based myself in the therapy office when I was not observing direct therapy sessions. This was because this was where therapists spent most of their time when not delivering therapy to patients. Therefore when I was not observing a clinical session I was usually observing therapists at work or interacting in the office. I sometimes based myself at the nurses station on the ward, or sat in the gym to get an overview of the activity in these areas. I experimented with different ways of arranging to accompany therapists in their daily work. In the first site therapists used timetables to plan their weekly sessions with patients, including individual and group work. At times I joined in with timetabling, using the same timetable template myself and booking in joint sessions with therapists. I would then go to find the therapist and patient at the arranged time, introduce myself to the patient, explain why I was hoping to observe the session, and seek their permission for this.

Much of the time I found that sessions had been re-arranged, so instead I changed my strategy and asked individual therapists if I could shadow them for a morning or afternoon. This was more useful, as I could experience the pace and pattern of their work time rather than just joining in with certain sessions. I therefore continued using this approach in the second and third sites, although with a good deal of flexibility. At times a therapist would become unavailable, and I often moved from shadowing one to asking to shadow another several times during the day. I observed all aspects of therapists' working day, including meetings, administration and lunch times.

Participant observation data was written up in the form of fieldnotes, and my method for writing fieldnotes varied according to the situation. In meetings it was possible to openly write plenty of notes in my notebook, as many other meeting attendees would also be doing this. I seldom took notes during therapists' clinical sessions, but kept my notebook nearby so I could jot notes down in the moments when therapists were writing up their own notes or busy with other things. In the times when I had nothing specific to do, being able to write in my notebook was a welcome task and helped me to focus my thoughts. I also wrote notes in my mobile phone. This felt more subtle in circumstances when staff around me would also be looking at or writing on their phones. I was able to write brief notes on my phone and email them to myself to edit and elaborate on in a fuller document when I returned home in the evenings.

In the first phase of data analysis I conducted line by line coding and analysed fieldnotes and interview data together, however I noticed that the fieldnotes often included an interpretation of my observations. In this sense, they differed from the more 'raw' interview data. Analysing them in the same way could give more weighting to things I had been thinking about and questioning, as these would be discussed in the fieldnotes. I therefore re-analysed the interview data without the fieldnotes, and instead re-read fieldnotes to remind myself of the things I had observed and experienced, and any early interpretations of these.

An example of fieldnotes from observation of therapists at a meeting is presented in Appendix C. As can be seen from these fieldnotes, they were used to document events as well as to prompt further questions for consideration or investigation.

5.4.5 Ethics and Research and Development approval

Ethical approval was obtained from National Research Ethics Committee London – Queen Square on 18th July 2014 (REC reference: 14/LO/0733. IRAS project ID: 144976). Site specific approval was obtained from each hospital trust's Research and Development (R&D) team. The processes for gaining the required approvals were lengthy, laden with bureaucratic requirements, unpredictable and inconsistent. It took seven months for ethical approval to be granted. R&D requirements varied amongst trusts, and unexpected obstacles usually needed to be resolved within the trust, so were beyond my control. Some of these concerned decisions about which managerial workstream the study should sit within, or who needed to sign off the costings. R&D approval for research to be undertaken took less than a month in the first site, four months in the second and over a year in the third site.

Many authors have bemoaned the bureaucratic demands of research governance as excessive and misplaced, particularly for conducting qualitative studies with a very low risk of harm (Chenhall et al 2011; Elwyn et al 2005; Fudge et al 2010; Pollock 2012; Stewart et al 2008; Wald 2004). The need to review and regulate research to ensure it follows ethical principles is not in question. However, it has been suggested that abstract or formulaic procedures that are based on bio-medical research and ignore the context of research do not fit well with observational research or interviews (Pollock 2012). Delays are frustrating, but of more concern is the risk that researchers may come to interpret 'ethical approval' as a tick in their research governance box, a requirement met prior to commencing the study. It has been suggested that qualitative researchers should seek to develop 'ethical mindfulness' in order to navigate the unanticipated ethical decisions which will inevitably arise in the field (Pollock 2012). Unlike controlled trials, qualitative research is by its nature 'flexible, emergent and negotiated' (Pollock 2012 p4), and the movement of people entering and leaving the observed field cannot be controlled by the researcher. I considered it important to strive for 'ethical mindfulness' as an aspect of the study methods, in addition to meeting the formal requirements. An example of this is the situation referred to above, in which an OT requested my assistance with a washing and dressing session. I anticipated that the patient and OT would both have consented to my 'observation', but this was not sufficient for me to feel that my presence in the shower would have been ethically justified. It is possible that I could have made a different decision based on different reasoning. The

98

importance, as emphasised by various authors, is to be mindful of the ethical implications of decisions that arise in the field, and to make these decisions conscientiously, pragmatically and appropriately to the situation (Librett & Peronne 2010; May 1980; Parker 2009; Pels 1999; Pollock 2012; Savage 2000).

5.4.6 Data analysis

In ethnography data analysis is not an isolated phase that occurs between data collection and writing up (Hammersley & Atkinson 2007). The ethnographic researcher is informally analysing observations in the process of jotting down fieldnotes and writing them up at the end of each day's fieldwork; when reading books and articles and musing on their relevance to what has been observed in the field; when transcribing and revisiting interviews; when listening to the radio or watching a film and making connections with their 'ideas and hunches' (Hammersley and Atkinson 2007 p 158). On the one hand, and consistent with the epistemological position of this study, ethnographic truths are 'partial – committed and incomplete' (Clifford & Marcus 1986 p7). However, the ethnographer should strive to tell the truth as they see it, and to be reflexive whilst avoiding the risk of being self-absorbed. Clifford and Marcus (1986) stated, "You only know a good ethnography when you read one, despite the widespread sense that there are standards" (Clifford & Marcus 1986 p 266). This is of little comfort to the novice ethnographer, already unsettled by the acknowledgement of the subjectivity involved in data analysis. It can be grounding and reassuring to have points of reference for evaluation of ethnographic research. The following possible criteria for assessing ethnographic research have been proposed: claims should be consistent with empirical data; the account should be credible to readers and those studied; the findings should have relevance to those in similar settings; the account should be reflexive; and there should be an audit trail (Hammersley 1990, Savage 2000).

Formal data analysis took place in between conducting fieldwork at the different sites. I experimented with various methods of analysis, initially feeling I was missing something as different ways of sorting or categorised the data took me no closer to the holy grail of 'findings'. I attempted to use Braun and Clarke's (2006) approach to coding and developing themes. Their six step approach is as follows:

- Familiarise yourself with the data
- Generate initial codes
- Search for themes
- Review themes
- Define and name themes
- Produce the report

The reality was less clear cut, and I found that my experience of data analysis was more attuned to that set out by Hammersley and Atkinson (2007) who note that there should be movement back and forth between ideas and data, developing ideas away from it and then returning to the data to test them. The authors liken the progressing focus of an ethnographic study to a funnel structure. Rather than entering the field with a clear hypothesis to be tested, the researcher will develop, transform and clarify the research problem as the study progresses. "It is frequently well into the process of inquiry that one discovers what the research is really about." (Hammersley & Atkinson 2007 p 160). Knowing the data is a key necessity, and although it is time-consuming to review a large body of transcripts and fieldnotes repeatedly, doing so at different stages of analysis enables different things to stand out as revealing or surprising, and different patterns to be formed (Hammersley & Atkinson 2007).

In the first stage of formal data analysis, between conducting fieldwork at the first two sites, the aim was to sort and find patterns in the data. During later fieldwork, certain theoretical ideas began to resonate with what was being observed. Therefore the second stage incorporated and tested these theories against the data. Data from all sites were revisited repeatedly. Working closely with the data I tested different ways of grouping codes, using Nvivo, sticky notes on flip chart paper, mind maps and writing prose. At a distance from the data, I read books and articles on the theories that I wanted to explore, made connections between these and the findings I had been exploring, and evaluated where they did and did not seem a good fit. I returned to the data to consider what was unaccounted for in the stories that had been prominent and the connections I had been making.

On my first attempt at coding I coded all the interview transcripts as well as all my fieldnotes. On subsequent attempts I changed my approach and only coded transcripts. My rationale for this was that interview data was raw data whereas fieldnotes were at a more interpretive level. I therefore decided to read my fieldnotes to remind myself of impressions and ideas that I had formulated, but not to code them along with transcripts. It has been noted that an important consideration in data analysis is the identity or social location of who is doing or saying things (Hammersley & Atkinson 2007). Through the process of trial and error in data coding, I found that it made sense to treat patient and staff responses separately. Although the topic guides for all interviews were similar, there was a clear difference between the content of the interviews for these two groups, and they generated different codes and themes. Treating them separately allowed me to see where there was overlap or duplication between what was reported by therapists and patients, without finding that the patient data (smaller in quantity) had been dissolved by the mass of therapists' responses.

Seeking to make connections between the data and different theories I sought to ask myself what aspect of each theory would help me to understand the data (Bensman & Vidich 1960; Hammersley & Atkinson 2007). In this way, data analysis was closely linked with selection of a theoretical framework. Data analysis involved going 'back and forth' between the data and different theoretical ideas, and attending to where these were or were not a good fit. As the fieldwork and data analysis proceeded, emerging findings were compared with the concepts and theories identified as relevant (Grbich 1999). After introducing the settings in the following chapter, the findings will be presented in the subsequent three chapters. These findings will be interpreted with reference to the relevant theory in the discussion chapter.

Chapter 6 Settings and Participants

6.1 Introduction

In this chapter I will set the scene for the study. I will begin with an overview of the three stroke units (SUs) where fieldwork was carried out, then present information regarding interview participants and how they were selected. I will then discuss each setting separately, including information about their SSNAP performance, stroke pathways, and therapy structures and processes. Descriptive details about each site will be included in order to convey my subjective impression of the different wards and the contrast between them. As well as providing a mental image of each unit to preface the findings, inclusion of information about personal connections I had with each site, access, first impressions, and interview recruitment strategies are provided in the interests of transparency and reflexivity. I will also discuss peripheral sources of information that added context and an alternative perspective to my analysis.

Pseudonyms are used for the hospitals, places and participants to protect their identity. Information about patients and staff who participated in interviews is restricted to details considered relevant to the study in order to reduce the risk of identification. The pseudonyms given to interviewees reflect the name most commonly used to address them, i.e. if a person introduced themselves with their first name then I have chosen an alternative first name. Doctors have been given full names as they would sometimes be referred to formally and sometimes by their first name.

6.2 Overview of the settings

Some details will be presented in this chapter to help set the scene and certain contrasting features will be discussed in more detail in subsequent chapters. Terminology to describe units (such as acute stroke unit (ASU), stroke unit (SU), Rehab Stroke Unit) was used differently in the different sites.

Staff band designations (i.e. Band 5, Band 6, Band 7, Band 8) are abbreviated as B5, B6, B7 and B8, with B5 being entry level for a qualified therapist and B7 generally being the most senior clinical level embedded within the teams. Different terminology was used for the role of therapy

support staff in each site. For simplicity and to reduce risk of site identification these will be referred to consistently as Therapy Assistants (TAs). In all the sites staffing was constantly changing, with staff leaving or joining, going on holiday or off sick or being unable to carry out full duties for various reasons. Comparing staffing on each unit is onerous. Should they be compared on the basis of if they were fully staffed (which they rarely were), or with consideration of part time hours (which range from half time to 0.9), or light duties? Some therapists did not solely work on the SU in question, and the roles and responsibilities of staff varied in each site. For example in the second site the Band 7 PT had a managerial role and attended the ward once a week for meetings but did not carry a caseload. In the third site the caseload was shared equally between the Band 7 and Band 6 PT. Additionally, the numbers of beds funded to accommodate stroke patients could be misleading, as these were not always used by stroke patients. Sometimes therapists were involved in the care of non-stroke patients, but not always. The staffing details presented in Table 3 are a snapshot of the staffing at the time I commenced fieldwork at each site. They are intended to give an impression of staffing levels, and the flux and variability should be noted.

I carried out over 300 hours of fieldwork in three SUs. SU details are presented in table form for ease of cross comparison, and will then be described in turn.

Table 3: Characteristics of the fieldwork sites

Site		Site A: Jade Ward, Chesney General Hospital			Site B: Olive Ward, Skydale General Hospital			Site C: Topaz Ward, Whimsford General Hospital		
Key Characteristics		London, non-routinely admitting (no HASU in the Trust). Commissioned differently for two boroughs (Chesney and Chittleford).			Outside London, routinely admitting (i.e. HASU on site). Mainly serving local area.			London, non-routinely admitting (HASU in a different hospital within the same Trust). Discharging to 3 boroughs (Whimsford, Burdale and Ormsbury).		
Number of stroke beds		24 beds			26 beds			19 beds		
Performance on SSNAP quarterly reports	July – Sept 2014	OT: A	PT: A	SLT: A	OT: C	PT: D	SLT: E	OT: C	PT: C	SLT: C
	Oct – Dec 2014	OT: A	PT: A	SLT: A	OT: A	PT: B	SLT: D	OT: C	PT: D	SLT: B

	Jan – March 2015	'Insufficient records'			OT: B	PT: B	SLT: B	OT: B	PT: C	SLT: B
	April – June 2015	OT: A	PT: A	SLT: A	OT: A	PT: B	SLT: C	'Insufficient records'		
Length of stay (days)¹ (SSNAP data April 2014 – March 2015)		Median: 63.6 Mean: 64.6			Median: 7.7 Mean: 26.4			Median: 25.5 Mean: 36.1		
Therapy staffing² (whole time equivalent per 10 beds) SSNAP Acute Organisational Audit Report 2014		OT: 2.5 (1 st quarter) PT: 2.1 (1 st quarter) SLT: 0.9 (1 st quarter) TA: 1.8			OT: 2.5 (1 st quarter) PT: 2.1 (1 st quarter) SLT: 0.9 (1 st quarter) TA: 1.8			OT: 0.5 (4 th quarter) PT: 1.1 (4 th quarter) SLT: 0.5 (2 nd quarter) TA: 1.3		
Time from first contact with R&D to approval		Under 1 month			4 months			14 months		
Fieldwork dates		August – November 2014			April - June 2015			September – November 2015		
Therapy staff in post on ward at start of fieldwork (regardless of whole time equivalent)		OT: B7; B6 x 2; B5 x 2  PT: B7; B6; B5 x 2  SLT: B7; B5  TA: 5 			OT: B6 x 4 (1 part time)  PT: B7 (part time); B6 x 2; B5  SLT: (covering whole hospital)  B7; B5; B5 TA: 2 			OT: B7 OT (part time); B5  PT: B7 (part time); B6 PT  SLT: B6; B5 (part time)  TA: 1 plus 1 on light duties 		
Summary of interview participants		PT: B7; B6; B5 OT: B7; B6; B5 SLT: B7; B6 TA Consultant Therapy Manager Patients x 3 Patient's wife			PT: B7, B6, B5 OT: B6, B5 SLT: B7, B6, B5 TA PT Clinical Lead (B8) Consultant Patients x 3 Nurse Specialist			PT: B7, B6 OT: B7, B5 SLT: B7, B5 TA OT Clinical Lead (B8) Therapy Manager Consultant Patients x 3		
Fieldwork hours		166			88			52		

¹ Length of stay from clock start to discharge from inpatient care (including death in hospital unless died on the same day as clock start)

² Staffing: *National Median: OT: 1.13; PT: 1.33; SLT: 0.52*

Staffing levels quartiles: The first quarter represents the highest staffing levels and the fourth represents the lowest nationally. All SSNAP data taken from SSNAP (2016).

6.3 Interview Participants

I interviewed 43 participants including therapy staff, doctors, managers, a nurse, patients and a patient's wife. In each site, I sought to interview OTs, PTs and SLTs of each level of seniority on the ward, a TA and a range of patients. In each site there were different prominent figures who it appeared relevant to interview in addition to these core participants. No staff members invited to participate declined, therefore interviewees were selected based on availability.

6.3.1 Staff Interviewees

Table 4: Staff Interview Participants

Site	Staff Name	Role and band
Jade Ward	Nathalie	OT B5
	Agata	OT B6
	Alexia	OT B7
	Tom	PT B5
	Joanne*	PT B6
	Jackie	PT B7
	Heidi	SLT B5
	Claire	SLT B7
	Tina	TA
	Dr Julie Hiller	Stroke Consultant
	Ann	Therapy Manager (overseeing all therapies throughout the trust)

Table continued on next page...

Olive Ward	Laura	OT B6
	Cheryl	OT B6
	Katie	PT B5
	Susie	PT B6
	Helen	PT B7
	Lucy	Clinical Lead (B8 PT)
	Sinead	SLT B5
	Sandy	SLT B6
	Judy	SLT B7
	Pip	TA
	Linda	Stroke Nurse Specialist
	Dr Stephen Adams	Stroke Consultant
Topaz Ward	Ken	OT B5
	Nancy	OT B7
	Rona	Clinical Lead (B8 OT)
	Ghita	PT B6
	Joanne*	PT B7*
	Mary	SLT B5
	Catherine	SLT B6
	Becky	TA
	Diedre	Therapy Manager
	Michael	Consultant

*Joanne was interviewed in two sites. She was a B6 PT in Jade ward during my fieldwork there, and when I started fieldwork at Topaz Ward I found that she had taken the position of B7 PT

there. Interviewing her again in her new post was an opportunity to explore the differences in her experiences of the two sites and compare these with fieldwork observations.

In Jade Ward I identified that the stroke consultant would be an interesting source of information as she frequently expressed strong opinions in meetings about inequity of services and the need to defend professional boundaries within the team. Mostly this was in relation to therapists being expected to do what she considered to be the role of social workers and discharge planners. I also identified a need to interview a therapy manager. This was in response to various observations. One was that a recurring theme in interviews with therapists was that the Trust was a good place to work, with hardworking staff who trusted and valued each other. I wanted to explore the origins of the values and culture of the institution, and thought a higher manager might be able to offer insights into this. Additionally, in the context of the evident disparity between community services and the sense of threat some therapists expressed regarding potential uses of audit data, I wanted to understand how much weight the national stroke guidelines and audits had in service commissioning and organisational decisions. In Olive Ward the clinical lead PT was very influential, so I interviewed her rather than seeking the manager equivalent the therapy manager I had interviewed on Jade Ward. Again I felt it would be useful to interview the consultant as he was very involved in discussions and meetings about SSNAP performance. I also invited the stroke nurse specialist to be interviewed as she presented as a key leader in the ward, frequently prompting staff about the need to comply with audit requirements. There was no equivalent member of staff in either of the other wards. In Topaz Ward I sought to include influential figures, such as Rona the Clinical Lead OT, but I also sought to mirror the range of participants I had interviewed in the other sites as far as possible.

6.3.2 Patient interviewees

Patient details were taken from their hospital notes (with consent) or from discussion with them or their therapists. 'Time since stroke' is measured from the recorded date of stroke to the interview date.

Table 5: Patient (and carer) interview participants at Site A

Site	Patient name	Age	Ethnicity	Time since stroke and functional level	Social situation / discharge plans
Jade Ward	Eddie	72	White British	3 months post stroke. Transferred from HASU B to a different hospital SU then Jade. No movement on right side. Dependent on wheelchair and needing assistance to use it.	Chittleford resident. 'Unbefriended' and previously unemployed. No next of kin. Previous accommodation no longer suitable as not wheelchair accessible. Discharge delayed due to need to re-house with appropriate support.
	Simon (wife, Mrs Rosenfeld, interviewed)	79	Jewish	1 month post stroke. Transferred from HASU A to Jade. Initially conversant and engaged but became unable to communicate. Dependent on a hoist to move between bed and specialist chair. Increasingly unwell – cause unknown.	Chesney resident. Previously had a respected role in 'Frum' Jewish community, living with wife and family. As condition deteriorated, family and team planned for him to be discharged to a nursing home when medically stable.
	Yemi	58	Nigerian	2 months post stroke. Transferred to Jade from HASU A. Left sided weakness but progressing. Doubly incontinent and using a hoist to move from bed to wheelchair. Progressing in therapy and managing to stand with support.	Chesney resident. Mother of young adult children, employed as a mental health care assistant. On waiting list to be transferred to neuro-rehab unit.
	Rafael	48	Brazilian	2 months post stroke. Transferred from HASU A to a different hospital SU to Jade. Made significant progress – at time of interview was able to walk with a stick and making progress with speech and use of right hand.	Chittleford resident. Was renting a room in a house share, now considered unsuitable due to stairs. Rafael was still in Jade ward when I left, but subsequently I heard from therapists that following a lengthy hospital stay he was transferred to a nursing home to await rehousing.

Olive Ward	Marcus	61	White British	12 days post stroke. Speech difficulties (expressive dysphasia), arm weakness, able to walk but deemed impulsive and at risk of falls by therapists.	Lives with girlfriend. Discharged home on day of interview with ESD input.
	Richard	80	White British	11 days post stroke. Speech difficulties (dysarthria), right sided weakness, inattention to right side.	Lives alone. Very active and independent prior to stroke. Plan to discharge home with ESD.
	Cerys	89	White British	13 days post stroke. Left sided weakness. Swallowing difficulties. Needing assistance to move between bed and wheelchair. Practising walking with assistance in therapy. Memory problems, sleep difficulties, anxious and low in mood.	Was living with husband in sheltered accommodation. Planned for one week of further rehabilitation then discharge home, but this was delayed as Cerys became unwell with a chest infection.
Topaz ward	Tristan	60	White British Jewish	18 days post stroke. Right sided facial and arm weakness. Dysphasia and dysarthria.	Previously lived alone in own flat in Ormsbury, but unable to return there due to uninhabitable condition of flat. Discharge already delayed by 12 days at time of interview, as distant relatives were taking responsibility for re-housing.
	Imran	66	Indian	14 days post stroke. Dense left sided weakness. Able to move between bed and wheelchair using a rotastand and assistance of two.	Whimsford resident. Lives with wife. Aiming to go home with support from ESD.
	John	68	White British	20 days post stroke. Able to walk with supervision. Incontinent. Cognitive impairment. Apraxia.	Burdale Resident. Lives with wife who has mental health problems, children are concerned about him being discharged home. The plan remained for discharge with support from community team, but admission prolonged due to family concerns and poorer community services in Burdale.

Recruiting patients was approached differently in the different sites. In Jade, I got to know many patients through observing groups and individual therapy sessions, and after three weeks of having an overview of the ward I decided to focus on five or six patients. I was keen for some diversity in the patients I interviewed, so I focussed on a selection of patients from different ethnic groups, with different levels of disability, age, gender, social situations or plans for discharge. I intended to interview three patients in balance with the numbers of each professional group I interviewed. The three patients who were interviewed were the first to provide consent. One of the patients I had hoped to interview began to deteriorate medically and functionally, and was no longer able to communicate. I approached his family with information about my study and his wife telephoned me later the same day, very keen to be interviewed on his behalf.

On Olive Ward I noted that the presentation of patients on the ward was very different from those on Jade ward. Patients who were able to transfer with assistance were discharged quickly with support from the Early Supported Discharge team. The stroke consultant nurse conducted her own daily round of the ward to check on every patient, so I accompanied her in the hope that I could introduce myself to as many people as possible. Many patients were unwell or too impaired in cognition or communication to consent to be interviewed. After excluding the unsuitable patients I was left with three who we agreed I could invite to participate. Therapists said I could try to interview one (Cerys) but it might be difficult as she had significant memory problems. Marcus and Richard both had communication difficulties and sometimes needed help to find the right words, or used gesture. This presented some challenges during interviews but I found that the participant observation prepared me well for the interviews as I had a baseline of understanding about what they had been doing and who they might be referring to. I approached family members with information about my study but none volunteered to participate. On Topaz Ward, I was guided by therapists regarding potential interviewees.

6.4 Individual fieldwork sites

For each site, I will present contextual information in the following order:

Name of ward, hospital, borough, and boroughs served by the stroke unit.

- SSNAP performance

- Stroke Pathway
- Therapy structures and processes
- Access and subjective impressions

6.4.1 Site A: Jade Ward

SU name: Jade. Hospital: Chesney General. London Borough of Chesney. Serving the boroughs of Chesney and Chittleford.

6.4.1.1 SSNAP performance

When I began fieldwork Jade ward had consistently scored an A grade for the therapy domains of the SSNAP audit. I was interested in finding out how they achieved this, whether this was important to them, what (if any) changes it had led to in practice, and whether there had been any unintended consequences. I was keen to find out how they decided whether patients should be deemed 'appropriate for therapy' and therefore applicable for to be audited for therapy domains. There was little sign of the controversy I had come to anticipate regarding the 45 minute guideline. The team appeared to be doing well almost by accident, as they had not changed practice to achieve the target. Prior to the introduction of the audit they had already used a computer system to record their patient contact time for organisational purposes, and an administrator extracted data from this system to enter onto the SSNAP website. Therefore there had been no change in the way therapists were required to record their time. The timetables they filled in for their weekly planning were divided into 30 minute blocks, so they would typically block out 30 or 60 minutes for a session. When I asked therapists how they recorded their time (e.g. what they included as patient contact; whether they recorded the actual or planned time) I found there was no consensus, and they either made decisions based on individual initiative or what they had been told in a previous team.

6.4.1.2 Stroke pathway

Following the restructuring of stroke services in London, the neighbouring borough of Chittleford commissioned a number of beds on Jade for stroke rehabilitation. This meant that there was a difference in the pathways for Chesney and Chittleford patients. I was told that Jade served as an acute and rehabilitation stroke unit for Chesney patients, but only as a rehabilitation unit for

Chittleford patients. Chesney patients were typically taken by ambulance to the designated HASU at a different hospital, and would then either be discharged straight home or repatriated to Jade within 72 hours. Patients from Chittleford were initially taken to a different HASU. From there they would go to an acute stroke unit and then, if not considered able to return home, would be transferred to Jade. There were also significant differences in the support options available to Chesney and Chittleford residents on discharge which influenced decisions about whether they should remain on Jade. Chesney had a responsive and well-regarded early supported discharge team (ESD) as well as a residential intermediate care unit available as a 'step down' for patients with rehabilitation goals. Chittleford's community rehabilitation team was not well regarded by the team who told me the waiting list was long and when input was provided it was not intensive. These differences were a significant consideration for the team in their planning, and will be discussed in more depth in a later chapter.

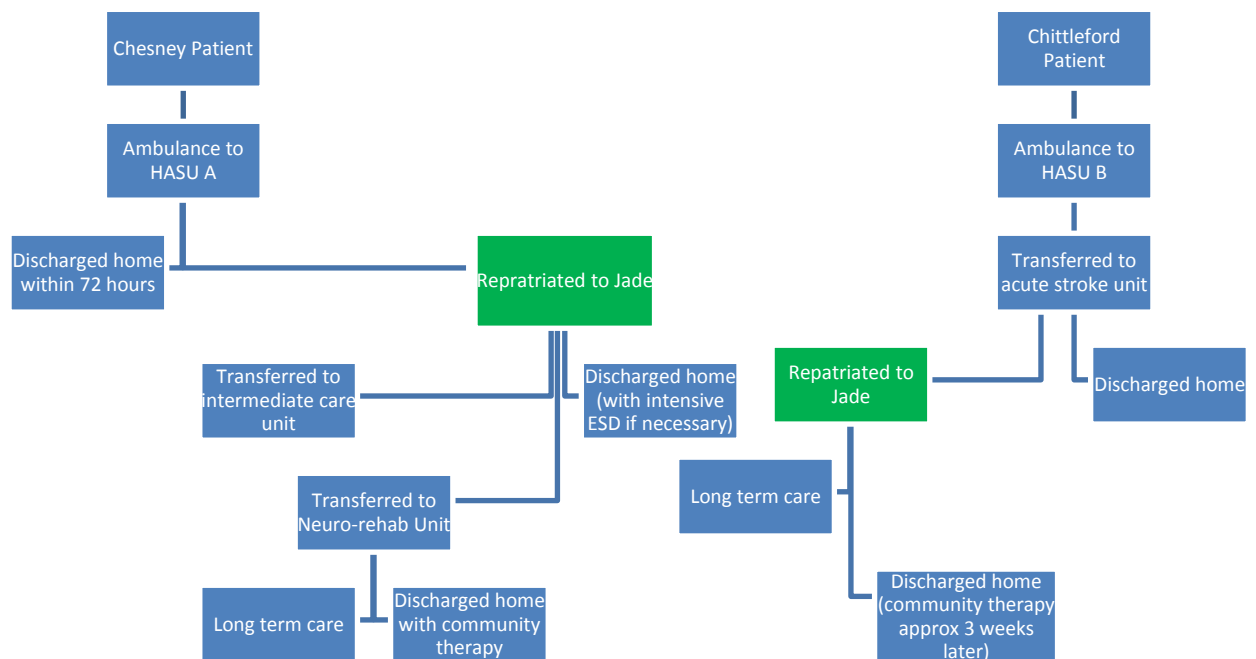


Figure 6: Flow diagram showing stroke pathway for Chesney and Chittleford patients

6.4.1.3 Therapy structures and processes

Notwithstanding a constant stream of staffing issues, Jade seemed to have a large therapy team including OTs, PTs and SLTs from junior (B5) to senior (B7) level and several therapy assistants (TAs).

OTs, PTs and SLTs working on Jade shared an office. The ward, office, gym and therapy kitchen were all located in close proximity and were all places where the therapists might be found working, having meetings, or talking to colleagues. Aside from the office, patients could be found working with therapists in each of these spaces, either in groups or individual sessions. Certain patients would also be set up in the gym to use the facilities such as the exercise bike on their own, or with the therapists in the office checking on them from a distance.

A weekly timetabling meeting was frequently spoken of as chaotic and stressful. All the OTs, PTs, SLTs and therapy assistants (TAs) would put the tables together in the gym to form a very large table, and sit around it, equipped with pencils, rubbers, marker pens and wipes. Each patient had a laminated timetable which would be completed in the meeting along with the therapists' timetables. At the start of each meeting therapists booked in sessions for groups, goal setting, arm reviews, discharge-planning meetings, the multi-disciplinary team meeting and allocated time to update patient outcome measures. Additionally, most therapists had teaching sessions and other meetings already planned, which meant there were often not many spaces left on their timetables to allocate to patient sessions.

A typical day involved a therapist coming in early for nursing handover, then reporting this back to the therapy team at 8.30am and checking on processes for completion by them. One or more therapists would then attend another handover meeting with medical and nursing staff. Most therapists considered it difficult to see patients before 9.30am as they were being washed by nursing staff. Through arranging joint sessions to shadow therapists I soon discovered that the carefully planned timetable was changeable. Therapists would rapidly shift, juggle and re-prioritise sessions in ad hoc conversations as they moved around the therapy spaces. I often arrived for a session to discover that it had been carried out earlier, postponed or cancelled. The patients I spoke to seemed to like having their therapy sessions marked on their weekly

timetables, and as the work of the therapists was highly visible to them they understood that sometimes plans would change.

By far the biggest preoccupation and source of complaints from therapists was the Continuing Care Panel paperwork (CCP). This was a lengthy series of forms completed by the team to document the level of needs a patient had for ongoing assistance. This would be used to inform decisions about whether funding would be provided from health or social services budgets to meet a patient's needs, and to what extent. Following a year of preparation for fieldwork I had expected to encounter some impassioned discourse about the merits and challenges of the 45 minute guideline, but instead found it was of little consequence to therapists here. I began to wonder what drove the feeling of imperative to complete the time consuming discharge paperwork that often took priority over spending time with patients, and I was also keen to find out whether this was a common experience in other sites.

6.4.1.4 Access and Impressions

I had previously worked in the borough of Chesney, and had been an OT on Jade from September 2005 to January 2006. This was prior to the introduction of HASUs and re-structuring of stroke services described above. Other changes since my time there included re-structuring of the physical environment (re-locating the therapy gym and therapy office closer to the ward); being commissioned to provide a service to the borough of Chittleford; and an increase in the therapy staffing levels. Therefore it was no longer a place whose workings I knew and understood. I did know some of the people working there, and this was helpful in speeding up the process of R&D approval and gaining access. I arranged to meet the B7 OT and PT (the B7 SLT was on leave at the time) to discuss how I would conduct the research. They gave me information about team staffing and we discussed what the best forum would be to introduce myself to the team. The meeting with them gave me an insight into the lack of clarity relating to the 45 minute guideline. We agreed that I should come and speak to the therapists in their next breakfast meeting, and begin fieldwork from then. The breakfast meeting was combined with time allocated to clean the office and therapy areas, and helping with this seemed like a good way to establish my participant observer role.

My impression of Jade was of a busy, bustling place. A hive of activity. Therapists were always engaged in something, and I felt uncomfortable about interrupting them to ask questions. Later, in an interview, a patient described it aptly.

“Sometimes in mornings this place look like a market, a market, do you know?”

Rafael, Jade

Like him, I sometimes found the noise and ‘hustle and bustle’ on the ward overwhelming, especially in the mornings. This was a combination of teams of doctors on their ward rounds, nurses getting patients ready, phlebotomists coming to take blood, phones ringing and staff interacting noisily to make themselves heard over the din. There was a full timetable of therapy groups: breakfast group, lunch group, newspaper group, standing group, creative group, stroke education group; and a steady stream of patients being taken to and from the bathrooms, gym or therapy kitchen.

6.4.2 Site B: Olive Ward

SU name: Olive. Hospital: Skydale General. Outside London. Serving own area with occasional outliers.

6.4.2.1 SSNAP performance

Olive’s performance on the SSNAP audit changed significantly and ranged from an E to an A, generally improving over time although with some fluctuation (see Table 3).

6.4.2.2 Stroke Pathway

The stroke pathway was less complex here than in the first site. All patients in the county with a stroke came to Skydale’s emergency stroke receiving unit. From the HASU patients would be repatriated to their local acute stroke unit, which for local residents was Olive Ward. From Olive Ward patients could either be discharged home with intensive input from the responsive Early Supported Discharge Team (ESD), or if necessary they could be transferred to a regional neuro-rehabilitation unit.

6.4.2.3 Therapy Structures

There was no weekly timetabling on Olive Ward. When I commenced fieldwork there were no groups, although some ad hoc groups were arranged during the time I was there. The only scheduled events were the weekly multi-disciplinary meeting and daily 9am meetings with the aim of moving patients through the pathway. OTs and PTs typically congregated in the office briefly at the start of the day and then met on the ward to plan and prioritise the caseload. They had a desk at a distant end of the ward, where they told me they had been 'banished' by nurses who said they made too much noise at the nurses' station. Every morning they reviewed the list of patients, prioritised who needed to be seen by therapists, and arranged times for joint sessions. A list of patients to be seen by TAs was written. The reasoning behind this prioritisation and division of labour will be discussed in subsequent chapters. Throughout the day in response to patients being unwell, unwilling or unable to participate in therapy, therapists would confer, take the handwritten lists out of their pockets and re-arrange their plans.

6.4.2.4 Access and Impressions

Skydale General was suggested to me as a potential site by a contact who knew about my study, and who had been liaising with the physiotherapy lead of Olive Ward about their efforts to improve their SSNAP performance. I was keen to take the opportunity to conduct research there because of the contrasts it offered to Jade Ward: it was outside London, it had been performing badly on the audit and then improved, and its local HASU was on the same site. I anticipated a different, more affluent local population. When I met Lucy (clinical lead) she struck me as very knowledgeable about the details of SSNAP including how scores were calculated, national variation and her own team's performance. We agreed that I would begin fieldwork by attending a multi-disciplinary team meeting the following week and she would introduce me to members of the team. I gave her several laminated posters with details about my study and a picture of myself which she put up in the ward and therapy areas. When I began fieldwork I was surprised how effective these had been, with staff members greeting me welcomingly and saying they recognised me from the posters. Coincidentally, I also had a personal connection with Skydale General. It was in the region where I grew up, and where some of my family still live. This, and

rudimentary knowledge of the local football team, gave me some common ground to help build relationships there.

There were multiple and various differences here from Jade ward. The therapy offices were located in another part of the hospital, so therapists were based on the ward for most of the day. Unlike the Jade therapists, they were rarely on a computer. A small gym was located on the HASU, and when therapists wanted to use this for a session they would wheel the patient there in their hospital bed (discussed on p134.) The ward seemed quiet, and I tried to identify why it did not have the 'market place' hubbub of Jade Ward. Therapists seemed calmer than those on Jade, and there was less sense of them juggling different demands. There was no mention of the discharge related paperwork that had absorbed so much of the Jade therapists' time. OTs did not appear to do home visits, instead asking relatives to provide information about the home environment and relying on the community team to address any issues that arose on discharge. The ward layout also appeared to be a factor contributing to the different atmosphere. It was formed of a series of long corridors with bays branching off it. Most patients were washed and toileted in or beside their beds; therefore there was not a flow of patients moving between bedsides and bathrooms. A large proportion of the caseload was very medically unwell, and the most common reason for the crowding of a corridor was the presence of family members keeping anxious vigil.

When noting the length of stay for patient participants I realised that it was appropriate to count in days, whereas on Jade I had measured this in months. This prompted me to ask about their average length of stay on the ward. I asked therapists, the ward clerk and the consultant, and was met with the same bewilderment by each. They told me they did not look at average length of stay because it would not make sense – some people stay for a very long time and some for a short number of days.

Another significant and stark contrast was the extent to which the whole team was aware of the 45 minute guideline and SSNAP. 'SSNAP' was used as a verb here, and various SSNAP-related neologisms had entered the therapy lexicon. Conversations occurred on a daily basis about

whether a patient was 'SSNAPing' or should be 'SSNAP-stopped'. This will be discussed in depth at a later point in the thesis.

6.4.3 Site C: Topaz Ward

SU name: Topaz. Hospital: Whimsford General. London borough of Whimsford. Serving the boroughs of Whimsford, Burdale and Ormsbury.

6.4.3.1 SSNAP performance

Other than some fluctuations and an absence of data in the most recent report, Topaz was mostly achieving Bs and Cs for therapy. In stark contrast to my experience at the second site, nobody I questioned was sure how they had been performing. Whilst there was a general awareness of the 45 minute guideline, most therapists had a limited awareness of the audit other than knowing that they had to write down the time they had spent with sessions on a sheet of paper. This changed towards the end of my fieldwork when the senior members of the team began to prepare for an external stroke inspection visit. At this point discussions ensued about how they were recording and reporting their time.

6.4.3.2 Stroke Pathway

Topaz Ward served residents of three different boroughs. As in Jade Ward, the disparities between services available in each of these boroughs was evident and problematic. Whimsford, the local borough, had a well-regarded and responsive Early Supported Discharge team, whose office was located on site near Topaz Ward. Burdale and Ormsbury had less adequate community therapy provision, and there was a strip of 'no man's land' between the two boroughs where unlucky residents fell between the geographical boundaries of community services.

6.4.3.3 Therapy Structures

Therapists and doctors shared an office and used this for their administration and the multi-disciplinary meetings. SLTs had a separate office but spent much of their time in the shared office. Every morning the team met for a meeting to discuss the caseload and action plans, and therapists would also have a 'wrap up meeting' at 4pm to check progress. Other than the weekly multi-disciplinary meeting and a fortnightly therapy teaching session, there were few fixed events

in the working day or week. Like the therapists on Olive Ward, therapists did not plan their time in advance but prioritised together each morning and re-grouped throughout the day to compare progress, re-arrange and re-allocate tasks. OTs, PTs and TAs worked a split shift, with some working from 8am – 4pm and others from 10am – 6pm. During my fieldwork it was identified by the team that the extra handovers and planning discussions that were taking place because of the split shifts were taking up too much time, and they tried to identify ways of improving the efficiency of communication within the team. Unlike therapists in the other sites, Topaz therapists were not allocated specific patients but shared responsibility for the whole caseload. As there were only two of each profession and some did not work every day it was considered essential for all therapists to know every patient and for them to be flexible in who they saw and what tasks they did. On Jade Ward the B7 OT and PT only took responsibility for one or two patients in order to accommodate their non-clinical, leadership roles, and on Olive Ward there was not a B7 OT or PT based on the ward, whilst on Topaz there was no differentiation between the clinical workloads of the B7s and their therapy colleagues. The throughput of patients was rapid, with the aspiration being to plan ‘a golden discharge’ which meant discharging a patient the next day before 10am. A ‘silver discharge’ was a discharge the next day before 12pm, and a ‘bronze discharge’ was the next day before 4pm.

6.4.3.4 Access and Impressions

I knew the clinical lead at the Trust as we had previously worked at the same Trust (but not in the same team), and through mutual friends and contacts in the network of professionals with an interest in stroke rehabilitation. She expressed an interest in the study and was keen to increase her team’s involvement in research. I had assumed that having her as ‘gatekeeper’ would enable easy access to the Trust, and I expected it to be my first research site. In fact it was by far the lengthiest and most time consuming R&D process and as a result this was my third and final site.

Unlike the other sites, this Trust included three stroke units on different hospital sites. Due to the time constraints of my PhD I limited myself to collecting data on one site, but further insights were gained by hearing staff and patients discuss the contrasts between sites within the Trust. The merging of trusts had taken place approximately two years ago, and staff who’s employment pre-dated the change referred to it as ‘the takeover’. My impression was of a team that had

suffered a trauma and was re-building itself in an attempt to rise from the ashes, but still in a context of severe financial difficulty. The entire therapy team was relatively new. The B7 OT and PT had been in post for under a year, and these were their first B7 posts. The B6 SLT had been in post for 18 months. Other therapists were rotational and had been in post for up to six months. There were many references to challenges that they were now going to be able to start working on; problems in the ward culture; difficult times and the history of the unit.

The poverty of the unit was striking. It appeared old, shabby and under-resourced. As I shadowed and spoke to therapists I learnt that equipment such as wheelchairs and hoist slings had to be shared amongst all the patients. The heating blasted out uncontrollably and was tackled with wide open windows and electric fans shifting the hot air. The hospital was in special measures following a scathing report from the Care Quality Commission (CQC), and this was often mentioned. Although Topaz ward itself had not been highlighted by the CQC, hospital initiatives aiming to improve performance were visible on the unit. Staff responsible for monitoring 'patient flow' would attend meetings, and discharging patients as quickly as possible appeared to be the primary objective for the whole team. Unlike at Olive Ward, where I was unable to gather data about the average length of stay because the team did not collect this information, on Topaz Ward reducing length of stay was considered to be imperative and worthwhile. When I met the clinical lead to plan my fieldwork she proudly informed me that in the past year the average length of stay on Topaz had decreased from 45 days to 18 days.

6.5 Peripheral sources of information

6.5.1 Meeting the key strategic leaders for stroke quality improvement

At the start of my PhD I was aware that the 45 minute guideline had been received with hostility by some therapists. During the planning stages of my study I wanted to gain a better understanding of who the key people behind the guideline and the audit were, how the 45 minute guideline came about and their perspective on the surrounding controversy. I struggled with what terminology to use for these key people, who are well known by name in the field of stroke policy and research. Policy makers may be accurate but does not seem fitting as it sounds governmental and bureaucratic, whereas many of the leaders in question come from clinical

backgrounds and some are still in clinical practice. When I asked one how she should be defined she suggested 'stakeholder', but this term is too broad to be helpful, as every participant in the study is a stakeholder. I also came to realise that there are blurred lines between the guideline setters, the audit leaders, and academics involved in stroke research. Through making contact with some of the key national strategic leaders I was able to gain a clearer understanding of the hierarchy involved.

The Stroke Programme is based at the Royal College of Physicians (RCP), began in 1996, and aims to drive quality improvement in stroke. The Intercollegiate Stroke Working Party (ISWP) is a group made up of senior representatives of professional groups and stroke researchers that contributes to programme decisions. In their own words, "The programme measures compliance in the organisation and delivery of stroke care against the evidence-based standards that it sets in the National Clinical Guideline for Stroke (now encompassed within the NICE quality standards)... The Intercollegiate Stroke Working Party (ICSWP) oversees the work. It is made up of senior representatives from all the professional bodies involved in stroke care, as well as the voluntary sector and patient representation." (Royal College of Physicians (RCP) 2016). The Sentinel Stroke National Audit Programme (SSNAP) sits within the Stroke Programme.

As part of my exploration of the research topic I arranged meetings with the National Clinical Director for Stroke (also chair of the ICSWP) and the SSNAP Programme Manager. I also had conversations either in person or by telephone with senior representatives of OT, PT and SLT who had been on the ICSWP at the inception of the 45 minute guideline. Through these conversations I learnt that there had been a strong push from the leadership that the intensity guideline should be aspirational and that increasing the provision of therapy would be beneficial. Later, when I was conducting fieldwork and interviewing therapists, I was interested in hearing their impressions about who the people behind the guideline were, and comparing this with my own (now better informed) impression.

6.5.2 Meeting the natives outside the field

In other types of study subjects may stay in the laboratory. In this study I found myself writing fieldnotes and reflections on a whole range of situations that had not been part of the study design.

I socialised with therapists who talked to me about the challenges they faced or changes they were experiencing in their services. I unexpectedly encountered therapists from the research sites (e.g. at conferences) who updated me about their wards and the patients I had known. Several weeks after I had finished fieldwork at Skydale General my father was admitted to their stroke emergency assessment unit and I found myself experiencing the service as a family member. The experience gave me a new perspective on the study and seemed to offer a sort of triangulation. I had previously been a stroke therapist, then through my PhD I found myself in the world of the Stroke Programme leadership, and now I was given a glimpse of the receiving end. In less dramatic and more deliberate examples of peripheral data collection, I attended meetings that I was invited to by people who knew about my study. These included a 'therapy intensity workstream', attended by senior practising therapists who wanted to improve therapy intensity in their stroke units. Other meetings included a regional stroke network group and Pan London Stroke Meeting. In all of these fora I sought to be clear about my role as researcher, beginning by introducing my interest in attending, minimising my own contributions to discussion and taking notes. While the findings presented in the following chapters are based on data from the observations and interviews at the three sites, some of these peripheral activities informed my thinking and raised questions for exploration. Where my analysis of fieldwork data was influenced by these peripheral activities I will acknowledge this and give examples.

Therapy on Stroke Units: Overview of Findings Chapters

This diagrammatic representation of Chapters 7-9 is included to provide an outline of their structure.

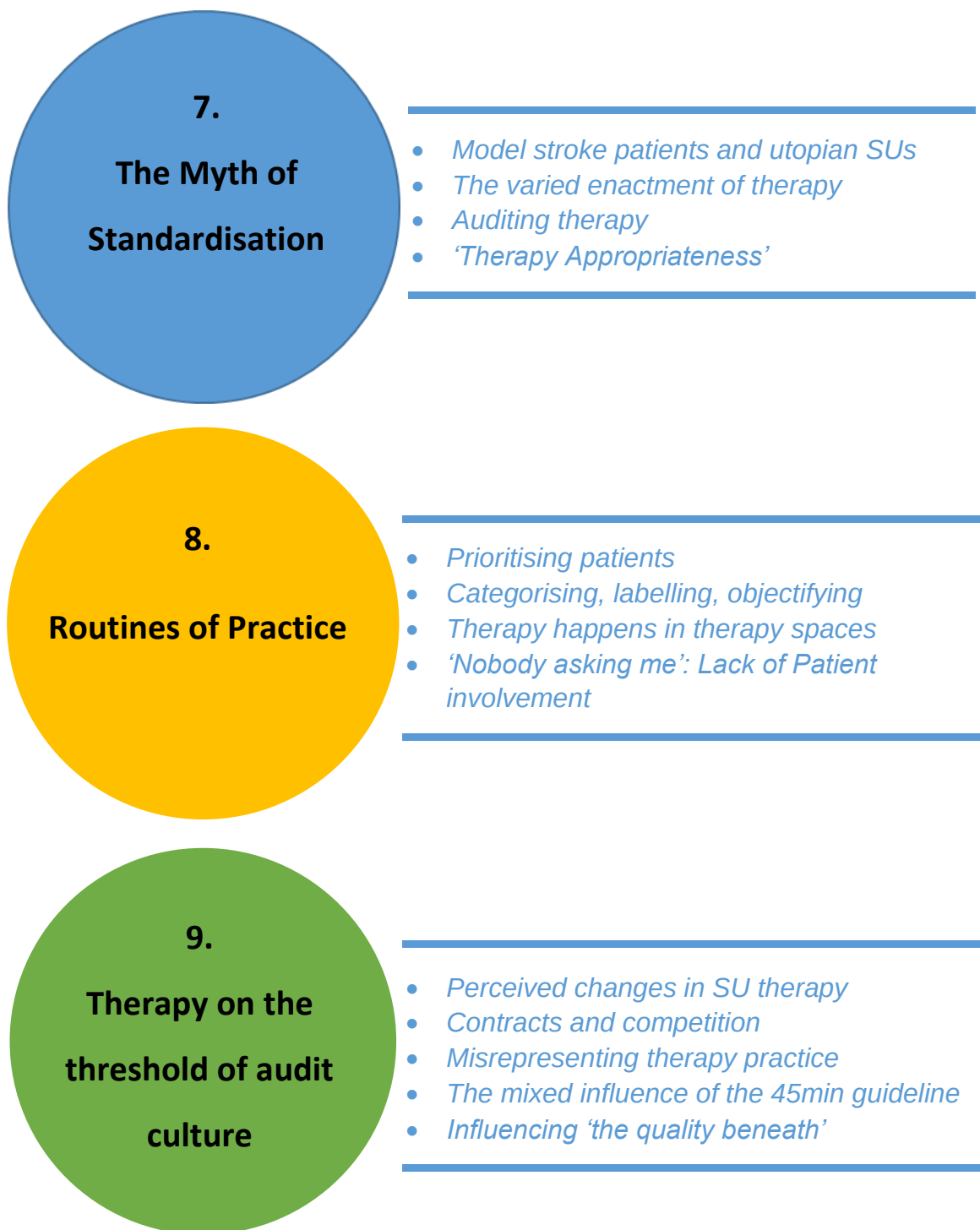


Figure 7: Structure of Findings Chapters

Chapter 7 : The Myth of Standardisation

7.1 Introduction

“A critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest...” (Foucault 1988 p155)

“We need to understand where we are before we jump in and change it. We need an underpinning theoretical understanding of what’s going on.” (Member of Therapy Intensity Workstream meeting, discussing implementation of the 45 minute guideline. November 2014)

In a narrative synthesis of qualitative studies I found that there was no consensus in the literature regarding how inpatient stroke unit (SU) therapy should be defined (Taylor et al 2015). Through my ethnographic fieldwork and interviews it became apparent that SUs and SU therapists did not have clear, singular or static functions. I found heterogeneity in individual SU patients, contrasts in the casemix of patients between sites, and contrasts in the approaches to stroke care and the atmospheres of the different wards. In this chapter I present examples of the different types and approaches to therapy that I found enacted in the settings, and describe the sense of muddle I discovered when I probed therapists about their purpose. Following Aristotle’s function argument (Aristotle 1998), I argue that the confusion therapists expressed regarding their purpose is problematic. In order to appraise the quality of therapy, it is important to understand its function or purpose. Like Lipsky’s street-level bureaucrats (SLBs), therapists on SUs were faced with conflicting expectations and goals, and pressures and priorities varied across the teams.

7.2 Model stroke patients and utopian SUs

In this section I argue that a false notion of archetypal stroke patients and SUs is implicit in the 45 minute standardisation programme. In practice, the therapy needs of individual patients varied. At the same time, there were contrasts in the overall presentation of patients in each SU. I refer to this as contrasts in the casemix. SUs also had contrasting attitudes and practices regarding stroke management.

7.2.1 They're not 'model stroke patients'

Many patients had co-morbidities, unclear diagnoses, or factors other than their stroke which influenced the teams' treatment decisions. A medical student doing an elective placement on Jade Ward during my fieldwork period conducting a snapshot audit of co-morbidities in stroke patients on the ward found that all patients with atrial fibrillation (AF) also had at least five other medical problems.³ Patients were often taken off the ward by hospital porters to attend oncology or cardiac appointments, as well as stroke-related scans and investigations. Many patients had dementia. Some were termed 'bariatric' due to their larger size and weight, and had specific needs relating to this.

The clinical intervention of therapists was not restricted to providing 'stroke rehabilitation'. Many of the problems they addressed were not a direct result of the stroke, and therapists were often involved in exploring differential diagnoses and alerting doctors to potential medical considerations.

Dr: I'm not quite sure what's wrong with this lady.

SLT: Before admission she had bouts of slurred speech. She had a fall and hit the back of her head 3 months ago. She had problems with her communication and memory and that's when she picked up the dementia diagnosis. I was querying MS [multiple sclerosis] or PD [Parkinson's Disease].

Dr: The scan looks like there are a few old strokes. She doesn't have risk factors.

PT: She has reduced initiation for sit to stand, and slow processing following commands. Her anxiety overrides her physical ability. She freezes and forgets how to walk when she is walking. She's got a weird gait and posture.

Dr: So she does walk? Can I please see her tomorrow standing and walking? That would be very helpful.

Figure 8: Notes from a multi-disciplinary meeting on Jade Ward.

³ The draft for the forthcoming Stroke Guidelines (ISWP 2016) states that three quarters of patients with acute stroke admitted to hospital have at least one comorbidity, and one in ten have at least three.

Variation in patients' presentations affected therapy plans. In interviews, phrases such as 'it depends on the person' recurred as therapists explained the various reasons why generalisations about patients' needs were not applicable. Junior therapists on rotations spoke of the SU being notoriously challenging compared with the other settings they worked in due to the range of problems they were expected to be able to assess and treat.

Patients' energy levels and ability to engage in therapy varied. Individual patients could fluctuate during their stay, and the stroke was not always their most pressing issue. Attempting to arrange interviews with patients gave me a sense of the experiences of therapists, who could not rely on forward planning or standardised approaches to treatment when working with very changeable people and situations. My plans to interview one stroke patient were delayed when I found he had been transferred to another hospital for HIV and syphilis treatment. Following his return to Jade Ward he engaged enthusiastically in intensive therapy for a time, then became angry and expressed wanting to kill himself and others. He remained on the ward but with input from the psychiatric team, and I wondered whether to abandon plans of interviewing him. Another patient I had intended to interview was initially very keen to engage in therapy and speak to me about his experiences, but he began medically deteriorating and the reason was unknown. Similarly, therapists were often monitoring how patients progressed on their unpredictable paths, rather than programmatically attempting to provide 45 minutes of rehabilitation to all.

7.2.2 Contrasts in the 'casemix'

Having completed preliminary data analysis from Jade Ward and noted the contrast between the patients there and the idealised stroke patient, I found fresh contrasts in Olive Ward and Topaz Ward. In Jade Ward I had got to know certain patients who received therapy over a number of weeks or months. In Olive Ward it was rare for patients participating in rehabilitation to stay longer than a week. Staff who had been working at the trust for several years told me they had noticed a change in the typical range of patients in terms of their ability to engage in therapy. In interviews I asked, "if you could wave a magic wand and set up SU therapy in a way that you thought would best benefit the patients, what would it look like, and what prevents it from being a reality?". The reply from an SLT was a perspective shared by her colleagues.

“Preventing it being a reality are the patients... So, if you thought about your utopian stroke unit with stroke patients that were sort of sitting out of bed at 9 waiting for you to wheel them off to therapy, or a lovely big group room so you could do good groups with you know, enough staff that you could do them well... Really that would require that not three quarters of the stroke unit were very unwell or had bits and pieces that are unwell. And the reality of stroke is that they often are unwell. And you don’t often get big swathes of younger, energetic well people. You just don’t.”

Sandy, B6 SLT, Olive

Although reminiscent of my observations of Jade Ward, the ‘utopian stroke unit’ Sandy described was far from the reality on Olive Ward. In Olive Ward many patients were too unwell for rehabilitation. Those who were well were discharged very rapidly. I realised that I would have to be quick and interview those patients who were willing and able to participate within the first days of admission, as their stays were likely to be very short. The consultant noted similar impressions of the ward’s typical caseload.

“We end up on our rehabilitation ward with quite a lot of dependent patients... We might have twenty-six patients on that ward and you might only have a handful who are actually having active rehabilitation at any one time. And there’s quite a lot having a trial of rehabilitation which is more for the benefit of the families, quite often, rather than for the – you know, because we genuinely think they’re going to improve.”

Dr Adams, Olive

Dr Adams speculated that factors influencing this were the introduction of a strong Early Supported Discharge team (ESD), the existence of a separate rehabilitation unit that people requiring inpatient rehabilitation could be referred to, and the increasing age of the general population including stroke patients, which he associated with an increased likelihood of frailty.

Topaz Ward was situated within a large NHS Trust and therapists had often worked in different SUs across the Trust. They described differences between the SUs, including the influence of local demographics on the therapy needs of patients. For example, in the hospital located in a

population with a high Bengali population it was common for families to be keen to care for their relatives at home, so these patients tended to be discharged relatively quickly. Therapists told me that Topaz Ward was in an area that was seen as having an older local population, therefore patients there were more likely to remain on the ward for a longer period awaiting discharge to nursing homes.

“But, with this older population, incredibly disabled - you’ve been on the ward, you’ve seen what they look like. It’s an old, very disabled environment.”

Rona, Clinical Lead, Topaz

The ‘hub and spoke’ stroke model (see p91) influenced which patients would be transferred to Topaz and therefore the type of therapy provision that was required. The priority for stroke teams across the Trust was to ensure beds were available in the hyperacute SU (HASU), located in a different hospital. Patients who could be discharged from the HASU with community support would go straight home, so those patients who were repatriated to Topaz were more likely to have complex discharge-planning needs which were too time-consuming to resolve from the HASU.

In Jade Ward, it was common to have patients with problems with an unclear immigration status, affecting their entitlement to certain services. ‘Social issues’ such as this often led to patients staying on the ward, despite being medically well, reasonably independent and able to participate in intensive rehabilitation. Jade therapists were commissioned to provide services to patients from the boroughs of Chesney and Chittleford. Chesney and Chittleford patients tended to have different therapy needs, discussed further in Chapter 8 (p8.3.2158).

7.2.3 Differences in SU culture: ‘Rehab was the ethos... we’re just a stepping stone’

Staff who had worked in different SUs observed that in addition to the patient differences outlined above, SUs had contrasting cultures of stroke management and rehabilitation. Topaz staff most often raised these contrasts, as they had experienced the three different hospitals within their Trust. The hospital in which the HASU was located was spoken of as big, modern and well resourced. The HASU was only intended to accommodate patients for up to 72 hours, so their process-focussed approach was often discussed.

“[The HASU] is a factory, it’s a proper, proper factory. And we know how to do it dirty and we know how to do it quickly and we know how to churn. It’s literally, it’s a machine.”

Rona, Clinical Lead, Topaz

Rona and others contrasted this with their impression of Topaz which they said had a very different atmosphere and felt like a family. Michael, who was the lead stroke consultant across the trust, had a different perspective. Whilst many Topaz staff spoke fondly of its familial atmosphere, Michael found it regressive and slow compared with the slick and speedy HASU. He noted that “stroke is a completely different thing at [other hospital within the Trust] to what it is here”. He blamed the ‘negative culture’ at Topaz for keep patients at a low level.

“They’re not trying to make people better, they want, they almost want them to be – there’s just too many people being fed nasogastrically. Every time I come, everyone’s in bed.”

Michael, Consultant, Topaz

Joanne had moved from her post as B6 PT on Jade Ward to B7 PT on Topaz Ward, and was therefore able to compare these SUs.

“Ultimately they [Topaz] don’t have as much money... So that’s in terms of equipment, but also in terms of staffing. And that’s very, very apparent... Jade is a lot more established and smoother running in that way... On Jade when I was there, rehab was the ethos. You go there for rehab. So the way you come in you should go out at a different level, a better level hopefully. Here we’re just a stepping stone to having your rehab at home.”

Joanne, B7 PT, Topaz

This depiction corresponded with my observations of both wards (see Chapter 6). Therapy was enacted differently on Topaz ward because the therapy team was far smaller and focussed on discharging patients rather than rehabilitation. There were differences in average length of stay and attitudes concerning this across the research sites. Jade Ward therapists were aware of the

number of days for which each borough commissioned their service, but patients frequently outstayed this number. The team at Olive had no regard for measuring or monitoring length of stay. This was in stark contrast to Topaz Ward, where the priority for the whole team was to facilitate discharge.

“It often feels like we do assessments, we put something in place and say, ‘Okay, at least if they go home now, they’ll be okay’. And then they don’t necessarily get to that next level all the time.”

Catherine, B6 SLT, Topaz

Topaz therapists repeated the mantra: ‘Rehab happens in the community’, and the clinical lead and consultant expressed approval that the message that ‘discharge is king’ was getting through.

I have shown the variation amongst stroke patients and their deviation from the decontextualized image of the ‘model stroke patient’ constructed by 45 minute guideline. I have highlighted contrasts between SUs, arguing that the categorisation of ‘stroke unit’ gives a false impression of uniformity. Having shown contrasts in the settings in which therapy is performed and the patients for whom it is provided, I will now focus on the variation in the enactment of therapy itself.

7.3 The varied enactment of therapy: Task, Place and Purpose

As noted in Chapter 2.5 (p25), differing definitions of therapy and rehabilitation have been used in the literature, some broad and some narrow. In this section I show that broad and narrow definitions of therapy were enacted on the wards. There was sometimes uncertainty about whether an activity was ‘therapy’ or not. This poses problems for the implementation and auditing of the 45 minute guideline, and begs the question: 45 minutes of what?

7.3.1 The varied scope of therapy

Therapists’ work encompassed more than ‘therapy’. On the first day of fieldwork I sat in Jade’s crowded therapy office. One person read through the patient list, checking progress and sharing updates from the nursing handover meeting. I jotted in my notebook the things that therapists

saw as their daily focus. This included ordering equipment, showing nurses how to fit orthotics, sorting out funding and care plans, carrying out home visits, preparing paperwork for panel, and sorting out a range of miscellaneous problems that were not clearly in the domain of any specific professional.

Therapists talked about discharge plans, funding, paperwork, equipment and assessment. Within the wider team, they contributed to discussions about patients' passports, immigration statuses, uncertain diagnoses, homelessness, and family issues. They typed reports and information packs, asked each other for advice and discussed patients' progress. A large part of their work related to solving problems, 'chasing things up', making referrals and completing assessment paperwork. Their role was far broader than the provision of direct rehabilitation to patients.

Therapists on Jade talked about being constrained by the administrative demands on their time – and I witnessed this as a burden. However, they also spent time with patients, in groups, individual sessions, home visits and joint reviews with colleagues. Alongside the administration and discharge-planning, a greater emphasis was placed on hands on therapy and face to face interactions with patients in Jade Ward than in the other sites. I observed a greater diversity of sessions in Jade Ward, whilst a more stripped down, impaired focussed version of therapy prevailed in the other SUs.

Patients received different types of therapy, and described their different experiences. On Jade Ward, Rafael partook in a large and diverse range of therapy interventions. He cooked and baked a repertoire of traditional Brazilian cuisine as well as carrying out physical exercises. In addition to his therapy sessions, Rafael carried out many activities and exercises on his own, such as making his bed and practising his handwriting. His SLT programme was almost entirely self-managed, with SLTs checking in with him occasionally to monitor his progress and update his exercises. Despite loathing being in hospital, Rafael was full of praise and appreciation for the therapists and valued the education and advice they had given him as well as the activities themselves. Not all patients were so positive. Marcus, on Olive Ward, perceived therapy as having a very narrow scope. He described therapy as 'bloody intolerable... bloody frustrating', and saw therapists as nothing more than gatekeepers preventing him from going home.

“That’s like tick, tick the stairs.... I don’t want any of this bullshit you know, to be perfectly honest... It’s a drag! I wanna be home with me cats... I need to be talking to my girlfriend. That’s what I need. This load of bullshit ‘oh you know, we’ve gotta keep you safe’ and all this stuff... the thing is, I just need to go home.”

Marcus, Olive

Eddie, a patient on Jade Ward, had participated in a range of different therapies and therapy sessions, but said that the value of these depended on the ‘nature of the therapy’. For Eddie, the most important factor was to be treated with empathy and understanding, and not pushed too hard as if it was athletics training. Eddie was suggesting that the same activity could be therapeutic or the opposite, depending on how it was delivered.

Less able patients did not experience a diverse range of therapy sessions, and for the most dependent patients, therapists would often use their session to hoist them out of bed. It was considered important that patients should get out of bed, but as the nursing staff felt over-stretched therapists were often asked to assist patients to do this. Getting a patient out of bed (and possibly back in again later) would often be considered to be a patient’s therapy for the day. Therapists often felt tension around this, as they promoted the importance of patients ‘sitting out’, but did not always feel this was the best use of therapy time. However, in some cases therapists incorporated assessment and exploration of rehabilitation into these sessions.

1130- 1215. In the patient’s side room there’s the OT, 2xPTs, TA, nurse, and me. Five people around her for the hoist transfer. So many tubes and wires. NG tube to limbo dance under. Fan to be moved, then re-plugged in, leaving another wire to step over. Oxygen tube to be disconnected then plugged back onto her trache. SATS monitor to be put on her finger - another trailing wire. Another tube to suction her. While she sits out, OT tries to get her to look at a comb, take it off her and help comb her hair. The only bit she manages is dropping the comb back into OT’s hand on request at the end. OT poofs air from her toiletries under her nose, but she doesn’t respond. She does sometimes look at us though, in the eye. OT puts cream on her arms and tries to get her to participate in rubbing it in, but she doesn’t. The PT gets a washing up bowl and

puts ice and water in it, to mop her brow. They are kind. They spend time trying to readjust her position and then decide to leave her and return at 1.30 to put her back to bed.

Figure 9: Extract from fieldnotes. Jade Ward 9.9.14

This demonstrates that the value or richness of a therapy session could not straightforwardly be measured by its duration, nor even by the task completed within it. Hoisting a patient into a chair could involve varying degrees of engagement on the part of the therapists as well as the patients.

As I became more embedded in the field, I was invited to various meetings that occurred outside the SUs in the study. One such meeting was set up by therapists across London who wanted to focus on implementation of the 45 minute guideline. The group talked about wanting to drive change and use resources creatively to improve efficiency, but revealed confusion regarding the very basics of how therapy should be enacted. An OT noted that the literature about therapy intensity predominantly focussed on physical activity rather than functional practice, and asked, “Does sitting at the sink looking in the mirror count as active? It might be all going on in their head, cognitively.”

Another OT said occupational therapy did not always involve functional rehabilitation. In her previous job, therapists would be based in the gym and patients would be brought to them to carry out different exercises. “The OTs and PTs split the patient in half at the waist and OTs did the top and PTs did the bottom. It was all physical, plinth-based work.”

This led to a conversation regarding the need to ‘make them sweat more’, with the suggestion that physical therapy should increase the patient’s heart rate within the session. Therapists based in community teams were asked for their perspectives, and reported that their patients were ‘taught self-management from day one’. Their patients might be more actively involved in therapeutic activity, but it might be self-directed or supported by a family member or carer. This would not count as auditable therapy for SSNAP, but the therapists felt it was the most beneficial approach for patients that could cope with it.

Even this group of relative experts had difficulty capturing the concept of therapy. This illustrates that the varying interpretations and enactments of therapy I observed on the three SUs represented more widespread variation in approaches to defining and providing SU therapy.

7.3.2 Therapy spaces

In each site I observed that therapy spaces were pertinent to delivery of therapy. The broad scope of therapy activities enacted in each SU also related to the spaces in which therapy was carried out.

In Jade Ward group sessions took place in the kitchen, gym or day room. Individual sessions could take place in the patient's bed area, in the bathroom, kitchen, gym, day room or outside. Every patient who needed one had an allocated wheelchair, which would be used to transport them between therapy areas. In Topaz Ward there was one wheelchair available, and two hoist slings were shared amongst the patients who needed them. This was a factor limiting therapists' ambitions within their sessions, and PTs told me they were more likely to complete a session in bed as it was difficult to take patients to other spaces. In contrast to Jade Ward, most of the time in Topaz and Olive Wards the therapy spaces were quiet and empty.



Figure 10 Gym, Topaz Ward 11am

On Olive Ward therapists usually took patients to the gym in their beds. I was curious about this practice, and asked therapists why they did this. Some said they did not know, it was just the

practice there. It was discussed when I met the therapists to feedback preliminary data analysis to them, and the B7 OT who had not been present during my fieldwork explained that it had been introduced as a way to reduce wasted therapy time. She explained that previously it had taken time to help a patient transfer from the bed to wheelchair in order to take them to the gym. Now, the 'therapy clock' started as soon as they were taken off the ward, and the time taken to transfer was incorporated into that timeframe. Other therapists felt that this practice led to patients seeming more like they belonged in bed, especially when they returned to the ward back in the bed and remained there. Many therapists expressed frustrations about the obstacles to rehabilitation presented by the setting, and being confined to the bed area was an element of this. Cheryl contrasted this with her experience on a spinal injuries unit, and bemoaned the lack of accessible bathrooms, day room or any space in which they could be together in a more stimulating environment.

"I think patients, this whole thing, it's like a little barrier around your bed... Patients should be more encouraged to be out and away from their bed. Because you never do that at home and... it encourages that institutionalised attachment to people's beds... And you just see patients that have come in, that you think, oh they've got quite good rehab potential, just becoming more and more bedbound."

Cheryl, B6 OT, Olive

The ward environment, spaces for therapy and the use of therapy spaces were raised as important factors particularly in Olive and Topaz Wards where this was more problematic. The space around the beds was restricted, and SLTs noted that completing communication sessions with only a curtain separating the session from other patients, families and staff was difficult, distracting and lacking in privacy.

"In this ward you can only do what you can with the space that you've got... I mean with my communication patients... if I'm seeing a patient and someone's, there's a nurse in the bed next to me and the patient is distractible and all these things, you don't get a fair session or they don't get a fair session because of that."

Catherine, SLT B6 Topaz

The physical environment sometimes determined the type or quality of therapy that could be provided. This is revisited in Chapter 9, as therapists perceived the loss of therapy spaces as a factor changing the nature of therapy.

7.3.3 What are we? The therapists' identity crisis.

Topaz therapists experienced a tension between their desires to carry out specialist assessments and rehabilitation, and the organisational and team pressure to discharge patients. One afternoon I joined the therapy team at a patient's bedside for his first assessment. The senior therapists considered it important to involve the whole therapy team in order to share their skills with the inexperienced therapists. As the patient sat on the edge of his bed, the therapists conducted a lengthy assessment of his hand. They focussed particularly on the potential for movement in his finger, trying to understand from him whether the problems were new or long-standing. The same patient agreed to be the subject of a clinical education session led by the Clinical Lead OT. However, these in-depth assessments did not develop into rehabilitation, as the pressure on therapists was to arrange the patient's discharge. In another example, I sat in the stroke team office while the SLT and OT discussed a patient's complex cognitive difficulties and how to address them. They looked up 'anosognosia' in their cognitive stroke rehabilitation handbook, and wondered how best to assess and address the patient's lack of awareness of her impairments. In the next team meeting the decision (led by the doctor) was made to aim for a 'golden discharge', meaning sending the patient home before 10.30am the following day. Rehabilitation was abandoned in favour of arranging the discharge. Junior therapists and therapy assistants spent time being shown how the senior therapists were working in order to develop their clinical skills and understanding of neurological rehabilitation, but frequently the plans would change and there would be a shift to urgent completion of discharge-planning tasks.

"I think one of the things that I struggled with when I first came here was like, "What are we? Are we like a rehab unit? Are we an acute unit?" like, and I don't think it was very clear. And I don't even know now if it's really clear. So I'm kind of constantly kind of struggling with this kind of identity of what, what should be our priority. And I think there is a real, I think there is, I don't think it is clear-cut really. And I think the emphasis seems

to shift and change depending on who we have... I know that it's something that Joanne [B7 PT] and I have struggled with. It's like, what are we?"

Nancy, B7 OT, Topaz

Junior therapists typically came to the ward keen to learn how to do neuro-rehabilitation, and, as Ghita (B5 PT) put it, were disappointed to find they were 'glorified discharge planners'. This showed a mismatch between therapists' prior expectations of the function of SU therapists, and the enactment of the role they were required to fulfil. The clinical lead and therapy manager spoke of therapists finding it difficult to adjust to the priority being discharge-planning. There was conflict between the top-down push to focus on discharge, and the desire to enact what therapists felt was their professional role. Therapists spent time doing joint sessions with junior staff and TAs trying to teach them practical assessment and treatment skills, almost in defiance of the fact they may not be able to see their treatment plans through.

7.3.4 The purpose of therapy

The question of what constituted valuable use of therapists' time proved problematic. Strong and conflicting views were expressed within and across sites, and it was not unusual for conflicting views to be expressed within one interview. In this section I present varying perspectives, and observe that exploring these with therapists only appeared to complicate matters more and highlight the conflict of purpose that many therapists experienced.

Therapists on Jade Ward talked about taking time to build therapeutic relationships, to take a step back from patients less keen to participate, and to introduce therapy in collaboration with colleagues in ways they felt would be more acceptable to patients. Nathalie, B5 OT on Jade Ward, told me several stories that exemplified this.

"With other patients I've tried doing things that not necessarily, you couldn't argue were therapy. So to the extent of just taking them outside if the weather's nice. So, working on the therapeutic relationship. Or with one of my patients I just took her into the kitchen and listened to some Elvis Presley. So, which did actually work! She remembered that and she told her daughter! And while we were there, I was like 'oh do you want a cup of

tea?', put the stuff in front of her, so it's less of a 'let's do a hot drinks assessment' and more of a 'let's have a social type scenario'."

Nathalie, B5 OT, Jade Ward

Nathalie seemed uncertain about whether these examples were 'therapy' or not. Claire (B7 SLT) was clear that listening to patients' concerns was an important part of her role.

"As a speech therapist as well you often are talking to the patients, you're not *doing*. So you get a lot of tears and a lot of worries and they say things, even simple things like worrying about their cat, and you think actually, that's the reality of it, you know."

Claire, B7 SLT, Jade

Jade Ward's therapy groups provided therapeutic activity which could relate to specific functional goals but could also be valued as opportunities for interaction, stimulation and enjoyment. Yemi, a patient on Jade Ward, gave an example of this when discussing the SLT input she had received.

"Because like me, it affected my voice... When we have a group... my own strategy is to speak louder so that other people can understand me, so it's, and because they organise groups as well, it helps, and it makes you think, oh you are not the only one, at least, so it doesn't make you feel so bad about yourself, that, you know, it can happen to anybody."

Yemi, Patient, Jade

This quotation illustrated the dual purpose therapy could serve – addressing functional difficulties and helping patients not to 'feel so bad'. This appeared to apply to group work in particular. Some therapists seemed conflicted about whether groups were a good use of time.

"Especially standing group, there's a lot of equipment to get in there, getting people up into the frames has to be done in a certain order – some people can tolerate more than others – so if they're not ready you have to juggle things around... And then afterwards the wipe-down and the notes and things takes a little while. I suppose arguably we should spend less time actually doing the group and actually boxing the hour to include the

administrative time and set up time, but quite often we're having quite good fun and the patients are enjoying themselves, and if they're enjoying themselves and if they're standing in a reasonable position then, we'll just keep it going really."

Tom, B5 PT, Jade

Thus it was unclear whether patients' fun and enjoyment could be good use of therapy time as an end in itself, or whether administration was more legitimate.

In Jade ward, after presenting my preliminary analysis, I explained that the purpose of therapy seemed elusive, and I asked therapists to reflect on what made them feel they were fulfilling their role. Some said they wanted to feel that the improvements their patients demonstrated were thanks to them and not spontaneous recovery. What was important to them was feeling that they had made a difference. This was expressed by therapists in all sites.

"You don't want to be seeing a patient just for the sake of seeing them. You know, what you really want is to think, 'Is this time I'm spending with them going to effect any change?'

Mary, B5 SLT, Topaz

Similarly, Sandy, had concerns about being asked to run groups as a way of increasing efficiency.

"Groups are great... I just can't cope with this whole thing of shoving people in a room playing cards with them and saying that's 45 minutes of contact."

Sandy, B6 SLT, Olive

This resonated with Tina's strong opinion, that therapy should be 'good'.

"Like, it has to be so that that input is like, what shall I say, it has to be *good* therapy, as well. There's no point in a TA seeing a patient if a) they haven't had a handover and b) it's not going to make any difference to that. I need to know why I'm doing that and have a good handover. So they get good therapy."

Tina, TA, Jade

Topaz therapists were under pressure to adopt a narrow conception of their role. Rona, the clinical lead, disseminated a clear message that therapists should be prioritising discharge. Yet, there was evident tension between her notion of ‘therapy love’ and the team’s discharge-oriented focus. The following two extracts from Rona’s interview illustrate this tension, and exemplify the contradictory aims that therapists were expected to uphold and fulfil.

“We don’t like to use the word ‘rehab’ in relation to inpatient stroke services at [NHS Trust] anymore because the concept is about community. Rehab happens in the community... I think I’m very clear...yes therapists don’t do therapy, but they get their patients home.”

“Sit down with them for half an hour, give them a little hand massage, read the newspaper with them... Just get them sat out and take them to the day room and just do something with them. Do something that they might enjoy doing. Paint their toenails, you know, do something – ask the family to bring in some toenail polish, whatever it is... I don’t mind what you do with them, as long as they’re getting a little bit of therapy love.”

Rona, Clinical Lead, Topaz

SLTs in all sites raised a separate issue, noting that the purpose of their therapy was different for patients with communication problems (such as dysphasia) and those with swallowing problems (dysphagia). Some said that when working with people with dysphagia they were not doing ‘therapy’ or ‘rehabilitation’, but assessment, reviewing and monitoring. Some SLTs felt pressure from managers to spend a certain amount of time with patients, but felt that this was not what the patients wanted or needed.

“It’s very difficult with language therapy that if someone is not in the right cognitive place just in terms of alertness or attention, then you sort of bash away... and it’s not really very kind. It sometimes can cause a sort of negative feeling to that person towards you because you keep going back and they think, ‘oh God here she is’.”

Sandy, B6 SLT, Olive

“So if we’re seeing someone with dysarthria... or someone dyspraxic, it’s not seen to be appropriate for intensive therapy because it gets worse the more work you do on it... if you sit with the patient and you’re like, ‘Right make this sound, make this sound, make this sound,’ they don’t. It doesn’t work, it doesn’t work like that.”

Sinead, B5 SLT, Olive

7.4 Auditing therapy

Having focussed on how SU therapy was interpreted and enacted, I turn the focus to therapists’ interpretation of the 45 minute guideline and their participation in the SSNAP audit. There was variation in therapists’ engagement, understanding and interpretation of the 45 minute guideline and SSNAP audit, and reporting practices varied amongst individuals and teams. Building on earlier observations regarding the purpose of therapy, I highlight the problems therapists faced with determining ‘what counts’ as auditable therapy and ‘who counts’ as requiring it for the purposes of the SSNAP audit.

7.4.1 Therapists’ interpretations of the rationale for the 45 minute guideline

I collected a large quantity of data across all data sources regarding therapists’ attitudes to and interpretations of the guideline and audit, including hundreds of examples of therapists expressing approval, disapproval, engagement, apathy or concern. Often, one interview or conversation would expose a range of seemingly contradictory attitudes held by the same therapist. Understanding of the rationale for the guideline varied, and individual therapists frequently had mixed feelings about it. There were also broad differences between the three teams.

Therapists had different understandings of the rationale behind the guideline, and many said they did not know what the rationale was. Therapists who recalled the launch of SSNAP and the initial controversy surrounding the 45 minute guideline were likely to say it was chosen because repetition and practice were known to be important for recovery, and 45 minutes seemed like a reasonable session length for which to aim. Therapists who had not worked in stroke for so long were more likely to assume that ‘45 minutes’ was more specifically evidence based, i.e. had been proven to be the amount of time required to effect a change in a rehabilitation session. Therapists

often expressed general approval of the 45 minute guideline - as they wanted to give patients therapy and wanted to promote equity – but would go on to critique it for failing to account for variations in the needs of individual patients. This corresponds with Lipsky's claim that SLBs are, on the one hand, expected to commit to standards of fairness and equity, but are simultaneously confronted with the unfairness of treating people alike (Lipsky 2010).

Some therapists claimed that by focussing on direct contact with patients, SSNAP misrepresented the breadth of their roles. Although they expressed frustration about administrative demands, they perceived some non-clinical tasks to be valuable for patients. This relates to the findings presented above regarding interpretation of therapy, as some therapists perceived there to be valuable aspects of their roles that were not measured on the audit.

“Talking to a carer, from my point of view to provide the right foods, or the right way of feeding people, communicating with people better, I think that's therapy. But... SSNAP isn't very specific on, basically it's this face to face obsession, where, I probably don't record the majority of my day. Admin-wise, taking a telephone call... which is all probably sometimes more important than seeing someone face to face.”

Claire, B7 SLT, Jade

7.4.2 Individuals interpreted the audit differently

As an example of the mixed attitudes that could be held by the same individual, Cheryl (B6 OT on Olive Ward) told me that the guideline was based on evidence that 45 minutes of repetition every day was the minimum that a patient could benefit from. Her understanding was that in order to be effective, the 45 minutes had to be provided within one session. In reality, she often saw patients for shorter sessions more than once a day, as she based her decisions on what she felt would be most beneficial for each patient. I observed this in practice on the ward when she saw one patient for separate sessions spread out over the day. The patient was experiencing severe pain and distress, therefore Cheryl considered multiple short sessions to be best. In separate short sessions she massaged her swollen hand, helped her to brush her hair, and cut out pictures with her to make cards for her family. Cheryl told me that she found the practice of writing down

the time she had spent with patients quite satisfying, as it made her realise how much she had done during the day. Yet she also talked about not being 'an audit person' and preferring to come to work and see her patients than to think about audits. Many therapists expressed similar mixed feelings. People made individual decisions about how to record time spent in family meetings, telephone calls to relatives, or computer based tasks such as preparing communication books or discharge packs.

"So, for me, for the SSNAP I only sort of count patient contact time, like therapy time for that or family meetings, I count for that as well just because of the audit, I'm thinking what kind of stuff do they want? And that's not saying that that's right. But that's what I tend to do... different people have said different things. So sometimes, for instance, if a patient has been seen by two therapists, they'll document double the time in the data on SSNAP. Whereas my understanding of it is that's not therapist time, it's patient contact time... So it might be two physios went and saw that person for 40 minutes. So they did a joint session for forty minutes, so then they'd be putting 80 minutes. And I think I realised people were doing this and I was like, "But can I just clarify, isn't it supposed to be contact time that the patient gets in terms of how much therapy they got rather than how much therapist time has been given?" And I think that made people go a bit like, "Oh yes." So I think there was a bit of – and I'm not sure that it has been clarified."

Catherine, B6 SLT, Topaz

7.4.3 Teams interpret the audit differently

On a team level there were contrasts regarding attitudes and audit practices. Chapter 6 introduced some of the contrasts between the sites in relation to SSNAP. Jade Ward had consistently performed well on the audit. Therapists were aware that there was a guideline to provide 45 minutes of therapy to each patient, but they appeared unconcerned about this. Band 5 and 6 therapists said they were not very aware of the 'audit side of things', and assumed this was taken care of by Band 7s. Band 7s said they protected their junior staff from unnecessary pressure, as they had enough to worry about without thinking about SSNAP. Jade appeared to achieve A grades incidentally, possibly due to a combination of being well staffed, having a full programme of groups and a technical issue that meant it was easy to accidentally duplicate

entries when recording contacts on the computer system⁴. Topaz therapists were aware of the 45 minute guideline but did not know how they were performing, other than having heard a rumour that they were achieving the target, which they felt was a misrepresentation of their performance as they were unable to see patients on a daily basis. One of the most striking differences between Olive Ward and the other SUs was the approach taken to determining which patients should be included in the audit, discussed in the next section.

7.5 ‘Therapy appropriateness’

The proportion of the caseload deemed to require therapy is important in SSNAP. Only those patients considered ‘appropriate’ have their therapy time counted on the audit. The proportion is one of several numbers factored into the total score for compliance with the guideline. In order to get a good score, teams must be meeting benchmarked figures for the proportion of appropriate patients for each therapy. With this in mind, I was keen to find out how therapists decided whether a patient should be considered appropriate for therapy and therefore auditable. On Jade and Topaz Wards the concept of therapy appropriateness did not exist, whereas on Olive it had become central to clinical discussions. I found that the publically reported SSNAP data includes a mixture of carefully reasoned and patient-specific information, and information arbitrarily applied across teams by administrators.

7.5.1 Therapy appropriateness is not a concept

I first noticed that Jade therapists did not consider the ‘therapy appropriateness’ of patients after a therapy session with an unresponsive patient. The OT and SLT had tinkled a cowbell next to the patient’s ears, and unsuccessfully attempted to stimulate her senses with various forms of touch and aroma. I asked the OT if such a patient would be counted as appropriate for therapy. She looked at me blankly. I gradually realised that the question I had planned to ask therapists in interviews regarding ‘appropriateness’ was meaningless to therapists unaware that this was being reported on. The administrator responsible for submitting Jade’s SSNAP data, who also seemed puzzled by the question. I learnt that the ‘yes’ box regarding whether patients required

⁴ After my fieldwork SSNAP contacted Jade to say they were ‘absolute outliers’ for therapy intensity. I was invited to a meeting to discuss this– see Appendix C.

therapy was being ticked as a matter of routine. Although this seemed to be done unthinkingly, it matched the responses of most therapists, who, when probed, said everybody was appropriate for therapy.

“I start by thinking that they’re all appropriate, and I guess as a physio it’s a bit different from OT in that if someone’s unwell, if they’ve got pneumonia or something, we can still treat them. So there are fewer cases where people are so medically unwell we can’t do something with them. So, yeah, so if they’re medically unwell I’d say well can I treat them medically, as it were. And if I can’t then I will say, right, there must be something I can do for this person. I nearly always think there’s something I can do. So it’s, the medical unwellness tends to be, tends to not knock people off my list as it were.”

Tom, B5 PT, Jade

Therapists commonly said that all patients needed some sort of therapy input, but not necessarily intensive stroke-specific rehabilitation. Some only needed ten minutes of chest physiotherapy, or some equipment ordering by the OT, or monitoring of their swallow by the SLT. Alexia, B7 OT on Jade Ward, said that whilst everybody should receive therapy, not everybody needed specialist stroke therapy. She explained that she was often addressing patients’ pre-existing issues rather than problems caused by a stroke. Nevertheless, none of the Jade therapists differentiated between types of patient contact in their data recording. They logged their time as they always had done on the hospital productivity statistics software and gave little thought to its subsequent extraction as data to be submitted to SSNAP. Topaz therapists also recorded contact time for all patients, and did not make a distinction based on therapy need.

In Olive Ward, Lucy had been given the responsibility of improving the therapists’ SSNAP scores. She was an expert on her local data and how it compared nationally. She had made frequent contact with the SSNAP help team to seek clarification about what should be recorded and how. Lucy was keen to comply in the way that SSNAP required, but felt there was too much ambiguity leading to varied interpretation by therapists. For example, the question of whether patients were ‘shown to be benefitting’ from physiotherapy was open to interpretation, as they might enjoy therapy without making physical gains. In her team, unless a patient was participating actively in

45 minutes of therapy every day, and was improving, they were not deemed appropriate to be entered onto SSNAP.

7.5.2 They stop needing therapy the Tuesday before Discharge

In Olive Ward, careful consideration was given to deciding whether a patient was 'SSNAPing' or should be 'SSNAP-stopped' (see Chapter 8). Topaz and Jade therapists were not aware that SSNAP collected data on when patients stopped requiring therapy. I spoke to Norma, the administrator responsible for Topaz's SSNAP data, asking what informed her therapy data entry for each patient. She told me that fortunately she had previously been a ward clerk, so knew her way around the patient notes. If she saw an entry for physiotherapy, she would tick that physiotherapy had been required. Having experienced the Olive Ward therapists' preoccupation with SSNAP-stopping, I was curious to find out whether she logged an end date, on which the patient stopped requiring therapy. She told me she had devised a practical solution to this question, and always wrote the date of the Tuesday before the patient's discharge, as that would have been the date of the last multi-disciplinary meeting. This was a stark contrast from the practice on Olive Ward, where there was an awareness that patients could be 'SSNAP-stopped' and 're-started' as they fluctuated.

I raised this contrast when I fed back preliminary study findings to therapists at Topaz Ward. There was a gasp when I told them about the practice of SSNAP-stopping, and outrage was expressed at the idea of deeming patients not to be appropriate for therapy. The clinical lead proclaimed that this was wrong as therapists should always have an attitude of having something to offer patients. I tentatively informed them of their own practice, and was glad that Norma was present to confirm that in their team the therapy cut-off date was the Tuesday before discharge. This was new information to the therapists, and the question of how to report on therapy appropriateness remained perplexing. (Chapter 8 develops a theoretical interpretation of 'appropriateness' as a categorisation.)

7.5.3 Changing attitudes

Sometimes my presence triggered discussion about the audit, and discrepancies were revealed in people's understanding of audit requirements. As a visit from the National Clinical Director for

Stroke drew near, Topaz therapists they began to focus their attention more on standards and targets. Attitudes, understanding and interpretations were not static, and the Topaz team's increased interest in clarifying SSNAP processes was an example of this. As new quarterly SSNAP reports were published, scores could go up or down. The results publically available on the SSNAP website were always for a time period in the past that was now perceived as out of date, and when I spoke to staff they would tell me reasons why things had been different then. Topaz staff often spoke about having heard that they were achieving 'top marks' in the SSNAP audit, but this appeared to be a rumour based on a memory of earlier data. Senior therapists on Jade Ward became more attentive to the auditing of therapy intensity when they were contacted by the SSNAP team to say their results would not be published for the next quarterly report as they were 'absolute outliers' and the high quantity of therapy time they gave to patients had seemed likely to be inaccurate (see p144 and Appendix C). Therefore, where I have attempted to draw together generalisations about each site, it should be noted that nothing stood still during the study.

7.6 Chapter Summary

"...about some things it is impossible to lay down a law... For when the thing is indefinite the rule is indefinite." (Aristotle 1998, p133)

In this chapter I have shown that SU therapy is not a clear or uniform concept. Drawing on Aristotle's function argument I argue that in order to judge or measure therapy, a shared understanding of the purpose or function of therapy is needed. Rather than finding a shared interpretation of therapy, I found that therapists were torn between conflicting purposes and experienced this as problematic.

Therapists offered conflicting interpretations of what the purpose or aim of therapy should be, and this related to conflicting views about what was, or should be, auditable. Some believed that therapy involved listening to patients, whilst others were uncertain whether positive interactions should be considered therapy *per se*, or an inroad to therapy. Some said that therapy must bring

about change in a patient's functional abilities. In one SU the primary role of therapists was not therapy at all, but discharge-planning.

It could be argued that this reflects a flexible approach to interpreting therapy, and that individual therapists and patients constructed 'therapy' differently according to their circumstances. Lipsky (2010) might refer to this as a feature of SLBs' autonomy and use of professional discretion. However, I argue that a prerequisite of making therapy measurable is being able to define what is being measured. In order to appraise the quality of therapy, it is necessary to agree on its purpose and function. The tensions expressed by therapists such as Nancy, who said, 'it's like – *what are we?*', demonstrate that the pressure to serve conflicting purposes is not a feature of autonomous practice. I argue that the evident variation in the interpretation and enactment of SU therapy undermines the mission of standardisation. In Lipsky's terms, policy is distorted in its implementation for a variety of reasons including the different and conflicting pressures and priorities within and between settings.

Chapter 8 : Routines of Practice

8.1 Introduction

Against the backdrop of a strategy for standardisation in stroke therapy, the previous chapter demonstrated the extent to which variation in therapy context, purpose and practice existed even across a small number of sites. This chapter continues to expose a mismatch between idealised, policy-based practice and the reality of SU therapy delivery, by extending Lipsky's (2010) concept of routines of practice. Lipsky argued that street-level bureaucrats (SLBs) work in services in which demand always exceeds resources, and are aware that they cannot provide an optimal service to each and every client. Desiring to do the best they can, but realising their limitations, SLBs develop patterns of practice, modify the concept of their jobs, and also modify the concept of their clients in order to justify their decisions regarding resource allocation.

Lipsky's central concepts are useful for interpreting study findings regarding resource allocation, prioritisation and the categorisation of patients. However, lawyers, judges and the police dominate in Lipsky's illustrations of SLBs, and the setting and participants in this study differed starkly from his examples. I begin by illustrating that, like SLBs, therapists felt unable to deliver an optimal service and were 'constantly compromising'. I discuss ways in which therapists simplified and categorised patients in order to ration and manage their complex work. I then focus on the siloed approach to therapy delivery that occurred in all sites. I argue that this is an example of 'routine control of clients' (Lipsky 2010). Going beyond Lipsky's analysis, I suggest that the auditing of profession-specific guidelines may subtly encourage this way of working. The clients in Lipsky's examples are active: attending appointments, receiving home visits and completing paperwork. Although therapists experienced SUs as busy and frenetic, patients were static and passive, or, as Bernhardt et al (2004) described them, 'inactive and alone', and expressed a desire to be more involved in decisions about their therapy. Lipsky's focus on SLB's working practices leaves the perspective of those receiving their services unexplored. I therefore draw on Galvin and Todres' (2013) humanisation framework in arguing that therapists' routines of practice – including those associated with the use of SSNAP – risked encouraging a focus on processes rather than people. Galvin and Todres' conceptual framework of humanising practice seeks to 'place people as human beings at the centre of their care' (Todres et al 2009 p68). I argue that

dimensions of dehumanisation were embodied in the care of patients on SUs, and that the routines of practice presented in this chapter were associated with many of these. I include the forms of humanisation and dehumanisation in Table 6 for reference, as I will draw on these to interpret my data later in this chapter.

Table 6: Conceptual framework of humanisation (Todres et al 2009 p70)

FORMS OF HUMANISATION	FORMS OF DEHUMANISATION
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenisation
Togetherness	Isolation
Sense-making	Loss of meaning
Personal Journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

8.2 Prioritising patients: ‘We’re constantly compromising’

Therapists’ prioritisation of patients was an example of resource allocation (Lipsky 2010). Lipsky argued that in public services high caseloads affect time for decision-making. Despite needing to allocate their inevitably inadequate resources amongst clients, SLBs must not appear to be rationing services, and their division of caseloads into active and inactive represents what they can manage to do rather than the needs of individuals. Re-prioritising and re-designating their time throughout the day, therapists felt pressure and guilt about their prioritisation decisions. When pressure on the service was increased, face-to-face rehabilitation was not prioritised. Lipsky suggested that stress affects the way workers respond as individuals, and I found new examples of this, such as therapists’ examples of not responding to patients’ immediate needs. In line with Foucault’s theory of governmentality (Foucault 1977, 1991), therapists appeared to have developed a strong sense of self-surveillance, and this was associated with feelings of guilt about never doing enough.

8.2.1 We're constantly juggling

Early in my fieldwork I attempted to 'book in' sessions with therapists, and repeatedly found the session had been cancelled, postponed or had already taken place. Jackie (B7 PT on Jade Ward) explained to me that this was the nature of working in the acute setting and it was important to be flexible. I became accustomed to therapists waiting, dispersing, appearing, quickly communicating changed plans - and felt that interrupting to ask for explanations would disrespect the sense of pace, activity and urgency that pervaded. I wondered if my experience, of learning to quietly accept unpredictability and a lack of control over my time, mirrored the experiences of the patients who were in the midst of this perpetual motion.

Unpredictability in the workload is a feature of SLB's practice. Lipksy suggests SLBs protect an element of flexibility to allow responsiveness to new surges in work. It was easy to miss the decision-making processes that were occurring for them as they re-prioritised and re-planned their days.

"There's not a single patient or situation when I wouldn't think, why is *this* better than the other type of time I'm spending on something? ... It's never a comfortable decision... If you do treat them, other patients will lose out. So we're constantly juggling... So I might get a relative asking me, 'I noticed this week on the timetable that they have less sessions this week – why?'. And I know that the answer, 'I had to see another patient more' is not gonna, they are not going to accept it, they will not be happy. Why should they? They'll say, 'I don't care about the other patients. Why is *my* relative not being seen as often as they were a few weeks ago?'... Or you might know that it would be lovely to put it in, there is space, but your patient is such that you know that they are not going to tolerate it, because that day they are particularly busy, so you need to make it shorter or not book the session you wanted on that day, because they are already being seen by lots of people. So, *constantly compromising* and finding what's the best for you and the patient, and the service."

Agata, B6 OT, Jade

Therapists talked about feeling guilty about the things that were not prioritised, and were always ready to justify their decisions in the hypothetical case that they were challenged by a patient's relative or a manager.

"A lot of the time I'll think, okay... if a family member challenges me today about, 'Why haven't you seen this person?' and then someone who I've not done any of this admin for and their family says, 'Why haven't you seen them?', at least with this person I can say, "Yes, but I've spent ages sorting, you know, I've spent time managing this case and I've spent time on this patient. So that's why, whereas I've spent no time on this patient, so I need to go and see them." And it becomes quite a, like an ethical dilemma at times."

Catherine, B6 SLT Topaz

8.2.2 When pressure is increased, rehabilitation is not prioritised

SLBs are never able to offer an optimal service to everybody on their caseload, and they must choose to give a larger number of people a less than perfect service rather than focussing all their attention on certain individuals at the expense of others (Lipksy 2010). On all wards I observed therapists meeting together to re-prioritise when staffing issues occurred. In one such instance on Jade Ward, PTs reminded themselves to 'prioritise chests and initials - rehab won't happen.' When resources were restricted, prioritisation became cruder as rehabilitation and 'maintenance' were luxuries that could not be afforded. On Topaz it was usual for there to be only one of each discipline at work, and rehabilitation was not a priority. Ken told me about his experience as a Band 5 there.

"All my mind is just thinking about when this patient will be able to go home. And we just work endlessly on that... I don't really have time to reflect, to really sit down to learn, to think, "Okay, today we go for - " Never, because it's just, it's like a motor... I just concentrate on not making mistakes to be honest, not making mistakes, okay, so whatever the team ask me to do or what I need to contribute myself in this discharge-planning, I just carry it out."

Ken, B5 OT, Topaz

Ken was nearing the end of his rotation when I met him, and he told me he felt disappointed with himself as he had focussed on keeping on top of the workload and 'not creating trouble to the team', and had not learnt 'how to treat people, how to make them better'. I discussed the prioritising of discharge-planning over treatment with Rona.

"I got three emails... with the guys going, 'I have spent six hours today getting this patient home.' 'I have spent six hours negotiating, key working, finding out this happening, finding out that that's happening, to get this person home.'... It does stop them from treating patients. There's no doubt about that."

Rona, Clinical Lead, Topaz

Jade therapists, who had a bigger team, explained to me that they might choose to replace seeing a patient with completing their lengthy continuing care assessment paperwork, but that they would try to make sure that patient was seen by a TA or attended a group to ensure they had some sort of therapy input that day. In contrast, Topaz Ward patients were never likely to be seen on consecutive days. Although Topaz therapists felt that seeing patients every day would be impossible for them, they regretted this, and felt that repetition and frequency of therapy would benefit many of their patients. Therapists perceived a need to constantly compromise on the various and sometimes conflicting pressures on their time.

8.2.3 Cutting corners

Therapists felt guilty regarding their conscious prioritisation of their workload. Nancy (B7 OT, Topaz) told me that she prioritised new patients and those about to be discharged, followed by patients who had not been seen for any therapy the previous day and who appeared to have more 'rehab potential'. I asked if she would maintain any involvement with the other patients.

"Not actively, and then that's more a timing thing again rather than a choice. It's the lower-level patients who perhaps haven't made any significant changes... Those patients then get seen for a bit and then you get reports back that actually they're kind of doing a little bit better, and then you'd like to go back in and reassess them and monitor them... And you don't always

get an opportunity to go back and reassess these people... It sounds really awful when I'm talking about it."

Nancy, B7 OT, Topaz

Therapists described how they had learnt to 'cut corners' in order to manage their workload. Examples included reducing interactions with family members and only giving them basic information; ignoring patients calling for help on the ward; completing administration instead of seeing a patient; and missing family meetings.

"If you are passing by and you are just about to do your admin, and a patient nearly cries that they need to go to toilet, or they are sitting in the chair too long and they are begging you – just with their eyes they are begging you, please help me to get out of this chair. This is another thing when people can cut corners, and just carry on walking... It's a moral issue. It's the ethical issue when you think 'that's why I'm here, I should help them, but that means I'm not gonna do what I've had on timetable to do now'".

Agata, B6 OT, Jade

Although therapists gave such examples, I also observed practice to the contrary, suggesting that their feelings of guilt about cutting corners might represent feelings of conflicting pressures and potential, rather than actual, neglect of patients. Therapists often attended to the immediate needs of patients, and therapy sessions in Olive Ward invariably involved changing incontinence pads and bedding. Accompanying Olive therapists to a planned patient's session one afternoon, the therapists noticed another patient's pressure mattress had deflated. The next half hour was spent addressing this: checking the patient's skin, changing her incontinence pad, hoisting her into a different bed, moving furniture in the ward to swap the beds around, and updating nursing staff. Nevertheless, patients often spoke of a lack of response to their needs, especially regarding toileting. Although therapists responded to patient's immediate some of the time, they were aware that there was always more need than they were able to meet.

Sandy talked about feeling pressure from her manager to miss family meetings in order to 'free up' time for therapy sessions. Despite this pressure, in practice she was driven by what she deemed to be important.

"I am quite passionate about good family meetings being important... So sometimes the kind of holistic view of this as a family coping, and what is going to happen in the future is lost by you know, medicalisation of things... I do get pressures from managers to not go to them. You know. It's 'how many family meetings are you going to? Is that the reason why we are not meeting targets?'."

Sandy, B6 SLT, Olive

Framing this within Galvin and Todres' (2013) theory, therapists perceived that pressures of time and / or pressures from above compromised their desire to provide humanising practice. In Sandy's example her manager wanted her to spend her time on auditable activity, but in humanising terms she wanted to protect an aspect of her role that involved advocating for attention to 'sense-making' and the 'personal journey' of patients and families.

8.3 Categorising, labelling, objectifying

In Lipsky's terms, the categorisations used by therapists were simplifications, or 'mental shortcuts that summarise and come to stand for more complex phenomena' (Lipsky 2010 p142). For Lipsky, such routines of practice enable SLBs to feel justified in their rationing decisions. Based on the prevalence of SSNAP terminology and the time and effort spent on deciding whether patients should be SSNAP-stopped, I argue that the engagement with the audit had led to a new way of classifying patients. Teams that were more passive in their compliance with the SSNAP audit were baffled by the idea of classifying patients as appropriate or not appropriate for therapy. However, concluding that auditing led to labelling, or that patients who were not 'SSNAPing' were neglected, would be unfounded. Different methods of simplifying patients took place in all sites, and often bore relevance to the delivery of therapy.

8.3.1 SSNAPing or not SSNAPing

As Lucy (Clinical lead, Olive Ward) explained, the opportunity to include a date on which each patient stopped requiring therapy was introduced by SSNAP in response to feedback from therapists. Therapists had complained that the data for their contact time was diluted in a length of stay during which the patient did not always require therapy. For Lucy, putting a stop-date on therapy helped her to be clearer about the audit criteria and disseminate a (relatively) consistent message to the team. SSNAP had become part of local Olive jargon. As a crude comparison, the word 'SSNAP' or derivations of it occurred 344 times in interviews with Olive Ward staff, and 34 times in interviews with staff on Jade Ward. Therapists frequently discussed whether patients were 'SSNAPing' or should be 'SSNAP-stopped'.

In principle, Olive patients were given a trial of rehabilitation for approximately 2 weeks. If they were not tolerating 45 minutes of therapy every weekday and showing progress the SSNAP-stop date would be recorded. This meant that their therapy input would no longer be included in the audit. Therapists told me this did not mean therapy was discontinued. Each morning therapists wrote the names of patients they considered to require active therapy at the top of a planning sheet. Underneath, they listed patients who they wanted TAs to see for input such as passive stretches or cognitive screening. Generally, the patients on this list were not 'being SSNAPed', but might have therapy needs that were being addressed by TAs.

Therapists were often unsure of a patient's SSNAP-status and sought advice from senior colleagues. In one example, Katie (B5 PT), spoke of a patient who had been deteriorating. Katie was still working with her every day towards a goal of managing to transfer without being hoisted, but she felt the patient could usually tolerate 30 minutes of therapy rather than 45. She was uncertain of whether she should be 'SSNAP-stopped', as she had a goal and was progressing but could not manage 45 minutes of daily therapy. She sought advice from senior therapists who decided the patient should have been 'SSNAP-stopped' when she began to deteriorate. I asked if these decisions made a difference to the input Katie would provide, or if it was just that she was uncertain of how to record the data.

“No it’s not that I don’t know what to do in practice; I still know what my goal is and my treatment and aim is. How I am going to go about doing that. But in terms of knowing exactly the correct time to put in a SSNAP-stop date that can sometimes be tricky.”

Katie, B5 PT, Olive

It was suggested by some that focussing on the SSNAP-stop date had improved the way they framed their decision-making about patients’ therapy needs. The process of having a rehabilitation trial and then ‘SSNAP-stopping’ was thought by some to be a way of clearly communicating to relatives that the focus was shifting from active, intensive rehabilitation to less intensive input focussing more on long-term management. For Lipsky, categorising clients serves to reduce demand, as clients understand that they have not met certain criteria. The use of SSNAP-stopping seemed to serve this purpose and pacify family members who sought explanations for a reduction in therapy input.

After I had presented preliminary findings to Topaz therapists, I was asked to return for a meeting with stroke therapists across the Trust to inform them of the variation I had observed in auditing practices. The aim of the meeting was to establish a consensus in the stroke teams within the Trust. Therapists, previously unaware of the potential to categorise patients in terms of their therapy need for the SSNAP audit, were in a dilemma regarding how to respond to this new information. They wanted to maintain the ideal that everybody should receive some sort of therapy, despite the fact that few were likely to receive 45 minutes per day. They worried that categorising patients according to their therapy needs would become a self-fulfilling prophecy, and that therapy judgements would be based on the audit rather than clinical need. Lipsky argued that the decisions made by SLBs in allocating resources amongst citizens become self-fulfilling prophecies. I had not discussed this theoretical perspective with therapists, and therefore it was striking that they framed their concerns in the same way, highlighting the implications of investing their efforts in certain patients.

For ‘audit-aware’ therapists, categorising patients according to ‘SSNAPability’ became a routine of practice. I now focus on other categorisations relating to therapy need used across the sites.

8.3.2 Borough boundaries: Chesney or Chittleford

Categorisation according to borough of residence was used as shorthand for the inequitable services available for patients from different areas. The simple words, “She’s Chittleford” represented much information that the rest of the team instantly understood. Chesney residents had multiple options for ongoing rehabilitation on discharge: intensive Early Supported Discharge (ESD) input; ‘re-settlement’ to improve the transition home; slow-stream community input; or a ‘step down’ rehabilitation bed for up to 6 weeks. Therapists lacked confidence in the community services available for Chittleford patients. They told me there was a waiting list of at least 3 weeks, and then sessions would be infrequent.

Additionally, residents of Chittleford who reached Jade Ward were those with either more severe strokes or more complex discharge-planning needs. Therapists were likely to spend time making a case for joint health and social care funding for them. Together these factors meant that Chittleford patients were often on the ward beyond the point in their recovery when they would have been discharged if they lived in Chesney. Therapists did not believe in these cases that their needs for frequent therapy were as high, and they often prioritised the lengthy application and assessment forms related to their discharge-planning. This was a common routine of practice, and overrode the imperative to provide 45 minutes of daily therapy. The same was true for the different boroughs served by Topaz therapists, who noted that the quality of rehabilitation could be very different for two patients on the same ward, purely because of their home address.

“We might have two people next to each other in the beds, one of them is for here and one of them is for out of borough. One of them will go home today, the other one stays another couple of weeks.”

Joanne, B7 PT, Topaz

Although both SUs experienced the impact of the ‘postcode lottery’, this was in different ways. Chittleford residents sometimes remained on the ward for longer with tapering rehabilitation, and more ‘behind the scenes’ input from therapists. For Topaz therapists, the stricter criteria set by

one borough's community team meant that they focussed more therapy on certain patients to get them to a stage where the team would accept them. In both sites, the use of borough of residence as a label for patients was a simplification of various information relevant to their therapy needs. This information included inequities in community services; administrative requirements; the level the patient needed to reach before they could be discharged; the length of time they were likely to stay in hospital; the type of therapy they would require in hospital; and the intensity of therapy they would need whilst there. This inequity was not lost on Rafael. As a result of his stroke he was now homeless and jobless, and he had been asking in vain to see a social worker for two months prior to his interview. He compared his situation with that of the Chesney resident in the bed opposite him.

"I don't want to compare the things, but... the family comes, the mother, the brother, the sister, the daughter, and... he have a social work who work with him about the things. The new house and the things. And I look and I say, 'Oh come on, just because I live in Chittleford – this is a hospital!'. The people of Chittleford, of Chesney, of – I don't know where they come here to get the treatment, you know, this is not my fault and it is important to me, why they fail with that?... It's a different neighbour, the only thing. It's not my fault if I live there, you know."

Rafael, Jade

Despite Rafael's considerable distress, the SU team took little action to resolve his predicament, which they appeared to see as his lot as a Chittleford patient.

8.3.3 Diagnosis: Stroke patients and medical patients

The term 'medical' was used by therapists on Jade and Topaz wards, but represented a different sort of classification in each site. On Jade Ward 'stroke patients' were distinguished from 'medical patients' because certain processes for stroke patients were recorded on the SSNAP audit. Recurring examples included 'She doesn't need goals, she's not a stroke', and in a weekly meeting to complete outcome measures: 'He's not a stroke, so he doesn't need doing'. Jade therapists met to plan which patients should be included in the various groups timetabled for the week, and would again consider whether the patient 'was a stroke'. If there were spaces in the

group, 'medical' patients who were considered likely to benefit were allowed to be included, but stroke patients took priority regardless of need, as their care processes were audited. Therapists and managers in Chesney and Whimsford hospitals said patients on other wards who would benefit from neuro-specialist therapy would not receive it because the stroke standards did not apply to them, or because audit data were not being collected beyond the SU. This represented a distortion of policy, but it appeared to be systemic and not solely attributable to therapists as SLBs.

On Topaz Ward a 'medical' patient was one who had a different coloured magnet by their name on the team whiteboard. This signified that doctors had deemed them not to be able to go home yet due to medical reasons, therefore therapists were not required to prioritise them for discharge-planning.

8.3.4 Death and dying

The label 'palliative' was often used to signal information about therapy needs and processes. On Olive Ward, therapists pursued doctors for decisions about whether a patient was 'palliative' as this signified a discontinuation of 'SSNAPable' therapy. The concept of being 'palliative' was interpreted differently in Topaz ward, and was not indicative of a termination of active therapy. Joanne, B7 PT, had been worried about one of her patients and asked the doctor to review him. He said this patient was not 'palliative', as he was still being actively treated, but he was doing badly so 'wouldn't last'. Another patient who had a malignant mass was classified as 'palliative' as they could not treat this, but she 'might last for ages' and was still considered to require therapy. In different ways, therapists in both teams were guided by medics regarding whether they should offer therapy to unwell patients. However, in the more audit-aware SU, the drive for categorising patients as palliative had become a routine of practice, related to the push to determine their SSNAPability.

A TA on Jade Ward declared one afternoon that therapists had just wasted their time completing outcome measures for one patient, as she was going to die over the weekend. Staff were aware that SSNAP data for patients who died on the ward would not be counted.

“I mean they don’t even record deceased patients, so they’ll get a lot of therapeutic input probably... so, like if they die on the ward, that information doesn’t get taken to SSNAP.”

Nathalie, B5 OT, Jade

These examples show the potential for patients to be reduced to their auditable value. Classification in its different forms became a way of homogenising people according to certain details such as their borough of residence, their ‘auditability’ or their ability to respond to medical treatment. Simplifying the caseload in these ways gave therapists a feeling of justification in disregarding the 45 minute guideline for certain patients. As noted in Rafael’s quote above, patients were not oblivious to these forms of categorisation, and could feel powerless and frustrated. Their perspective is presented in the final part of this chapter. First, I turn to another routine of practice that featured in all SUs.

8.4 Therapy happens in therapy sessions

The siloed enactment of therapy, in terms of space, time and professionals, presented as important in data analysis of every SU. Multi-disciplinary rehabilitation is frequently referred to in literature regarding reasons for the success of SUs (Kalra and Langhorne 2007; Stroke Unit Trialists’ Collaboration 1997, 2007), and NICE guidelines state that the team should work together towards goals for each patient (NICE 2013). In all SUs, although OTs, PTs and SLTs generally formed allegiances and worked together, the work of nursing staff and therapists was distinct and divided. Nursing input was frequently seen as a barrier to therapy input, as nurses and therapists sought to see the same patients at the same time and in the same spaces. I observed a professional-focussed and process-focussed approach to rehabilitation, as opposed to a whole team, patient-centred approach. Some therapists perceived that the 45 minute guideline, among other profession-specific guidelines, had encourage this way of working.

8.4.1 Competing for time and space

In Jade Ward, a theme of preliminary analysis was ‘wasted time’. Therapists felt that the beginning of the day was likely to be wasted for therapy, as nursing staff were attending to patients. I witnessed the morning mayhem as nurses and therapists negotiated over access to

patients and spaces. The extract from fieldnotes in Figure 13 (below) illustrates this sense of competing for time, space and objects, and also shows that patients were ascribed different functional levels for nurses and therapists.

9.30am

I arrive on the ward with Jackie (B7 PT) and Tina (TA) for our session with Yemi (patient). She is in bed. The nurse is there. The nurse has to do her medication and Yemi wants to go to the loo. The nurse says there's a lot of medication - it all seems a bit muddled and chaotic. The ward is very noisy and busy... There is a hubbub of talking, beeping, the odd patient calling out to request a bed pan. It isn't clear how soon we can have our patient, or why the nurse can't just quickly give her the meds. The nurse is wandering off but says she has the meds in her hand. Meanwhile another PT approaches the patient in the bed next door who has been calling for a bed pan. 'You can take yourself to the toilet, M' he says. 'Come on, I'll go with you.'

Jackie is getting frustrated and points to the clock, which by now says 9.45. 'See, this is how it is!' She exclaims. 'You book in to have a nice full hour with a patient to do some good standing and it's like this. We haven't managed to do any standing with Yemi because of this.' I say, what none at all? She says not much. It's usually bits and bobs, the arm, whatever can fit into the time. She and Tina help Yemi to get from the bed to a commode and go to wheel her into the bathroom. Jackie gasps again because the bathroom she had set up with Yemi's wheelchair is now being used by someone else (in fact, the patient next door who had been calling for the bedpan)... Eventually they get her into the bathroom, and I say I don't need to come in, so wait outside on the ward. They pop out and give me positive progress reports on her standing and transferring from the commode. We go to the gym when she's finished, and she does more standing and transferring. Despite managing this with therapists, she still has to use the hoist to transfer with the nursing staff.

Figure 11: Extract from fieldnotes 3.9.14, Jade Ward

Therapists and nursing staff were frequently trying to complete similar activities with patients, but there was no suggestion of coordinating their efforts and working together. Rafael suggested that even therapists and nurses leaving notes for each other would improve problems experienced by patients.

“They work separate. I think if they speak about that, must work better, do you know? Just to speak or leave a note in the table ‘this one have a breakfast so we don’t give the breakfast.’ Because today, I ate my breakfast. My memory’s not good like that... I see ‘oh you have breakfast group’, and I was eating. So what I gonna do in the crowd? Just go there and speak with the people, do you know? But if you leave a note, the nurse she come ‘oh I don’t gonna give the food now, he gonna eat in the breakfast group’, you know.”

Rafael, Patient, Jade

8.4.2 Uni-disciplinary working

‘Whatever happened to 24 hour MDT rehab?’ was a theme that arose from data analysis at each site. Some therapists recalled a time when, even if it was not perfectly enacted, the message was that rehabilitation should be promoted by the whole team at all times. The stroke nurse specialist on Olive Ward was emphatic that the stroke guidelines (in their broader sense, and including the 45 minute guideline) had caused only positive changes. However, others suggested a connection between the profession-specific guidelines and professional-focussed care.

“It really encourages a uni-disciplinary focus on what an OT, physio, speech and language therapist and dietician is aiming to achieve in order for them to meet their guidelines and I personally feel the patient element has come out of that. So, we are all here to ensure the best clinical experience and outcome for the patient. The theory is that technically by each of us doing our jobs really well, that we achieve that but actually how we work together cohesively as a team has suffered. Because there is a bit of ‘well we are doing ok, what are you doing?’.”

Lucy, Clinical Lead, Olive

Other therapists also made this connection explicitly, but in some cases it was more implicit in interview discussions. For example, SLTs raised the issue of the disparity between their scores and those of PTs and OTs (which were always higher). Some of them talked of pressure to raise their score, and felt this was regardless of patient need. The concept of ‘seeing people for the

sake of it' was raised in the previous chapter, and fitted with the notion of prioritising the needs of the professional group over the needs of the patient.

An exception to the charge that the 45 guideline led to uni-disciplinary care, was the fact noted by some therapists that cross-disciplinary sessions were worth 'double minutes'. For the therapists who were aware of this, this encouraged joint sessions across disciplines (e.g. OT and PT rather than OT and OT). Some therapists saw this as a positive move, but others expressed cynicism and stated that the same amount of the patient's time had been used either way. Therefore, in this case, although different therapists may be encouraged to work together, this was still for the benefit of the professional groups, and any benefit to the patient was incidental. This also only applied to therapists, and therefore there was no encouragement of joint working with others, such as nursing staff.

Therapists and nurses worked separately with patients, behind drawn curtains, or therapists took patients away to therapy spaces for their designated session. Therapists said that ideally there would be a more integrated approach to rehabilitation.

"Seeing patients that you've worked quite hard on getting them up and getting them engaging and then finding someone is feeding them in bed and stuff, just really upsets me... I can't think of anything worse than someone feeding me and I just can't get my head round why... They can pick up a cup, they can pick up a fork, they can feed themselves but – and yes, just investing a bit of time maybe repositioning patients, so they're sat up a little bit more in bed and just all the things, these are things – because it's not just the therapy time that we spend with patients. That's such a big thing as well isn't it? It's the amount of time that the patients are in bed... or sat by their bed. And there's just nothing going on around them."

Cheryl, B6 OT, Olive

"It seems like we turn up to their bed and start it with, "We're going to do some therapy now". But they've not got much control over it."

Therapists were the gatekeepers of independence, assessing patients' safety and passing recommendations on to nursing staff. It was common in meetings for therapists to give an update on a patient's ability to transfer, such as 'she's a Sara Steady with therapists, she's a hoist with nurses'⁵. In this way, patients were ascribed different levels of independence by therapists, depending on whether they would be assisted by nurses or therapy staff. An SLT was told that nurses would like her to check a patient who kept choking at mealtimes. She was exasperated, saying 'I've told them he's a red tray!'. A red tray at mealtimes indicated that the patient needed to be helped to eat their meal. The SLT felt she had 'done her bit', and nurses should now take responsibility for managing the situation.

In another example, Yemi was desperate for a shower. Several times, she asked nurses to shower her and they referred the decision to the OT. After over a week, the OT eventually completed her assessment and agreed she could now shower with nursing staff. As noted in Figure 11 above, Yemi was able to stand up, but only within therapy sessions. In the absence of any joint working, nurses referred to a whiteboard above each patient's bed for instructions regarding the assistance they required.

"It's not that it's frustrating but you just think, oh, they should let them know. Because like now, transferring from the wheelchair to the bed and the bed to wheelchair, with the physiotherapist, at least if they want they can call the nurse, the staff and tell them to come and see me or to inform them. Where the thing is that every time they say, 'oh we've not been told, your board has not been changed'. Because they have to put how you can transfer... on the board that they have to follow. So, if they don't change it, the nurses, they're not happy to risk with you. Because say if anything happens, they're liable, which I could understand."

⁵ These are two different types of manual handling equipment used to assist patients to stand and move e.g. between bed and chair. A hoist provides full assistance, and therefore the patient does not participate in the movement. A Sara Steady allows the patient to pull up to a supported standing position, therefore involves more participation from the patient and represents a greater level of independence.

Yemi's perspective was informed by her own background as a healthcare support worker. Other patients were less conscious of the distinct roles of different staff. When I asked about therapy, it was not uncommon for patients to tell me about the noise on the ward at night, or the lack of response to the call bell when they needed to use the toilet. Their needs, problems and experiences were not divided into professional categories.

"I can't tell the difference. I don't judge them, I just see whoever comes along. If it's a human being, good. If it's got that capacity to feel and sense; good."

Eddie, Patient, Jade

The lack of joint working between therapists and nursing staff was raised by therapists in most interviews. They sympathised with nursing staff who, they felt, were even more overstretched and under-resourced than they perceived themselves to be. They felt that the high proportions of bank and agency staff made it difficult to form good working relationships. When I visited SUs to discuss preliminary findings, therapists in all sites became animated about this topic, and more experienced stroke therapists asked, 'Whatever happened to 24 hour rehab?!'. They recalled that this had previously been an aspiration on SUs, and involved principles such as patients wearing their own clothes instead of hospital pyjamas, and maximising opportunities to be active and independent with all staff at all times. Whilst there was no suggestion that this aspiration was ever fully realised in the past, there was a sense that it was no longer even an objective for SU teams.

It is evident that therapy delivery should not be considered or reviewed in isolation, as SU therapists work within multi-disciplinary systems. Factors including workforce issues clearly added strain to the system. However, I argue that the faded aspiration of '24 hour rehab' may be related to a culture in which performance measurement encourages workers to focus on tasks that fall within their rated domain. I propose that the demarcation of therapy and nursing responsibilities was a routine of practice. Therapists, required to provide 45 minutes of therapy for each appropriate patient, controlled and rationed their time by portioning it out amongst

patients in designated sessions. Under pressure, each professional group controlled their workload and restricted themselves to the tasks for which they felt responsible. The profession-centred approach to working I observed may therefore unwittingly be encouraged by the auditing of profession specific guidelines.

8.5 “Nobody asking me”: Lack of patient involvement

E: Do you ever ask the patient, do you ever ask them what they want in terms of intensity or how much they want to be seen?

J: No.

E: Do you think you should?

J: No.

E: Why not?

J: Because I can't necessarily offer them. I can't offer them what I think is appropriate. So, or it's like giving someone the cookie and saying, "Ah but you can't have it."

Joanne, B7 PT, Topaz

In the preceding sections of this chapter I have argued that Lipsky's notion of routines of practice can be usefully extended to illuminate certain therapy practices. However, Lipsky's account does not address the perspective of the recipients of SLB's services. The perspectives of patients are a crucial part of the story of therapy on SUs, and I use Galvin and Todres' (2013) humanising framework to interpret them. Patients wanted to be seen within the context of their *personal journey*, but instead were subject to *objectification*, e.g. by being categorised according to their auditability. I argue that the routines of practice described above promoted *passivity*, and that patients wanted a sense of greater involvement in their care. Stroke rehabilitation guidelines (NICE 2013) state that patients and families should have the opportunity to be involved in decisions about their treatment and care. In all three SUs I observed that despite wanting to be included in decisions, it was not standard practice for patients to be given choices or an overview of their therapy.

8.5.1 'It would have been good, being more involved'

In most cases, patients did not have expectations of therapy. Most patients interviewed had not experienced a stroke before. It was a sudden, unexpected shock. Some said that they did not know what they needed, and therefore put themselves in the hands of the SU team. Regardless of whether patients were positive or negative about therapy, or whether they felt lacking in the knowledge required to make decisions about their care, they were united in wanting to be included.

"Nobody asking me. Like, professionals, they maybe have the answer, but I think they must ask for everyone how much therapy you need, if it's less they must stimulated the people with conversation, I don't know, but I think the person must decide how many time they gonna make up therapy. I think the person know her body like this and the answer must come from the body."

Rafael, Jade

Mrs Rosenfeld's husband, Simon, was a patient on Jade Ward. The following extract from her interview conveys the feelings many patients had of lacking the expertise to make decisions themselves, but wanting to be involved and informed.

Mrs R: We just assumed that whatever needs to be done is gonna be done... because there's no choice otherwise. We're not going to be there and know when he goes in for therapy, when he goes out, what he thinks about it. Half the time he couldn't talk anyway. So we had no choice but to – and after all, these people have learnt it all, this stuff. We don't know anything about anything. Know about other things, don't know about that.

E: So you wouldn't necessarily want to be asked how much therapy or what sort of therapy your husband should be getting?

Mrs R: No - I would have liked that... It would have brought us into the picture more, then we would have said we don't know, and what does 45 minute mean? Is he very tired after that? And how does he compare to other people? We could have asked all sorts of questions. But there wasn't that sort of space.

E: So, it's not necessarily that you were going to know the answer, but you'd like to be in the conversation?

Mrs R: Yes. And even experts sometimes have different opinions. So if you're part of it... yeah definitely I think it would have been good, being more involved.

Mrs Rosenfeld, wife of Simon, Jade

Of the 9 patients (and 1 carer) that I interviewed, only one reported having been involved in decision making about his therapy plans. John told me he had initially been resistant to therapy. He commended the OT for taking time to really explain his difficulties, the reasons behind them, the terminology used for them, and how she proposed to help with therapy input. He emphasised the importance of this involvement, which had made the difference between him rejecting and embracing the therapy offered.

"I met Nancy [OT] and I thought, "Oh my god I can't do this, it's so hard." So it was, and I thought, "Oh god, I've got to opt out of this, get on to something else... But Nancy was supportive. She was always supportive. She gave me solutions or answers to things. So she was very encouraging in that. So she gave me a choice basically. Yes work on it if you want, but you have to be committed to it in terms of whatever. So I thought, "Oh well let's go ahead." So that's what I did, you know."

John, Topaz

During data analysis I had included 'passive acceptance' in the label for a data category regarding patient perspectives. Galvin and Todres (2013) use the term *passivity* to refer to an aspect of dehumanising practice which I argue applies to the lack of patient involvement I observed. However, I became troubled by this term when my fieldwork extended to becoming a relative visiting the emergency stroke admission unit at Skydale General (where Olive Ward was the SU). I include an excerpt from my reflections on this experience, as it was influential in my continuing analysis and interpretation of the data.

I'm sure they'll do the right thing, I trust the experts. These were my words but I remembered coding words like this from patient and family interviews and putting them in a category of 'patients and family don't know; trust the experts; passive acceptance'. This now seemed patronising. You trust the experts because of desperate hope, not some sort of passive ignorance.

Figure 12: Extract from reflective diary, July 2015

I therefore suggest caution when interpreting the finding that patients were passive. Patients were doing their best to cope in a very challenging and unfamiliar situation. As Richard on Olive Ward told me,

“I don't say I'm calm, I think I'm resigned to the fact... And you make the best of it... I'm out of my depth here. So I have no idea what's a good system and what's a bad system... It is a pain in the neck at the moment and I want to get complete use of my arm as quickly as possible. But I'll wait and see. I'm sure that they're going as fast as they think to get a progression.”

Richard, Olive Ward

Shocked by the unforeseen circumstances in which they found themselves, patients had to trust that their best interests were being promoted. They did not desire control over decisions, but wanted to be a part of the conversation.

8.5.2 Attending to the whole person

Simon, a patient on Jade, had been keen to participate in the study before he became very unwell. He continued to receive therapy, and his wife expressed concerns to me that it was too much, too demanding, and that therapists were not attending to him as a whole person with consideration of his past and history when they continued to put him through therapy.

“I believe in it a lot that if a person, like that's why I want him to go to [Jewish nursing home]... he'll meet other people similar backgrounds. There are lots of things Jewish people do during the day that if he's part of he'll be really happy. And if he has those, I think that helps the body get better... So in other words you have to judge for each person.

That's why I would always go for therapy to be on the lighter side. I still think you know, you have to do it by the experts, but that's just the way I see it. And to make the person feel good, and then that will help them to have both things going on at the same time."

Mrs Rosenfeld, Jade Ward

I finished fieldwork in Jade Ward in November, but in January I had a telephone call from Mrs Rosenfeld, worried that her husband was being given too much therapy as a matter of routine.

She asked me if I had a minute to chat. I said yes. She said, 'It's about the therapy. He's still in hospital, and he's been having therapy, but we're a bit worried as we think it's too much for him. He's got a new therapist now. I mentioned it to him and he said they are just continuing with what was being done by the previous therapist, and it has been written down that he should have 30 minutes a day. I wanted to ask your advice.'

I asked her what they were doing with him in therapy. She said she didn't know. I asked her what made her think it was too much. She said,

'Well he is able to talk now, and I said to him 'how is everything?' and he said 'terrible'. I told the therapist that and he laughed and said yes well it's the same with us.'

... [I asked her if she knew what the therapists were aiming for with Simon] She said,

'Yes, there was something about him having a goal to get back to the synagogue, but they don't seem to realise he hadn't been going to the synagogue for some years before his stroke.'

Figure 13: Extract from reflective log: January 9th 2015

Other patients also spoke of the importance of aspects of their lives that pre-dated the stroke, expressing a desire to be considered, listened to and understood as an individual formed by a multitude of past experiences. On Jade Ward, Eddie told me about traumatic experiences in his life that had made him mistrustful of doctors and highly anxious about being in an institutional environment. He was desperate to get home, but was now dependent on being pushed in a wheelchair and his home was no longer accessible to him. He said he had no choice but to allow the therapists to make decisions about him and find him a new home which he would be discharged to without seeing first. On Topaz Ward, Tristan had felt very anxious about trying the stairs in a therapy session, because it brought back memories of his slow rehabilitation from a severe car accident when he was a child. Imran cried as he told me of falling in the bathroom during a previous hospital admission and being stranded there as someone put an 'out of order' sign on the door. He told me, "Those stories are what I am." Every patient I interviewed told me

stories that revealed something of their sense of identity and their attitudes towards their current predicament.

My interview questions sought patients' perspectives on the quantity of therapy they felt they needed, but patients talked more about their interactions, the way therapists delivered sessions, and a desire for therapists to understand their individual needs. Eddie told me that he was a 'guerrilla gardener' and took pleasure in deciding what sort of flower to plant in which urban environment. He said it was the same with all the caring professions: the important thing was to have sympathy and empathy to judge what each person needed, and 'what would brighten people up'. To Eddie, the 'core qualities' of a person were important. He strongly objected to being 'soft soaped' by therapists, or told he was doing well when he was struggling. Imran expressed the same feelings, criticising therapists for giving 'false encouragement' and 'pumping' him. Patients consistently commented on the personal qualities of therapists and the significance of these. Rafael described therapy as a 'passion job' and expressed the importance of being treated with kindness.

In humanising terms (Galvin and Todres 2013), patients expressed desires for their 'uniqueness' to be attended to and valued. Therapists' focus on process and 'doing to' patients entailed a loss of personal meaning, and routines of practice described earlier in this chapter risked reducing individuals to numbers, labels or work tasks. The tendency to categorise and process patients, and the lack of focus on their individuality, was not entirely attributable to the 45 minute guideline and audit. However, therapists are being actively included in audit society (Power 1997) for the first time, and this is likely to be a factor in developing a certain working culture in which measurable performance takes priority, and quantity becomes a proxy for quality. The personal qualities and clinical expertise of therapists was a greater consideration for patients than the quantity of therapy they received.

8.6 Chapter Summary

Using Lipsky's notion of 'routines of practice', I have shown that therapists across all sites used systems of categorisation to simplify their workload. This also served the purpose of justifying

their prioritisation decisions, appeasing their guilt about never doing enough, and moderating the demands of patients and families. It had become routine practice in all sites for therapists and nursing staff to delineate their work in ways that both perceived as counterproductive for patients. I have argued that reasons for this are likely to be multifactorial, but as a new addition to audit society, auditing therapy may play a part in increasing a process- and profession-specific approach. I will explore other contextual factors influencing these changes in Chapter 9.

An NHS document has stated that stroke team members should 'make rehabilitation the basis of the patient's day' (NHS Improvement 2011). Evidence regarding the mechanisms of recovery of brain function after a stroke has been used to argue for 'interdisciplinary, collaborative input 24 hours a day for stroke survivors, to facilitate useful movement patterns and optimise function' (Aries and Hunter 2014). This approach was not evident on any of the SUs where I carried out fieldwork.

Therapists expressed worries that their work pressures were causing them to change their behaviour in ways they saw as unethical. Lipsky claims that although the stated intentions of street-level bureaucracies are to be more client-centred, SLBs cannot become more responsive to clients without it leading to further need to ration their service in some other way, assuming resources remain the same. I argue that the demarcation of therapy time and tasks was a way of controlling workloads and making productivity measurable. Therapists retained control over therapy decisions, partly because of an awareness of the need to ration their limited resources, but also within a culture of processing patients rather than attending to them as 'whole' individuals.

Patients reported that although they did not necessarily want to make choices about their therapy, they wanted to be involved in decision making. This reflects previous findings regarding patients' desire for more involvement (e.g. Howell et al 2007). I have suggested that the experiences described by patients and therapists in this chapter can be understood within the framework of humanising values proposed by Galvin and Todres (2013). Categorisation was a 'homogenising' practice that detracted from their 'uniqueness'. Patients desired more inclusion in decisions about their care, and valued 'agency' in the rare examples where this occurred.

Chapter 9 : Therapy on the threshold of Audit Culture

9.1 Introduction

This study posed a question: how is SU therapy interpreted and enacted in the era of the 45 minute guidelines? In Chapter 7 I argued that the purpose of therapy was diversely interpreted, and multiple contextual factors influence its delivery. There was variation in therapists' approaches to auditing their practice. I argued that these factors presented a challenge to the ideal of standardisation. In Chapter 8 I illustrated routines of practice therapists developed to simplify and ration their workload, and argued that these did not embody the humanising values that mattered to patients (Galvin and Todres 2013).

In the final results chapter, I position SU therapy at the threshold of audit culture. I present changes in SU therapy delivery that staff perceived occurring over recent years. I argue that the guideline and audit are part of a bigger programme of performance measurement, which bears the characteristics of Power's audit society (1997). Situated within a quasi-marketised health system, therapists were mindful of the power of commissioners to allocate or remove their funding for services. Auditing therapy encouraged a sense of competition and rivalry between teams.

Borrowing Turner's (1966) anthropological term, I argue that SU therapists were at a liminal stage of participation in audit society (Power 1997). Some teams were on the periphery, feeling pressure to start playing the data game. Olive Ward had gone through the 'rite of passage' (Turner 1966) of suffering poor SSNAP scores and were now highly audit-focussed. Therapists did not believe their SSNAP results reflected the quality or quantity of therapy they provided. Therapists had internalised the message that 'more is better', but some saw the 45 minute guideline as a threat to individualised, clinically-reasoned treatment.

Small-scale quality improvements were initiated by therapists in all SUs to improve therapy delivery. 'Bottom-up' and 'top-down' mechanisms for change appeared to serve different purposes, and the guidance of therapists in leadership positions influenced the quality of therapy delivery.

9.2 Perceived changes in SU therapy

I begin by presenting a mixed picture of recent change in stroke management. Medical stroke management was seen to have improved whilst inpatient rehabilitation had regressed over recent years, and changes in the ward environments had influenced the nature of therapy delivery.

9.2.1 Medical management has improved, but SUs are now less rehabilitative environments

All three stroke consultants who were interviewed told stories of their involvement in setting up specialist stroke services at a time when there had previously been no such thing available. There was a clear narrative of progress in the medical management of patients.

“I’ve sort of built up the stroke service from the ground up... and we very quickly, overnight, demonstrated the sort of reductions that you see in the stroke unit trials. So the reduction in terms of mortality and increase in people being discharged to their own homes.”

Dr Adams, Olive

However, Dr Adams echoed the statements of many Olive therapists when he stated that regarding inpatient rehabilitation,

“in some respects, I think we were doing it better at some stage in the past than we are now.”

Dr Adams, Olive

Therapists, doctors, TAs and nurses from all SUs told me that stroke care had changed unrecognisably in the last decade. When talking about hyperacute care and access to medical interventions such as scanning and hydration, these changes were considered to be beneficial.

“Oh it’s beyond all recognition. When I first started in 2003... there was no consistency... they very rarely would get a scan within 24 hours. They probably wouldn’t get their NG tubes passed for sometimes weeks. It was really, really awful.”

Linda, Stroke nurse, Olive

The acknowledgement of these benefits was unequivocal, but other changes elicited mixed feelings. Some talked about the days when people who had a stroke were ‘scattered randomly’ across wards and sites. Helen (B7 PT) explained that by 2004 it was recommended that all stroke patients should be treated on a designated SU. Like many, she felt that the better days of stroke rehabilitation had been around this time, after the establishment of SUs but before the reconfiguration of stroke services and ‘pre-SSNAP’. The year of her maternity leave coincided with the reconfiguration of stroke services and introduction of hyperacute units.

“When I went off on mat leave say I suppose 3-4 years ago, everyone had really engaged with the national clinical guidelines and the kind of evidence-base for quality and really striving to achieve that and I felt that the rehab ethos in the team I was working in at the time was really strong as an MDT... I have come back to this role, and I do feel that the rehab ethos here is slightly splintered. And I personally feel that some of the guidelines are responsible for that... There was an awful lot of changes from how we used to run our stroke unit to how we run it now.”

Helen, B7 PT, Olive

Similar narratives were given by other therapists who had worked in stroke rehabilitation over this time period. In Chapter 8 I reported that therapists ‘cut corners’ to make their workloads manageable. Agata, who had worked in Chesney Hospital as an OT for 10 years, and said during this time she had learnt to spend less time on things like talking to relatives.

“In the past... I felt it’s worth investing the time into the relatives... And it would help the patient definitely even long term beyond discharge, if you spent the time with relatives. But again, that’s what I had to learn, that, ok that’s what people do... that’s just the way to cope.”

Agata was not alone in discussing how she had changed her practice in order to cope with the workload.

“So, before I used to try and do everything... Now, I try my best not to do that, and I cancel the patient’s sessions, one to one, and that session becomes an admin session.”

Joanne, B6PT, Jade

I wondered why therapists felt a growing need to cut corners, despite an increase in therapy staffing on Jade and Olive Ward. Although the therapists stated that these changes had occurred in recent years, the 45 minute guideline did not directly appear to be increasing their workload. I stepped back from focusing on the guideline, adopting a systems approach to interpreting the changes (Seddon 2008). The reconfiguration of stroke services was evidently a factor. Therapists understood that their priority was to keep the flow of patients moving through the pathway in order to ensure beds were always available at the HASUs. As well as relating to the bigger picture in terms of the stroke pathway, many of the changes discussed by therapists were related to the need for the SU to function as a business. Service expansion, team fragmentation, and the loss of therapy spaces arose as factors influencing therapy delivery. I will elaborate on these changes first, and then situate them within the context of a quasi-marketised health system (Hupe and van Kooten 2015; Power 1997; Seddon 2008).

9.2.2 Changing spaces

In *Discipline and Punish*, Foucault discussed the organisation of spaces, movement and time in institutions including hospitals (Foucault 1977; Rabinow 1984). He charted historical changes in the hospital environment in relation to its purpose. I argue that changes in the organisation of SU spaces also related to changes in the perceived purpose of therapy and the nature of its delivery. The ethos of Jade Ward was rehabilitation, and therapy there took place in a range of therapy spaces. There was a flow of patients and therapists moving between the ward, gym and kitchen. On Olive Ward (where the Foucauldian gaze of SSNAP was strongest), patients were taken

passively to the gym in their beds in order to maximise SSNAPable time. They were rarely seen moving between beds and bathrooms, and were instead attended to by nurses behind curtained bed areas.

Olive Ward had relocated to a ward that could accommodate more patients. Some felt that the 'geography' and layout of the ward in itself had significant effects. Staff who had worked on the previous ward said it was smaller, with the nurses' station at the hub, surrounded by patients and ward activity. The new ward, large and long and quiet, was described in the 'settings' chapter. My contrasting impressions of Jade and Olive Ward seemed to parallel the contrasts between the old and new Olive Ward.

Changes had also occurred more recently within the new ward. The therapy room was converted into bed space for four additional stroke patients. This loss of space seemed very significant to therapists, in terms of the practical loss of a place in which they could bring patients together, and the message they felt this conveyed to them about the worth of a place for therapeutic activity. When the therapy room had existed, therapy incorporated bringing patients to the day room to sit and chat to each other or take part in music group; lunch club; art club; an upper limb group or exercise group. This had all stopped when the space was removed. A space linking the corridor with the meeting room was available as an alternative, but had limited wheelchair accessibility. These changes related to the narrower definition of therapy that I observed being enacted in Olive Ward (see p130).

"It just means we have nowhere to bring our patients to, because bringing them to that blooming room just before the MDT [room], it's not a nice place is it? ... It just looks like a blooming meeting room, doesn't it, that you shove a patient in with a television... We've lost that ability to bring patients together to chat, to talk through their own experiences, the good things, the bad things, you know, to get any sort of feedback, it's very difficult."

Helen, B7 PT, Olive

Whereas Jade Ward still ran a busy timetable of groups, and utilised a range of therapy spaces, Topaz and Olive Ward therapists both saw these as things of the past. On Topaz Ward therapists

perceived a change in the nature of therapy delivery to be an inevitable consequence of the change of focus from inpatient to community rehabilitation.

“I don’t think we’re ever going to be seeing a time again when we’re going to have inpatient, inpatient stroke therapy as to what I was doing when I was a Band 7... I don’t think it’s modern, it’s not modern, it’s not modern healthcare.”

Rona, Clinical Lead, Topaz

9.2.3 We’ve lost that loving feeling

In all SUs the longer-standing therapists perceived a shifting focus from rehabilitation to discharge-planning. Staff discussed the changing ‘feeling of the ward’, and having lost ‘that cosy feeling’. Norma had been the Ward Clerk on Topaz Ward for many years before becoming the SSNAP data administrator. She talked with sadness about the changes that had occurred over recent years. She said the hospital was like a family, and prior to ‘the takeover’ people had worked there for years and everyone knew each other. The previous OT and PT had been ‘fantastic, best ever’ and worked really well with the nurses, but people had left because of cuts and low morale. In the reconfiguration of services, the hospital in which the HASU was established was perceived by Norma as ‘taking everything’. Nursing staff had been downgraded, and the feeling of the ward had changed. She reminisced about the stroke re-union parties they used to host for ex-patients. She told me ‘they loved coming back, and it was great’, but that would never happen now. This resonated with the consultant’s understanding of the changing remit of SUs.

“It’s very difficult nowadays, like I say, because so much rehab happens in the community, that those sorts of things used to happen in the old-fashioned units where they accepted people were going to be there for a long time so they might have pets and a more homely environment. That we’ve lost across the board because we’re pushing, we’re doing rehab at home which is better. So people in hospital are often a lot more acutely unwell. So the focus becomes much more sort of a medical mould.”

Michael, Consultant, Topaz

9.3 Contracts and Competition

Economic factors and a focus on healthcare as a business influenced some of the changes described, and the short-term commissioning of stroke services concerned staff. There was rivalry and mistrust amongst teams regarding their audit ratings.

9.3.1 'Beds' means money

When I heard about Olive's lost day room I understood the implications, but did not question the reason for it. I assumed that the needs of stroke patients for beds was naturally prioritised over their need for other available spaces. I learnt that from a business perspective, patients were needed by the Trust to fill beds and generate income. Considerations such as finances and contracts often arose in interviews and discussions. Dr Adams discussed the economics of the hyperacute model, and though the detail is superfluous here, the basic principles are relevant to the story of recent changes in stroke rehabilitation. Dr Adams told me that his job as consultant was now 'really like running a small business'. He explained that in order to provide efficient services, a large throughput of patients is needed – Dr Adams suggested 900 patients per year. His hospital had 550, so there was pressure to increase this number by attracting commissioning groups to choose the hospital to provide a service for a population in a given geographical area. Contrary to my naïve assumption of putting beds on the ward to meet demand, the aim was to expand and bring in extra activity from neighbouring areas in order to generate income which could be invested, for example, in nursing staffing. This is an example of the quasi-marketisation of healthcare (Hupe and van Kooten 2015; Seddon 2008).

This explained another factor in the changed 'feel' that therapists and others described in the ward. As in Jade Ward, the number of patients and staff had increased considerably. In Olive Ward the nursing staff establishment had increased from 28 to more than 50. The previous workforce of 28 had been fairly stable, made up of nurses and health care assistants who had been there for a long time. Those who remembered these days recalled a sense of solid continuity and a small, strong team. Nurses contributed more to 'the therapy process' and the ward had a

'rehab ethos'. Nursing posts had proven difficult to fill when services were reconfigured, and there were problems retaining nursing staff. In all sites nursing staffing was seen as inadequate, cover was provided by agency staff, and nurses were under immense pressure to do the basics of their job and could not go beyond this to be involved in rehabilitation.

Dr Adams' lesson in health economics also shed light on some of the concerns expressed by staff on Jade Ward. In early data analysis from Jade Ward I had grouped 96 separate references under the title 'the bigger systems picture', and re-visiting this category I found that much of it related to the need for clinicians to consider the business side of healthcare, such as commissioning and funding. The changes Jade Ward therapists discussed included increased paperwork and processes, and a focus on discharge taking priority over rehabilitation. The paperwork they were required to complete to make a case for the funding allocated to a patient on discharge was by far their biggest source of frustration. Those who had been in post for long enough also talked about their roles becoming more challenging when the ward won a contract to serve another borough (see p158).

9.3.2 Contracts and commissioners

For Jade therapists, winning the 'Chittleford' contract had complicated the discharge-planning element of their jobs, but despite this they saw the potential loss of the contract as a threat. These concerns were mainly raised when I asked questions about what therapists understood to be the consequences of performing well or badly on SSNAP.

"I worry that one day they'll look at our stats and say, ooh speech therapy isn't meeting the [45 minute] standard.... And they want to take the contract off us. So if that was the case, if they were to take the contracts off us then some of us could lose our jobs."

Claire, SLT B7, Jade

I wrote in my fieldnotes of a sense of ominous fear of what might happen in the future, and asked the therapy manager for her perspective.

“Well there’s a little bit of paranoia there but at the same time ... what we don’t want staff to do is to be naïve, and you know, shielded or protected from any sort of other conversation. So when the Chittleford stroke beds came here it was a tender for a service which this organisation won, and it’s a tender for 3 years, so at any, you know, and obviously we’re 2 years or so into that. So it will need to be reviewed at some point. So obviously as it goes increasingly closer to review, then people will become anxious.”

Ann, Therapy Manager, Chesney Hospital

Ann talked about the ‘new way of providing healthcare’, with tenders coming out for very short term contracts, sometimes just for one year. Her talk of not being able to ‘bed down’ services in this time resonated with Dr Adams’ talk of organisational memory that had existed on the old Olive Ward and had not been developed yet in the new ward. It also related to Norma’s story of disruption, change and the loss of an established workforce ‘family’. Revisiting the data, I realised that many changes therapists had perceived in their work were linked to service contracts and commissioning. The term ‘commissioning’ had 40 references across the interview transcripts. Broadening the search to include the terms ‘CCG’, ‘cost’, ‘money’ and ‘budget’ yielded 152 results.

Across all sites there were fears about potential implications of SSNAP for service commissioning. The clinical lead on Olive Ward was alone in viewing the inclusion of therapy on the SSNAP audit as an opportunity to engage with commissioners. Lucy did not think the improvements in the therapy SSNAP scores for her team reflected actual improvements for patients (see p186). However, she did value SSNAP for drawing attention to therapy as an important part of stroke care.

“I think for me it’s opened a dialogue. It’s giving a really nice, from my experience a really nice platform for therapies. So I sit on a meeting in a very privileged position being able to steer the expectations of commissioners in the direction I want to steer it in. And I feel really privileged for that and SSNAP has given me that. So it has given me a common language in which to talk to people who make the funding decisions but actually by the door being open and me being there I am able to wangle in my ethical patient experience viewpoint... So I do ambush the meetings quite a lot with the patient experience side-line.

And as I have said to the others I feel like I am championing that side of things and making sure people don't gallop away with ratings."

Lucy, Clinical Lead, Olive

Lucy had become an active member of audit society, and appreciated being 'at the table' with the commissioners who held power over funding and contracting services.

9.3.3 Rivalry and Mistrust

In all sites, teams expressed rivalry and mistrust about neighbouring services' SSNAP practices. I initially categorised this data as an unintended consequence of SSNAP; however, competition is an intrinsic aspect of publicly rating services. Therapists attended regional meetings and continually learnt more about how colleagues in other services were reporting SSNAP data. The following is an extract from an email that was sent to me by one of the therapist participants regarding a regional meeting where SSNAP reporting was discussed.

Literally every team in the room had a different way/method of reporting to SSNAP – some teams were even stopping the clock when pts were unwell and restarting the data later... somehow, not clear how.

Overall, the accuracy of the data is probably close to abysmal! There appears to be no consistency in what teams are doing and it appears that some teams may well be "bending the rules" to suit them. I don't know if SSNAP has picked this up...

We are currently reviewing our process and we have a more robust plan of how we are going to tackle SSNAP data from now on.

In case you are wondering, no, we did not bend any rules, so any data you may have included in your study from us is very true and honest to our knowledge!

Figure 14: Extract from email from therapist. February 2016

This exemplifies several features that regularly occurred in conversations and interviews with therapists. They were aware of the variation in audit practices across services; they questioned the quality of the national audit data for therapy; and they used language such as 'bending the rules', 'playing the numbers game', or even 'lying' when discussing the practices of other teams.

When discussing their own practices, therapists invariably emphasised that they wanted their data to be an accurate reflection of their therapy delivery, and their intentions were to use integrity in their audit practices.

Senior staff from Olive Ward had visited neighbouring hospitals to find out about their audit practices and investigate why they were achieving better scores.

“It was really interesting to get insight into how other people do it... So their clinical decision-making for who got a session that day was based on ‘two-two-five’ for the week. So 45 minutes a day for 5 days is 225 minutes. But that was the language and I found that really interesting that that clinical decision seemed to be based on 225, as opposed to perhaps what was presented that day from a patient perspective. So that was interesting to come away thinking: this is a high performing A rated unit. What I took away from that is, do we really want to be one of those?”

Lucy, Clinical Lead, Olive

Lucy was implying that she would prefer to have a lower SSNAP rating and feel that she had participated in the audit with integrity, than to do well by focusing on numbers over patients. Lucy demonstrated a detailed knowledge of SSNAP scoring systems, and told me that the difference between 30 and 35 minutes was the difference between a B and an A. She felt that her therapists were more likely to underestimate the time they spent with patients, so encouraged them to be more vigilant about ‘doing a bit of a clock watch’.

When talking about their own team’s practice, therapists often said they estimated, but never over-estimated, session length. They were likely to regard higher-rated services with suspicion. Susie said she preferred to be in a team that was ‘honourable’ instead of ‘milking’ data. Dr Adams noted that whilst other audited aspects of care such as time of scan or thrombolysis were clear and unambiguous, auditing therapy intensity left room for varied interpreting. Nevertheless, his comments suggested that his team were following the available instructions correctly, whereas others were not.

“Some of the therapists phoned around colleagues elsewhere and found out, ‘Oh so and so are, they’re reporting all the time that they spend talking to patients’ relatives on the phone,’ ... Some would round up to the nearest five minutes or ten minutes... If you look at the FAQs on the SSNAP audit, it’s actually quite clear what should be included and what shouldn’t be included. But that doesn’t stop a lot of people just interpreting it for themselves. So whether they read it and decide that they’re not going to bother with it and they’re going to interpret it the way they want to, or whether they just didn’t realise it was there and just, and made up what they felt was a reasonable interpretation.”

Dr Adam, Consultant, Olive

These findings support the claim that audit society encourages a culture of mistrust (Power 1997). It could be argued that this is a small price for if standards improve. In the following two sections I will show that therapists did not believe that the audit represented their practice. They did not feel it had led to an increase or improvement in therapy delivery, and presented examples of unintended consequences.

9.4 Misrepresenting therapy practice

Therapists had internalised the guideline as an aspiration, but they talked about it pragmatically as a guideline not a rule. Many informed me that it had changed the way they recorded data, but not their practice. Olive Ward had made conscious changes as a direct response to their poor SSNAP performance, but these were not changes they felt would make a difference to patients.

9.4.1 ‘It doesn’t reflect our practice’

Therapists in each site expressed a lack of confidence in the SSNAP therapy data, both nationally and for their own teams. As already noted, they perceived wide variation in the way different teams interpreted audit requirements and managed their data. Jade Ward had been a consistent high scorer at the time of my fieldwork, but the B7 OT told me that she had noticed that their local data was ‘skewed’ due to technical issues. She said it was easy to duplicate data entries accidentally on the local computer system, therefore therapy minutes were often disproportionate to the length of a patient’s stay. Olive Ward therapy scores had improved in response to the

changes described above, therefore I was surprised when their therapists told me they did not believe their grades reflected their practice. Olive Ward therapists scored their best SSNAP grades at a time when they felt they were providing an inferior service due to staff pressures. Lucy (clinical lead) charted the changes that she had initiated and the subsequent improvements in their SSNAP scores. When I asked her whether these improvements reflected 'real life' improvement, she responded with a clear 'no'. When I posed the same question to Laura (B6 OT), who was also very involved in the SSNAP data management, she replied,

"No, I think we're just jumping through more hoops."

Laura, B6 OT, Olive

She felt that over the Christmas period the OT score should have been an E instead of an A, if it reflected the quality of service that was being provided (see p188).

Topaz Ward therapists did not have the same insight into their SSNAP performance, but still held the opinion that their score did not reflect their practice.

"Obviously the data that we're getting doesn't reflect our practice. So something is not quite right. So I think they're just trying to figure out what the problem is and have a bit more effective way of collecting that data... Joanne [B7 PT] has told me that we're complying. To be honest, I know it's not right, and she said, yes and that's why we need to actually look into it."

Ghita, B6 PT, Topaz

This perspective was team-wide, and was raised in interviews as well as in meetings I observed. Therapists believed that their SSNAP score was too high, compared with their experiences of the service they provided.

"Apparently we were getting like a 100% and we were like, 'no way'... because there's no way that we're seeing every patient 45 minutes a day. No way. You've seen it."

9.4.2 Counting what shouldn't be counted

Commonly cited unintended consequences of audit include 'misrepresentation' and 'hitting the target but missing the point' (Pfleuger 2015). Rather than reducing therapists' administration time, the tendency of some therapists to misreport this as contact time masked the realities of their practice. Jade and Topaz therapists often said, 'his discharge paperwork will be his session today'. An SLT in Olive Ward had started logging time spent on the computer preparing communication packs for patients as patient contact, as she felt this was valuable and should be recorded as therapy time.

The 45 minute guideline is for patients to be *offered* 45 minutes of daily therapy. SSNAP attempts to audit the therapy time patients have *received*. Topaz and Jade therapists, accustomed to locally reporting their use of time to demonstrate their productivity, recorded the time they were spending in patient related activity. They logged the time they had devoted to a session, despite the fact that a patient may only have been involved for a small amount of time within that window. Some therapists talked about deriving a sense of satisfaction or validation associated with logging their use of time, or needing to demonstrate that they had been occupied even if the patient had not.

9.4.3 Excluding patients from the audit

As discussed in Chapter 8, Olive Ward was the only SU that was utilising the option of noting a date on which intensive, active therapy was no longer appropriate ('SSNAP-stopping'). Olive Ward therapists told me that introducing the use of 'SSNAP-stop' had been a way of defining existing practice, in which patients who were not able to participate or showing signs of improvement would receive 'maintenance' input rather than active, goal targeted therapy. An exception to this was the Christmas period, when staffing was low and OT and PT received their best ever SSNAP scores.

“[The OTs] said we did *really* prioritise when we were really short staffed so that SSNAP did not suffer... I think patients were perhaps being SSNAP-stopped prematurely. So, I think they were making SSNAP-stop decisions on resource availability as opposed to patient need. And I don’t actually support that. I understand the reality of why it happened but I wouldn’t like to analyse that in too much detail in front of a commissioner, or a patient’s relative for instance.”

Lucy, Clinical Lead, Olive

In the above email (p184), the therapist was surprised that other teams were ‘stopping the clock’ and she was not aware that this was even possible. I understood stopping the clock to be synonymous with Olive Ward’s practice of ‘SSNAP-stopping’. Teams who were not doing this expressed shock that others would do so, and suggested that this was a form of cheating. In contrast, Lucy (Clinical Lead, Olive Ward) felt that the practice of SSNAP-stopping patients had a detrimental impact on her team’s scores, but was a more honest approach. She told me that she could ‘get them an A tomorrow’ by simply setting a lower threshold of SSNAP-appropriateness, as it was this, and not contact time, that was bringing their scores down. But she wanted to follow what she understood to be the rules of the audit, and represent her team fairly. For her, the 45 minute guideline was not appropriate for all patients, so adherence to it should only be measured for those patients for whom it was appropriate.

Whilst Lucy had informed me that increasing the proportion of patients considered appropriate for therapy would improve her team’s scores, the Topaz Ward consultant was of the opposite opinion. His perspective was that all (or at least most) patients should be considered appropriate for therapy, and teams that reported providing therapy to a lower proportion of the caseload did so to improve their scores by ‘changing the denominator’. He believed that discharging people from SSNAP was a game other teams played to improve their ratings. He gave an example of a SU he had visited that was divided into two wards: one for those receiving active therapy and the other for patients for whom SSNAP was not deemed applicable.

“Stroke patients went to this other place and it was literally behind some closed doors and we opened these doors and there was a whole load of patients there and they were,

I can't remember what they were called, but they didn't need rehab, they were bed blockers basically. Slow stream or something... they were waiting for placement or whatever. So they were moved off the stroke unit, they were discharged from SSNAP, they didn't need any therapy. And then the rest of the unit was performing really well."

Michael, Stroke Consultant, Topaz

Whilst excluding patients from the audit could be clinically justified, there was a risk that it could be driven by a focus on measured performance, to the detriment of patient care.

9.5 The mixed influence of the 45 minute guideline

Therapists had internalised the aspiration to deliver more therapy, but did not feel that they did deliver more as a result of the guideline. An exception to this was when new starters adhered rigidly to the guideline rather than making individualised decisions. The less audit-focussed teams felt a push to catch up with the teams that were 'playing the data game'. In Olive Ward, changes had been made specifically in response to the guideline and audit. It was suggested that overall SSNAP is providing 'potentially useful dirty data'.

9.5.1 Pragmatic internalisation: It's in the back of your mind, but it's just a guideline

Those who had remembered the inception of the 45 minute guideline told me that the initial controversy had died down, and therapists had broadly accepted the guideline as an aspirational (if unachievable) target. The message of 'more being better' had been absorbed. Therapists wanted to provide face to face therapy, but if this was not possible or prioritised then it would remain a background aspiration. The overriding attitude was one of pragmatism. "It's a guideline" was repeated time and time again in interviews, meaning therapists saw it as guidance rather than a rule. This message appeared to filter through from senior therapists.

"Actually, it's a guideline. It's guidance. Very woolly... What I tend to say to them is that as people approach discharge... other things need to take priority such as reports, paperwork, equipment orders... which people may argue it's not direct patient contact, but actually it's, if these things don't happen, people will not go home... I would say that

in the long run it is more important to spend that extra time to sort all this paperwork out and make sure that people are discharged as best supported as they can be at that given time, rather than battling as to whether I can fit yet another 45 minute session of upper limb a couple of days before the person is going home. I don't think that's gonna make a difference."

Alexia, B7 OT, Jade

The internalisation of the guideline relates to observations noted in the previous chapter regarding therapists' self-surveillance and sense of guilt (see p150).

"I think it's always in the back of your mind, like you look through your patient list and you think, "Oh, you know, actually that patient, I wasn't able to see them yesterday, so it would be good if we could see them today because of the guidelines."

Mary, B5 SLT, Topaz

Although it was 'in the backs of their minds', many therapists also conveyed an attitude of ambivalence.

"Seems a bit arbitrary. So a lot of our patients either don't seem to want that amount of therapy – they tell you to go away or that they're tired or it just seems, I think probably for them it seems a bit relentless... So that can be difficult, in that you might have scheduled 45 minutes 5 times a week, but either the patient doesn't want to come, they've gone off for a scan, they're in the toilet which can take half an hour of your 45 minutes. I mean I see why the goal is there, I suppose it's meant to be motivating, but I suppose it's just a guideline isn't it though, so you don't actually have to hit it."

Nathalie, B5 OT, Jade

Most therapists told me that the guideline had not changed their clinical practice. Where there had been an increase in the amount of therapy offered to patients, this was because of increased staffing. Therapists were keen to offer more face to face contact; however, in Jade and Topaz wards, discharge-planning processes were always prioritised, and the guideline was subordinate.

9.5.2 A threat to clinical reasoning

The risk of SSNAP-stopping too soon (see p188) related to the concern expressed by many therapists that the 45 minute guideline was a threat to clinical reasoning. Their concern was that instead of making individualised clinical judgements, therapists would try to give all patients 45 minutes of therapy regardless of their needs, willingness or ability to tolerate this.

“I don’t want SSNAP to take us down that route that we have to follow procedures and protocols all the time, because actually part of the fun of being a physio is actually having that freedom and thinking, ‘Well this is this patient, that’s that patient, that didn’t work with that one, but it worked with this one’, and why and all those types of things.”

Helen, B7 PT, Olive

In the high-scoring Christmas period on Olive, senior therapists reflected that the junior staff had focussed too much on the guideline rather than their clinical reasoning. Mary, a B5 SLT on Topaz Ward, described the conflicting feelings she experienced when she started on the unit.

“For me it’s difficult to, you know, if you’ve got the guidelines and you’ve also got your clinical judgement, and if your clinical judgement is still developing, because you’re newly qualified, then you might rely on the guidelines too much and then be seeing patients for the sake of it, where it would be more effective to just see the ones, spend more time with the ones who really need you to see them. So I guess the guidelines can be negative as well if it knocks your confidence in your practice, because you think you’re not meeting them.”

Mary, B5 SLT, Topaz

9.5.3 Data-driven services

In Topaz Ward, senior therapists all expressed a sense of guilt that they had not spent time getting to grips with their auditing, and felt that they ought to have a better understanding of their SSNAP

data. Rona had an overview of the three SUs within her Trust, and noted the differences in engagement with SSNAP between them.

“Both [hospital A] and [hospital B] know how to play the data game... The data game is as the government would want us all to be, purely concentrating on, you know, ‘What are the targets?’ So a target-driven service. [Hospital A] and [hospital B] know how to deliver a target-driven service... They focus in on the data. They focus – all of their processes, all of their paperwork, the ways that they work, focussed in on actually ticking the data box... That’s the data-driven service. That’s being smart about how good you can make yourself look.”

Rona, Clinical Lead, Topaz

Olive Ward was also the only ward in which changes had consciously been made to improve the SSNAP score for therapy intensity.

“So OTs were getting like Es. We were doing terribly. And we realised when [OT] and I reviewed the data, that the reason we were getting Es is we were filling the form in incorrectly. So we looked back at it and worked out what we were doing incorrectly, corrected it and our score went from like an E to a C... We were marking everyone down as needing therapy... and then if we only saw them literally to go in and say ‘hello’, do an initial screen, we would then discharge them. But we’d only seen them for ten minutes. So we hadn’t hit the 45 minutes for that patient. And it was pulling our SSNAP stats down.”

Laura, B6 OT, Olive

The therapy lead was nominated to improve their SSNAP scores. She had gained in-depth knowledge of SSNAP and how their scores were calculated. This led to target setting, e.g. to increase the percentage of patients considered to require PT. The team had looked at the practice of ‘local competitors’. They were considering purchasing software to help with their data management at a cost of £30,000 per annum. The use of ‘SSNAP-stop’ had been introduced (see p156). Therapists were encouraged to complete joint sessions across disciplines as these

counted for double minutes compared with uni-disciplinary joint sessions. Previously all members of a patient's treating team might have attended team or family meetings, but this was discouraged. There was an increased focus on the recording practices used for SSNAP data, and weekly SSNAP meetings were carried out to make sure all necessary information was completed. These SSNAP processes were audited internally.

Therapists gave mixed reports about whether they were motivated to do well on the audit. Lucy felt that she could achieve an A by compromising her values, and felt torn about whether to strive for this. At the same time, she had the role of improving therapy scores, and felt that the idea of promoting more therapy was a good one. On Jade Ward, Alexia was sceptical about the scores and concerned about how they might be used in the future, but she still wanted the team to do well.

"No one wants to work in a place where they think, where they know that they're underperforming, where they're not viewed as a high quality service. I wouldn't. I mean there is an element of, yeah let's just, you know, kind of grade or mark drive. I mean you do want to sort of show that you're doing well. And especially now that we're surrounded by... a very big trust."

Alexia, B7 OT, Jade

Topaz Ward therapists expressed similar mixed feelings.

"So I want to boost our numbers, but not falsely. I want us to show what we're actually doing, because what's happening right now is that we're not, we're not in any way, shape or form – and some of it is just purely just – 'I've got too much to do, I can't be thinking about that'. It's not in our culture, it's not our line of thinking. We're thinking 'patients, patients, patients, patients, patients.' And we're not thinking 'Okay let's take a step back, let's do this audit, let's do the paperwork bit because we might get some more support to actually have better rehab with patients.'"

Joanne, B7 PT, Topaz

This suggests that the study captured a liminal stage in the auditing of stroke therapy. Olive Ward had entered audit culture, whilst Topaz was on the periphery, feeling a pressure to become more audit-focussed. When I asked whether it mattered to do well on the audit, responses were mixed. Some said that, naturally, it feels better to do well than to do badly. Most people I interviewed on Jade Ward were ambivalent and uninformed about SSNAP. However, Tom remembered hearing feedback about the team's performance and found this motivating.

“Seeing the stats, the SSNAP stats and how we perform... that is at the back of my mind, that we should be a good unit, and we should function well, and I know that not all targets are right and appropriate for patients and they may or may not be evidence-based but, all other things being equal and so long as it's not to the detriment of patient care... then doing well to try and meet those targets is probably a good thing. And I feel it, you know, feel that the service we offer is good... And yeah, I do care about that.”

Tom, B5 PT, Jade

Michael, consultant on Topaz Ward, was involved in the Stroke Programme and talked to me about his perception of the relationship between SSNAP scores and quality.

M: You're trying to measure quality which is much more nebulous... So that's one of the problems with audit that you, you change people's behaviour towards the indicator, but it's then not telling you about the thing you want to know about, which is quality... So what you do is, you have so many indicators that they can't focus on one thing. And we did put 45 minutes in to try and get people to change their behaviour... So here we're talking about quality. And there are some bits of quality that we can measure. And we happen to have chosen these ones.

E: Do you think that intensity is a good measure of therapy quality?

M: It's a start.

Michael, Consultant, Topaz

The attitude of acknowledging limitations of the audit but believing it was a useful quality improvement tool resonated with words spoken by the National Clinical Director for Stroke at a public event. Speaking about the use of SSNAP to improve stroke care, he explained,

“In a slightly random way, in the guidelines of 2008, we decided that everybody should receive at least 45 minutes of therapy, a number plucked a little bit out of the air, but it has become a bit of a mantra... Things are improving very dramatically... Unless one sets the standards, unless one measures them, unless one publicises them, unless one makes them important to do, things won't change.”

National Clinical Director for Stroke, SLSR20 Event 22.7.15

In response to a question from the audience about the validity and reliability of the data, he acknowledged that it was self-reported and therefore at risk.

“I accept that it is potentially quite dirty data. But it's nevertheless quite useful dirty data.”

Ibid

He stated that the purpose of the audit was quality improvement, and the audit was a powerful tool because nobody would want to be the weak unit in their area.

John, a patient on Topaz Ward, voiced the different arguments regarding the 45 minute guideline as a quality indicator. He initially said the 45 minute guideline sounded like a good idea, but also noted that ‘you’ve got to look at the people doing the sessions’ and ‘question the whole therapy behind it’. This echoed the common concern raised by participants that quantity is not an indicator of quality. He reflected that in a previous hospital the therapy he received was ‘no good’, as ‘they were nice people, but they didn’t know much’. He drew on his experience of targets and league tables as a headmaster.

“I’m thinking about things that I’ve been doing in education. And get systems in place and I just wonder why? What would you get out of that in terms of things? ... Do you say

it as, “I’ve got this plan, and this plan is I’ve got 45 minutes”? But why is it just that? Why is it not more things?”

John, Patient, Topaz

Although SSNAP’s promotion of the value of therapy was welcomed, there were concerns that it could wrongly give an impression of quality.

“I think it has been positive, I just am concerned about the value being attached to it in its raw kind of sense, so its overall grading system doesn’t allow you to see the quality beneath.”

Lucy, Clinical Lead, Olive

9.6 Influencing ‘the quality beneath’

I have argued that auditing the 45 minute standard had influenced therapists in various ways, but did not appear to have influenced the quality of therapy delivery. As I carried out my fieldwork and data analysis I tried to unpick why different teams had different priorities and focusses, and what the effective drivers for change were. I argue that quality improvements were likely to be initiated at ‘street-level’, and the top-down policy was more likely to influence management decisions. I argue that influential senior therapists emphasised or filtered policy and priorities for the team.

9.6.1 Bottom-up versus top-down

In each site there were multiple examples of therapists examining their service and taking action to improve. Jade therapists routinely carried out team audits and projects. On Olive Ward, the clinical lead was concerned that the SSNAP data was at risk of reducing patients to numbers, so intended to set up a project asking patients about their experiences. In Topaz Ward the senior therapists did not feel they were able to offer enough therapy to patients, so planned to collect data on the quantity of therapy they were providing, in order to make a case for more staffing. This was striking, as it appeared that therapists, motivated to improve their service due to their experiences, were unwittingly re-inventing SSNAP locally.

In other examples, small steps were being taken to improve patients' experiences. Olive therapists discussed a research article about creating a more stimulating ward environment. Pip, the TA, was inspired by this, and went to a local shop and purchased a whiteboard for each bay. Every morning he updated these with the date, place, and an item from the day's news. Pip had other ideas too.

"I've just been noticing myself, there's a few gaps in terms of things that we could offer patients that would be so simple to get, but we don't have them. The best way to do it is, is just sort of facilitate those kind of things ourselves. We've had about four or five patients who have, like, music as a hobby... From like, just a charity shop, I've managed to acquire like a £5 keyboard and things like that... I wanted to get a clothes airer, because that's functional test that people do, folding things, putting them, reaching, grabbing."

Pip, TA, Olive

On Topaz Ward, Ken (B5 PT) decided to pick up a pile of free newspapers on his way to work every day and take them around to the patients.

"A newspaper is just on my way come to work, I pick up the Metro and, like the paper boy, because sometimes I couldn't see them during that day. So in my own mind, at least I do whatever I can, so that they get something."

Ken, B5 OT, Topaz

These examples suggested that changes were more likely to be initiated if the need for them was identified at 'street level'. However, speaking to more senior managers I found that 'top-down' guidelines and policy had influence at higher levels. Although Deidre bemoaned the disparities in service provision between SU patients and other patients, she credited the stroke guidelines with the protection of stroke services.

“Well, what’s the drive to meet the guidelines? Well, we get lots of threats about how they’ll withdraw the service from the Trust and things like that... there’s a lot of political machinations ... lots of shroud waving and ‘this will happen and that will happen’... yet I cannot make sensible decisions about the allocation of my staff across the thing without then sort of hitting all these problems about stroke. So we have protected stroke, we’ve put the thing in and I think that’s a good thing about the guidelines, it has protected that service. But... there is no doubt about it, it’s at the expense of other services.”

Deidre, Therapy Manager, Whimsford General

Therefore, although Topaz therapists did not have up to date knowledge about their SSNAP performance, at a commissioning and management level, the stroke guidelines and SSNAP appeared to influence decisions.

9.6.2 Clinical leaders emphasise or filter policies

Different teams had different priorities. In Jade Ward, the lengthy assessment used to apply for continuing care funding was completed at the expense of other work. In Olive Ward, SSNAP processes were a major focus. In Topaz Ward, discharge was ‘king’. Although variation also occurred at an individual level, there were strong priorities that came through in each site, and I explored where these originated.

On each SU the range of different policies and imperatives was being filtered by senior therapists, who would promote, emphasise or soften these demands to their teams. OTs and PTs in all sites clearly stated that they did not receive pressure from their supervisors regarding therapy intensity, and the quantity of therapy they were delivering was not checked in their supervision sessions. OTs and PTs in leadership positions within the teams talked about wanting to support therapists, whom they perceived to already be managing a lot of pressure.

“As a Band 7 supervising and overseeing all the physios I don’t find that they need any extra pressure to say, oh you’re not seeing them for 45 minutes. So I would be more focussed on looking to see if people have got input every day, and how busy their timetable is looking, and if they’re getting enough rest if that’s appropriate for them.”

Lucy and Rona, clinical leads on Olive and Topaz wards, talked about not wanting to 'beat therapists over the head' with a target. For Rona, this was because she felt it was unachievable so it would be an unreasonable expectation. Lucy echoed the views of many who also felt that using session length as target or measure of therapy quality was problematic.

"A number of minutes interacting with the patient any shape or form of what you're doing in those 45 minutes might not have any value whatsoever to that patient, and that comes down to clinical reasoning and identification of the best thing, in intervention, to use to meet that person's needs. And you could wheel someone into a gym and be face to face with them for 45 minutes and achieve nothing. So it doesn't reflect at all the quality of actual therapy being provided, nor the intensity. Because you can faff about for quite a long time with some of our patients just getting them positioned well in a chair, and is that intensive input? Or is it just it took a long time to do what you needed to do?"

Lucy, Clinical Lead, Olive

The relaxed or protective attitude of senior staff recurred in many interviews with therapists, but was not always the case for SLTs. An SLT on Jade Ward described the 45 minute guideline as a 'huge pressure'. An SLT on Olive Ward told me that her manager had set her an objective in her appraisal to improve the team's SSNAP score for SLT, and talked of resisting management pressure to see patients 'for the sake of it'.

Rona, clinical lead (B8) covering Topaz Ward, identified that she chose between policy messages in order to avoid giving staff conflicting targets.

"Is it something that I'm going to beat the guys over the head? No because actually I know that I've told them, "Get them out." And I'm not going to get therapy if I've told them, "Get them out."

Rona, Clinical Lead, Topaz

Nancy told me that the protocols she followed and advised the team to follow had been set by the clinical lead, and she was uncertain of their origins.

“The local target kind of protocol that’s been put together I think by Rona, that is in the forefront of my mind, which I always kind of get a little bit confused with, whether that is what is the kind of national targets. But actually I only recently found out that those are the targets that’s been set by Rona.”

Nancy, B7 OT, Topaz

The therapists I interviewed spoke of the influence of their supervisors or significant clinical leaders. The positions of the specific influential leaders varied in each site. In Jade Ward, the Band 7 therapists shared leadership responsibilities. When I interviewed their manager, who oversaw therapy for the trust, I identified that their values appeared aligned with hers. She spoke of ‘light touch’ leadership and the importance of trusting the therapists, who she believed were hard working and provided a good quality service. In Olive Ward, Lucy was influential. She was a Band 8 and did not work in the SU, but did work clinically in the ESD. Lucy explained that her role in implementing the guidelines was to make sure that her team understood the rationale behind it and were therefore ‘making effective decisions about intensity based on the patient need, as opposed to thinking in 45 minutes’. Her experience of the realities of practice was valued by the staff. Similarly, in Topaz Ward therapists valued Rona’s clinical expertise and were openly influenced by her guidance.

I have shown that therapy staff identified opportunities for quality improvement at a local level, and this appeared to be more influential on them than national policy. National stroke guidelines and audit were used at management and service-commissioning levels to protect stroke services, although this only benefitted patients who were admitted to SUs rather than other wards. Therapists in clinical leadership positions acted as an interface between the multifarious local and national policies and imperatives, and the therapists practising on SUs.

9.7 Chapter Summary

Despite recent progress in medical stroke management, I found a different narrative regarding changes in SU therapy. I situated these changes within a wider context of audit society and quasi-marketised healthcare (Power 1997; Seddon 2008). Power's theory of audit society situates the 'audit explosion' within the context of New Public Management (NPM), therefore perhaps the discovery of marketisation as a contemporaneous factor shaping changes in SU therapy should not be a surprise.

"The most significant structural innovation in the field of health care provision has been the creation of quasi-markets for medical services... It is also with this created space for contracting that medical auditing in the UK is evolving beyond its humble and obscure origins." (Power 1997 p104)

Building on findings from Chapters 7 and 8, and drawing on Foucault (1977), I argued that changes in the delivery of therapy were related to changes in therapy spaces, and both were related to the purpose of therapy in changing healthcare system. This links with the Aristotelian focus on the function of therapy presented in Chapter 7. SU therapists were experiencing a shift in purpose, from providing rehabilitation to processing patients through the system.

I argue that at the time of the study, SU therapy was in a liminal state regarding its entry into audit society. Being publically rated against other services encouraged a sense of rivalry and mistrust between services. Therapists were conflicted: they wanted to do well, they wanted the data to be an honest reflection of their services, and some felt guilty about not being more audit-focussed.

Therapists did not believe that therapy quantity reflected therapy quality, and they did not have confidence in the accuracy of national audit data for therapy intensity. I presented examples of misrepresentation (Pfleuger 2015), and potential unintended consequences of the audit. A Health Foundation paper called for measurement of what matters to patients, and noted the importance of using the right measure in the right place (Collins 2014). Raleigh and Foot have argued that not everything that matters can be measured (Raleigh & Foot 2010), and that careful interpretation

of quality measures is vital. Therapists in this study had concerns about whether the SSNAP audit was a good measure, and they also had concerns about how the data would be interpreted. Nevertheless, some examples of the strategy being influential and motivating were noted.

There was a prevalent attitude of pragmatic internalisation of the guideline, with therapists seeing it as an aspiration and not a rule. This can be viewed either as a success of the Foucauldian disciplinary strategy of normative judgement, or as an endorsement of Lipsky's view that street-level bureaucrats accommodate themselves to measures and remain independent of organisational control (Lipsky 2010 p44). Most therapists said that the audit was more likely to have changed their recording of their practice than their delivery of therapy.

Therapists were most likely to change their practice in response to problems they observed in practice and in line with the priorities set by influential therapy leaders within their teams. This suggests a divergence from Lipsky's depiction of street-level bureaucrats who act autonomously, often in tension with their managers. Despite experiencing conflicting pressures, interpretations and enactments of therapy often had coherence within teams, and attitudes and priorities were influenced by clinical leaders.

Chapter 10 Discussion and Conclusions

10.1 Introduction

Stroke care has been transformed by quality improvement efforts over recent decades. It has metamorphosed from being an aspect of general geriatric medicine to becoming a distinct specialism, and rehabilitation from therapists with expert knowledge is now seen as a key component of stroke unit (SU) care (NICE 2013). Research evidence and the implementation of national guidelines have been important drivers for change. The guidelines are regularly reviewed and updated, and the '45 minute' guideline for therapy intensity became a controversial addition to the 2012 edition of the National Clinical Guidelines for Stroke (ISWP 2012). This applied to occupational therapy (OT), physiotherapy (PT) and speech and language therapy (SLT). The same year saw the launch of the Sentinel Stroke National Audit Programme (SSNAP) – an ambitious new programme for the auditing of stroke care against the national guidelines. Therapy was to be audited for the first time. Performance was to be based against the benchmark of deeming a certain percentage of patients to require therapy, and against the target of providing these patients with 45 minutes of daily therapy for a minimum of 5 days per week. SSNAP produced national quarterly public reports which showed that on average, the therapy intensity target was not being met, and that there was wide variation across teams in the quantity of therapy being delivered. There was also notable variation in the percentage of each team's caseload reported as requiring therapy. This raised various questions. How was the decision about patients' therapy requirements being made, and by whom? On what grounds were patients deemed to be 'appropriate' for therapy? What were the reasons for the variation in allocation of therapies? Were therapists influenced by the guideline and audit, and was this making a difference to patients? This was the context in which the current study was set.

The majority of studies regarding therapy delivery on stroke units have either sought to identify the optimum quantity of therapy required for specific interventions to be beneficial, or to measure the amount of time patients spend engaging in therapeutic activity (see p28). Empirical research has been conducted examining the efficacy of performance measurement in improving quality in

healthcare (Cadilhac et al 2012, Fung et al 2008), but there has been no investigation into implementation of guidelines and audit for quality improvement in stroke rehabilitation.

The research question at the core of this study was: how is stroke unit therapy interpreted and enacted in the era of the 45 minute guideline? The aim was to investigate the ways in which factors such as policy, patient need and professional judgement influence the delivery of therapies in the inpatient stroke setting. An ethnographic approach was used, including observations and interviews on three different SUs. The SUs were selected because they contrasted in their SSNAP performance for therapy intensity, and many other contrasting features were noted during fieldwork. Data were also gathered in meetings with national strategic leaders; at conferences; and at regional meetings with clinicians.

At an early stage in exploring the topic I identified Lipsky's street-level bureaucracy as relevant to my research question. Although Lipsky did not refer to therapists or the inpatient hospital setting amongst the public servants he discussed, his theory has been used as a framework for ethnographic research into the allocation of health and social care for stroke patients (Allen et al 2002, 2004). Allen et al's study included therapists as part of the wider multi-disciplinary team making decisions about allocation of resources. Although I identified the applicability of Lipsky's theory to my research question, I recognised that using this on its own could lead to a very practice-based interpretation of the findings. Use of a macro-level theory enabled an analysis with a broader perspective that went beyond the stroke unit. Power's concept of audit society (Power 1997) critiques the 'explosion' of audit in public services, and this seemed increasingly relevant to the findings as I analysed the data. Power draws on other theorists including Foucault. As the fieldwork continued, Foucault's discussions of surveillance, normative judgement and hierarchical observation illuminated my observations. Other theoretical perspectives enabled further interpretation of the findings, including Galvin and Todres' (2013) humanisation framework.

In this chapter I will summarise what was found in relation to the research question and aim. I will then present my interpretation of these findings, with reference to theory and previous

literature. These will be organised into three sections. I will then consider the limitations of the study, implications for practice and future research.

10.2 Summary of findings

Challenging the dominant narrative of progress in stroke care, this study found a mixed picture of progress and regression regarding SU rehabilitation. Auditing the 45 minute guideline is based on an ideal of standardisation – that setting benchmarks and rating services against these will address inequities and raise standards. Its implementation in the fieldwork sites was influenced by the diversity of interpretations and enactments of SU therapy, of the guideline, and of the audit.

Therapists developed 'routines of practice' (Lipsky 2010), to simplify their workloads. They worked in delineated and contested time and spaces, rather than enacting an integrated approach to rehabilitation alongside nursing staff. Some felt that the national guidelines and audit had led professional groups to have a uni-disciplinary focus, concentrating on their own measured performance and responsibilities. Patients did not exhibit any freedom to initiate or choose their use of time and space outside of designated sessions. They did not have specific expectations of stroke rehabilitation, as stroke was sudden and unexpected. Their hopes and expectations were to do with being treated with kindness, compassion and expertise. The routines of practice developed by therapists did not promote a focus on the humanising practice that was desired by patients.

The study took place at an early stage in the national auditing of therapy, and SUs were at different stages of engagement with SSNAP. Participants perceived changes in the nature of SU rehabilitation over recent years, including loss of therapy spaces and an increasing focus on discharging patients rather than providing inpatient rehabilitation. Their experiences were embedded in a wider context of audit society, incorporating the marketisation of healthcare. Auditing therapy intensity had fuelled a sense of competition between services. This was related to therapists' perceptions that the SSNAP data might influence decisions about the commissioning of stroke services.

Therapists had internalised the message that ‘more therapy is better’, as a form of self-surveillance. They were more likely to change the way they recorded and reported what they did than to increase the quantity of therapy they provided. Therapists’ desires to do their best for their patients were separate from their desire to do well on the audit. Where they strove to preserve their integrity and quality of care, this was *in spite* of the audit, not because of it.

Certain clinical leaders in each site had influence on the priorities and attitudes adopted by therapists. Therapists’ decisions and attitudes were shaped by priorities, ‘messages’ and ‘mantras’ amplified by clinicians with leadership roles. Leaders straddled a position at the interface of ‘top-down’ policy and ‘bottom-up’ drivers for change. ‘Top-down’ policy was used to support strategic decisions at management level. At street level, quality improvements occurred on a small scale when individuals were moved to respond to their experiences in practice.

During the final weeks of writing this thesis, I presented my findings for discussion with the members of the Stroke Research Patients and Family Group at King’s College London⁶. I had presented findings at various stages of analysis to staff participants, but this was the first time I was presenting a finalised version, and the first time I was presenting data to former stroke patients. I was hugely relieved to find that the findings not only reflected their experiences, but also mattered to them. Some of the participants summed up better than I had, and I therefore borrow their wording to summarise my findings and introduce the narrative running through the rest of this chapter.

In the words of one member, the study has shown ‘what happens when a grand plan is set up, with the best of intentions, instead of patient-centred care. Somewhere the planners seem to have lost sight of the fact of what a human being is, whether the human being in question happens to be a patient or wearing a hospital uniform.’

⁶ The Stroke Research Patients and Family Group brings together stroke researchers from King’s College London and people who have had a stroke and their family members.

The following sections will expand on this statement. In section 10.3 I argue that the 'grand plan' of standardising therapy time is problematic. Audit requires a simple, measurable indicator, and the wordy and nuanced 45 minute guideline did not translate into such an indicator. Key principles regarding the function of therapists were not shared across sites, and contextual factors led to diverse interpretations of 'what counts' as therapy, 'what counts' as auditable therapy time, and 'who counts' as auditable. In section 10.4 the influence of a top-down 'grand plan' is examined, and I situate clinical leaders at the interface of policy and 'human beings'. Finally, in section 10.5 I argue that within a healthcare context in which stroke consultants treat SUs as small businesses, audit shifts the focus of clinicians from the patients receiving their care, to the commissioners allocating funds for their services.

10.3 The problematic standardisation of therapy time

The policy context for this study was the introduction of a new recommendation within a set of clinical practice guidelines, and the auditing of therapy practice against this as a new benchmark of quality. This can be viewed as part of the standardisation movement in healthcare, an aspect of which is evidence-based practice (Timmermans & Berg 2010).

Standardisation, especially using evidence based guidelines, is the new 'gold standard' in medicine (Timmermans & Berg 2010). This is increasingly also true for professions allied to medicine such as OT, PT and SLT. The ideal is for conclusions regarding best practice to be drawn from robust research, and for these conclusions to be translated into clinical guidelines. This is intended to encourage conformity to best practice, thereby improving quality. In response to criticisms that this is a threat to professional judgement and autonomy it has been stated that evidence based practice should integrate the best external evidence and clinical expertise (Sackett et al 1996). However, not all guidelines are based on clear and relevant evidence, and the 45 minute guideline for therapy intensity is an example of a consensus based guideline (ISWP 2012). It is not uncommon for guidelines to be decided by consensus in the absence of clear scientific evidence, but this approach has been criticised as a group's opinion cannot be proof of the benefits of an intervention (Timmermans & Berg 2010; Woolf et al 1996). However, basing clinical practice guidelines on RCT evidence has also been criticised, on the grounds that these

studies do not reflect the realities of patients and clinical practice (Sullivan 2010, McCartney et al 2016).

McCartney et al (2016) recently called for a shift from disease-focussed, best practice guidelines, to resources that promote shared and individualised decision making between patients and doctors. The authors argued that evidence based guidelines are based on RCTs which exclude patients with comorbidities; they ignore the values and preferences of individual patients; they often make recommendations based on a sole expert opinion; and they perpetuate the power imbalance between clinicians and patients. McCartney et al. focus on medical guidelines, but this study found that their concerns applied to the 45 minute therapy guideline. Stroke patients did not conform to the prototype envisioned in the 45 minute guideline. Some had unclear diagnoses. The effects of a stroke varied widely. Some patients were well, eager and able to participate in intensive therapy, others were keen but fatigued, and others saw therapy as a health and safety checklist or something to be tolerated, but just wanted to get home as soon as possible. Many had significant co-morbidities. This has been noted to be a problem for the implementation of evidence based practice in general, and not just in stroke care, as “the patient with a single condition that maps unproblematically to a single evidence based guideline is becoming a rarity” (Greenhalgh et al 2014 p3).

A key aspect of the improvement strategy for stroke therapy was the measurement and publication of performance against the 45 minute guideline. The use of audit in healthcare is prolific and increasing, and this follows a trend in public services and Western society that Power (1997) has termed ‘the audit explosion’. Auditing therapy against the 45 minute guideline is an example of this, and can also be seen as an example of Foucault’s concepts of normalising judgement and hierarchical observation (Foucault 1977). Normalising judgement occurs when a rule or regulation is set and individuals are judged against this ‘norm’. Hierarchical observation takes this principle further, and involves the rating of individuals against each other, as occurs in examinations. Foucault considered these concepts in relation to the disciplining of individuals, but I argue that they can be applied to the rating and comparing of individual stroke teams against the new standard of therapy time.

Lipsky (2010) noted that in the case of complex interventions provided by street-level bureaucrats (SLBs), measuring productivity or use of time is the simplest way of measuring performance. However, he claims that this is problematic and reveals nothing about the quality or appropriateness of the way that time has been used. SSNAP's auditing of the 45 minute standard is an example of using time as a performance measure. There is mixed evidence regarding the efficacy of using performance measurement to improve quality (Raleigh and Foot 2010, Fung et al 2008, Kirkup 2015). It has been suggested that a good performance indicator should have reliability and validity; be based on agreed, fully described definitions; and be relevant and actionable for those using it (Mainz 2003a, 2003b; Raleigh & Foot 2010). This was not the case for the 45 minute guideline. The study found that therapists did not share an understanding of the rationale behind it; there was confusion about audit definitions and requirements, and therapists lacked confidence in its reliability and validity. Whilst therapists (and other participants in the study) thought that other elements of standardisation had improved stroke care, they saw the therapy guideline as specifically problematic compared with more concrete targets such as time taken to be scanned after a stroke. More fundamentally, therapists (and others) lacked a shared vision of good quality SU therapy. The role and remit of SUs varied, as did the role and remit of therapists in different sites.

Therapists across the three different fieldwork sites envisioned their roles in different ways, sometimes revealing tensions in their own understanding of what was required of them. For some, the main role of SU therapists was discharge-planning, and the concept of inpatient rehabilitation was 'old-fashioned'. For others, therapy should 'effect a change' for the patient, targeting their impairments or functional difficulties. Some talked about wanting to improve patients' experiences in hospital or building 'therapeutic relationships'. They discussed aspects of their work that fitted Mattingly's description of 'therapeutic emplotment', whereby, "it is not easy to identify the significant therapeutic encounter and the profound is not always displayed in words" (Mattingly 1994 p814).

As well as envisioning their roles in different ways, contextual factors influenced the delivery of therapy in different SUs. Lipsky (2010) claimed that workers in different teams may behave quite differently due to different pressures, such as demographics and availability of resources.

Although SUs must meet certain criteria to retain their SU status, the SUs in the study varied in multiple ways including their remit and their position on local stroke pathway. Availability and quality of community services influenced the point at which therapists considered a patient to be ready to be discharged, and this influenced the type and quantity of therapy they were considered to need while in hospital. All these factors, plus demographic differences, lead to differences in each SU's sense of their 'typical casemix'. Staffing levels also varied considerably and comparisons were problematic as staff were utilised differently in different hospitals.

A further confounding factor in the mission to standardise therapy intensity lay in the translation of the 45 minute guideline into an auditable performance measure. The wording of the 45 minute guideline conveyed an understanding that this quantity of therapy would not suit all stroke patients. Rather than prescribing that all patients should receive 45 minutes of daily therapy, its wording left room for interpretation and clinical judgement by therapists.

"Patients with stroke should be offered a minimum of 45 minutes of each appropriate therapy that is required, for a minimum of 5 days per week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it"

(ISWP 2012 - Emphasis added.)

Whilst the guideline itself offered flexibility and individualised judgements to be made, the audit rated teams on the numbers of patients they considered to meet these criteria. Expectations that had not been set out in the guidelines - that teams should consider 80% of their patients to require OT, 85% to require PT and 50% to require SLT – were used in the calculation of teams' scores. In practice it was problematic for therapists to decide whether 'requiring therapy' meant requiring any type and quantity of therapy, or should be interpreted as 'able to tolerate and benefit from 45 minutes of therapy for a minimum of 5 days per week'. When therapists became more aware of the audit questions they found that deciding how to interpret them presented them with a dilemma. Some had difficulty with the concept of distinguishing between patients who needed therapy and those who did not, and objected to the idea of stating an end date for therapy. For those who had

become more emerged in 'audit society', decisions regarding 'who counts' had become integral to everyday clinical discussions.

Classifying patients according to their requirement for therapy has parallels with the classification of patients according to therapists' perception of their 'rehabilitation potential'. The dangers associated with the latter form of categorisation were recently expounded by Enderby et al (2016). Authors claimed that patients may be wrongly deprived of rehabilitation due to an inadequate decision about their needs made at an early stage after their stroke. Similarly, patients not considered able to participate in 45 minutes of daily therapy (and therefore not 'SSNAPing') are less likely to be prioritised. In a self-fulfilling prophesy, they may then do less well, re-enforcing the idea that therapy time need not be invested in them.

Even those most engaged with the auditing of therapy did not believe that the guideline and audit reflected the diversity of stroke patients or the nature or quality of their work. They were cautious of making clinical decisions based on categories determined by SSNAP, but at the same time did not want to give a false impression of their service because of the way they reported data. In keeping with criticisms of performance measurement (Lipksy 2010; Pfleuger 2015; Power 1997), there were examples of 'hitting the target but missing the point'. The intention behind the 45 minute guideline was to increase the time patients spent in therapy, and to reduce the time therapists spent doing paperwork. In practice therapists often made statements such as 'his paperwork will be his session today', which showed that the reality of practice was likely to be masked by their data reporting. There was variation in interpretations of 'what counted' as auditable therapy time. Therapists typically reported that their clinical practice had not changed as a result of the guideline, but in some cases they had changed the way they recorded and reported on their clinical work. This corresponds with the concept of SLBs who shape policy to fit their existing practice, rather than changing their practice because of policy.

There was a common sense of pragmatism: that the guideline was a guideline, not a rule. In Foucault's terms, therapists had internalised the message that they should be more productive and they used self-surveillance, constantly checking and justifying their prioritisation decisions to

themselves as if they were being challenged by a manager or patient's relative. They felt ready at any moment to explain how their decisions about allocation of their time had been made.

Despite recognising that they were unable to provide an optimal service to everybody, they wanted to treat their patients according to their individual needs. Greenhalgh et al (2014) have promoted a more individualised vision of evidence based medicine.

“Real evidence based medicine has the care of individual patients as its top priority, asking, “what is the best course of action for this patient, in these circumstances, at this point in their illness or condition?” It consciously and reflexively refuses to let process (doing tests, prescribing medicines) dominate outcomes (the agreed goal of management in an individual case).” (Greenhalgh et al 2014 p3)

Many therapists perceived the auditing of their practice against the 45 minute guideline to be a threat to a flexible, individualised approach. Some expressed concerns that a uniform approach would replace future therapists' clinical judgement and sensitivity to patients' individual needs. There was evidence that therapists entering the field of SU rehabilitation assumed the guideline ought to be followed rigidly, and their approach changed with experience and under the influence of other therapists. Benner's (1982) framework of the development of knowledge and skills in professions such as nursing from 'novice' to 'expert' suggests that novices learn rules free from context and apply them universally and inflexibly. Therefore, it could be argued that any rule may be followed too rigidly by practitioners who have not yet developed the skills and confidence to interpret it in context. However, the concern expressed by therapists also appears to corroborate Lipsky's assertion that “the fundamental service dilemma of street-level bureaucracies is how to provide individual responses or treatment on a mass basis” (Lipsky 2010 p44).

The varying scope of therapy enactment, and the diverse approaches to the guideline and audit, challenged the ideal of standardising therapy delivery. Many spoke of the need to make sure that patients, and not SSNAP results, were driving their decisions. This imperative was voiced by influential therapy leaders in each setting, and their role as arbiters of policy and potential bastions of quality will be discussed in the next section.

10.4 Street-level leaders: at the interface of policy and people

The degree to which therapists were influenced by the 45 minute guideline and SSNAP audit was influenced by certain leaders within each team. I argue that this extends the theory of street-level bureaucracy, which focusses heavily on the autonomy of individual front line workers. Street-level leaders walk an 'ethical tightrope', as they filter conflicting demands and imperatives for their teams. Non-clinical managers (and sometimes consultants) believed that the guidelines and audit enabled quality to be maintained or improved, but at 'street level' quality improvements were more likely to be made in response to the direct experience of individuals.

Lipsky's theory of street-level bureaucracy has been criticised for losing relevance in the new era of performance targets, as it is claimed that in the age of New Public Management (NPM) workers no longer have the levels of autonomy they previously enjoyed (Ellis 2007; Howe 1991; Taylor & Kelly 2006). Other authors (Evans & Harris 2004; Halliday et al 2009) have countered the suggestion that NPM is removing workers' autonomy, saying that this threat is exaggerated. The timing of the current study is pertinent as, due to SSNAP, SU therapists are experiencing a new level of surveillance and monitoring which could alter the extent to which Lipsky's model of SLBs describes them. Normative judgement and hierarchical organisation (Foucault 1977) have become ubiquitous in areas of public service such as education, with schools routinely rated on league tables. Until the first public report of the SSNAP pilot was published in September 2013, SU therapy had not been measured and publically rated. This study offered an opportunity to present empirical evidence regarding the influence of this on therapy practice. Lipsky's theory has recently been used to interpret the work of general practitioners and hospital doctors as street-level bureaucrats (Harrison 2015), but SU therapy has not previously been investigated in this way.

Although there were examples of discrepancies between the attitudes of therapists within the same team, there was evidence in each site that certain individuals influenced the attitudes of the team and their decisions. Whilst the post and banding of these influencers varied, they shared characteristics of being respected by their teams as clinicians and being in a position of seniority

within the teams. They had management roles, and were aware of the different and sometimes conflicting local and national policies and priorities relevant to their teams.

Lipsky proposed that SLBs are often expected to work towards conflicting and ambiguous goals, and that there can be a tension between client goals and organisation goals. He distinguished between workers (who try to maintain their autonomy and resist attempts to constrain it) and managers. He did not account for clinicians in leadership positions, who act as an interface between policy and practice. In a continuation of his theory, I term these influencers 'street-level leaders' (SLLs). I argue that SLLs filter the different top-down expectations, standards, recommendations and protocols, and understand that it is impossible to demand that therapists give them all equal weighting. They prioritise and amplify the messages they consider to be most important.

It has been argued that in turning the study of policy implementation on its head, Lipsky neglected the role of managers who may come from the same professional background as the workers they supervise (Evans 2011; Hupe & van Kooten 2015). Hupe and van Kooten (2015) noted that despite an abundance of literature regarding public management, this tends not to focus on middle management or work supervisors. They suggested that in processing rules, public managers a) formulate additional rules, b) pass on rules, or c) buffer rules, and that in this way first-line supervisors are also discretionary actors (Hupe & van Kooten 2015 p229). My findings support this claim in the case of SU therapists.

The role of clinical leaders in improving or maintaining quality has been widely discussed (Fielden 2015; National Institute for Health Research 2013; Storey & Holti 2013). Some have claimed the importance of leaders being 'actually in the arena' (Fielden 2015), and discussed the role that these embedded leaders can have in ensuring that values, such as putting the patient first, are upheld (Fielden 2015). A recent review of healthcare leadership (West et al 2015) reported that out of thousands of publications on the topic of leadership in health care, relatively little research had been conducted to a high academic standard and there was a lack of reference to theory in many papers. There was no specific discussion of the role leaders have in filtering or prioritising

the conflicting demands placed on front line staff. Furthermore, the clinical leadership literature predominantly discusses medics or nurses, and not therapy leaders.

It has been claimed that managers have become Foucauldian 'technicians of behaviour', instilling attitudes in their subordinates and promoting the aims of accountability and competitive performance measurement (Ball 2003). Unlike non-clinical managers, in the current study, the SLLs recognised that there was potential conflict between their values and policy imperatives, and saw part of their role as to reconcile this and make sure that their values were not subjugated. A qualitative study of medical leaders found that they had to manage moral tensions, and that they had to balance the need to be advocates for patients with their role as gatekeepers for resources (Shale 2012). It has been claimed that the current evidence base lacks attention to the 'ethical tightrope' clinical leaders feel they have to walk in this sense (Oliver 2016). This study offers new empirical evidence of this 'ethical tightrope', in the unexplored area of therapy leadership. A report responding to the Francis Inquiry called for leaders at every level of the health system to cultivate a values-based culture in which financial performance and productivity do not over-ride patient-centred care (King's Fund 2013). Similarly, Galvin and Todres (2013) propose that there is a need to balance technologies and systems of care with values based on personal human experiences, and I argue that SLLs are in a position of influence to promote such values.

The extent to which therapy leaders are or remain successful in promoting values in an increasingly audit-focussed culture requires further investigation. In this study there was evidence of dehumanising practice including passivity and objectification of patients (Galvin & Todres 2013), despite therapists' feelings of guilt regarding compromising and cutting corners. When patients discussed their experiences of therapy, they reported valuing the quality of care they received in terms of the personal qualities of the therapists and their expertise. This resonates with findings from the ActNow trial which found that the personal qualities of the person providing communication practice for stroke patients were more important for the patient's recovery than whether or not they were professionally qualified (Bowen et al 2012; Young et al 2012).

It has been noted that the pressure to focus on performance measurement can have negative consequences for quality and values-based care (West et al 2015). However, it has also been claimed that “local clinical leadership is not an alternative to top-down national strategies; rather the two can productively feed off one another” (Storey & Holti 2013 p14). This study identified the influence of both the top-down therapy improvement strategy and bottom-up improvement initiatives. Examples of small scale quality innovations and team projects suggested that change was motivated by the experiences staff had at ‘street level’, and that in these cases implementation could occur very quickly. It was striking that senior therapists on one SU suggested a team project investigating the amount of therapy they were providing to patients. They perceived that they were not providing enough therapy and sought to measure current practice and find a way to improve it. There was no mention of SSNAP in these discussions, despite the fact it was gathering the same data from them to serve the same aim.

Non-clinical managers had a different perspective on the utility of the stroke guidelines and audit, seeing them as powerful tools for protecting services. They noted that staffing levels had been protected in stroke teams whilst other hospital teams had not had the same protection. The influence of the guideline and audit on these higher-level decision makers was not the focus of the study but was included to show that it had different levels of influence and was utilised in different ways in the hospital hierarchy. This is an area for further investigation.

In summary, therapists are influenced by policy, patient need and professional judgement, but certain influential therapy leaders amplify or filter top-down policies and balance these with their professional and ethical priorities. I argue that despite SLLs’ expressed commitment to patient-centred values, unless there is firm commitment to enact these values there is a risk that dehumanising practice will prevail in the pressured and process-driven stroke unit setting. Street-level leaders are in a pivotal position and can foster a culture of patient-centredness and bottom-up, local innovations, or encourage a focus on numbers, categorisations and ratings. In the next section I will develop the idea of these aspirations being in mutual opposition.

10.5 SSNAP as a tool of commissioner-centred care

In Chapter 9 I reported that a sense of rivalry and disapproval was expressed by some therapists towards SU teams in other hospitals. This mainly arose when they were comparing SSNAP practices or ratings. During data analysis I categorised this as an unintended consequence of the SSNAP audit. However, interpreting this with reference to the background literature prompted me to question whether it was an unintended or an intended consequence. Competition is integral to the principles of hierarchical observation and of NPM. Yet, the therapy intensity guideline sought to increase equity and standardisation. This suggests a tension of principles. I will explore some of these principles, referring to NPM and neo-liberalism and following Power in associating these with the audit explosion. The study found that many of the changes that therapists described in the delivery of SU therapy were likely to be due to factors other than the guideline and audit. These wider contextual factors, regarding the marketisation of healthcare, were not easily separable from the implementation of SSNAP. One consultant said that using the audit to demonstrate good performance enabled them to expand their service with more funded SU beds. Although therapists were generally uncertain of the implications or consequences of their SSNAP rating, some therapists reported concerns about how commissioners might interpret and use the data. I will draw on theory regarding the influence marketisation can have on citizens' attitudes and sociality. In the previous section I noted that focussing on numbers and statistics instead of people is a threat to person-centred, humanising practice (Galvin & Todres 2013). A central principle of a competitive market is consumer choice; however, in the case of acute inpatient stroke rehabilitation, it is not the patient that has consumer power, but the commissioner. I will conclude that the marketisation of healthcare is reshaping the nature of therapy on SUs. In this context auditing stroke therapy may be a double edged sword: a threat to quality as well as a safeguard for services.

NPM is a term used to refer to the public sector's adoption of certain private sector principles and practices (Hood 1995; Power 1997). NPM includes an emphasis on "... the creation of market and quasi-market mechanisms separating purchasing and providing functions and their linkage via contracts, and the enhancement of accountability to customers for the quality of their service via the creation of performance indicators" (Power 1997 p43). Power argues that the audit

explosion is a result of this movement. NPM is driven by ideological neo-liberal ideals of small government, and by the need to control and restrict public service spending (Power 1997). The term neo-liberalism has been debated, with some saying its over-use renders it meaningless, and others saying it is a useful term that represents a particular view of personhood (Erikson et al 2015). In the latter view, the dominance of marketisation goes against sociality based on reciprocity and solidarity (Erikson et al 2015; Polanyi 1944). Neo-liberalism actively encourages the position that people are consumers, and this affects their self-understanding (Erikson et al 2015).

Although the language of neo-liberalism, NPM and marketisation was not used by participants in the current study, they were mindful of working in a competitive market and the audit itself engendered a spirit of competition. Short term commissioning was part of the 'new way of providing healthcare', and this provoked uncertainty amongst staff, and concern about how the influence of audit data on commissioning decisions. It was good business to have a high number of patients using the service, and to secure funding for additional beds. From the perspective of therapists, expansion was associated with the loss of therapy spaces and a change in atmosphere and team working. Part of the recent and large scale re-organisation of the NHS has been the allocation of commissioning responsibilities to Clinical Commissioning Groups (CCGs). It has been argued that CCGs may be the UK's version of the 'administrative elite' Freidson described in the United States context (Freidson 1994 cited in Harrison 2015), and that this development is likely to "further entrench the commodification of medical practice" (Harrison 2015 p75).

As noted above, an ideal of NPM is accountability to customers. Yet this study found that in economic terms, SU patients were not customers in the market, but commodities. Unlike in other specialisms such as elective surgery, in stroke rehabilitation it is not the patient who has 'consumer power' to choose based on the published performance data. Staff participants discussed the need to win contracts and beds, demonstrating their engagement with the marketised model of healthcare. Patients did not anticipate their circumstances, and were not aware of the guideline or audit. They had certainly not selected their SU through 'consumer choice', but had been moved passively through a pre-determined stroke pathway sometimes involving multiple hospitals. It could be argued that the principles of marketisation and

accountability in this case are based on protecting the citizen as a tax payer, and ensuring responsible use of public funds (Power 1997). The 45 minute guideline was not intended to be a cost-saving target, but to improve therapy input for stroke patients. However, as discussed in the previous section, auditing therapy time encouraged a focus on measurable performance rather than humanising practice. Therapists spoke of wanting to deliver a good service in spite of the audit, not because of it.

When I explored the meaning of the SSNAP scores with therapists, it was common for them to report that they did not reflect the quality of therapy they provided to patients. Although they were uncertain of exactly how the SSNAP data might be used, the most common assumption was that results might be used by commissioners to make decisions about service contracts. The clinical lead on Olive Ward had seen the inclusion of therapy data on SSNAP as an opportunity to attend meetings with commissioners and tell the stories behind the numbers and 'wangle in her ethical viewpoint'. Like others, she expressed concern that funding decisions would be made based on SSNAP ratings, which did not show 'the quality beneath'. I therefore argue that therapists perceived SSNAP as a tool of accountability to commissioners, rather than to patients.

These findings were not anticipated, and therefore additional theory was sought in order to make sense of them. Many philosophers and theorists have claimed that the type of society we live in shapes the characters and social relations of its citizens. Aristotle paved the way for Marx in suggesting that the development of a market economy changes the aims and values of society (Nasser 2012, Marx 1977). Aristotle's function argument is useful for interpreting the influence of both audit and marketisation in healthcare (Aristotle 1998). Aristotle argued that everything has a function (*ergon*). For example, the function of a knife is to cut, so a good knife is one that cuts well. This study revealed ambiguity about what the function of a SU therapist is, and therefore their virtues and qualities are elusive. Therapists do not have a clear goal or aim (*telos*). If their function is to discharge patients quickly, then a good therapist would be one who gets patients out of hospital quickly. If their function is to give patients intensive therapy, then it makes sense to measure them accordingly. If their function is to help patients to overcome the consequences of a stroke, then the portrayal of a good therapist will be quite different. Lipsky's observations regarding the conflicting goals SLBs are expected to fulfil is relevant to the current study and

resonates with Aristotle's philosophy of functions, virtues and *eudaimonia* (meaning happiness or 'human flourishing'). For Aristotle, to live a good, happy and fulfilling life, one must be able to serve one's purpose well. Marketisation changes the goal (*telos*) to one of financial efficiency. Securing service contracts and funding more beds are ultimately directed to this end. In a discussion of the impact of targets and performance measurement on education professionals, Green (2013) proposes a neo-Aristotelian model for understanding why a focus on audit, which is bound up with a focus on financial efficiency, is at odds with a focus on accounting 'for oneself in ethical terms' (Green 2013 p 9). This study has found empirical evidence that this also applies in the case of SU therapy.

The field of education has been fertile ground for exploration of the influence of performance measurement on unmeasured quality. Teachers have been found to be 'split' between their own judgments of what pupils need and the demand to demonstrate institutional performance (Ball 2003). However, to my knowledge there has been no previous exploration of the impact of marketisation or performance measurement on the delivery of therapy. There has been empirical research into the effects of marketisation on citizens' values and behaviours in the broader field of healthcare, as discussed in Titmus' *The Gift Relationship* (1970). Titmus found that when blood donors were paid for their contributions, their motivation for giving changed and was no longer rooted in altruism. When a market for blood donations existed, donors no longer saw their blood as a special gift, so were less likely to want to give at all. The quality of blood was also inferior in the marketised system. Titmus' study provided empirical evidence that supported claims regarding the influence of marketisation on the motivations of citizens. This study found that even at an early stage of the auditing of therapy, therapists' attention was shifting towards the implications of their ratings for the commissioning of their services. Measuring performance within a marketised health system provides an alternative motivation for workers, and in this study the motivation to do well on the audit was sometimes seen to be in tension with the motivation to be patient-centred.

In praise of market competition, a study examining the relationship between hospital competition and quality based its methods on the premise that patients bring revenue. The study found that in hospitals that had more competition over patients (e.g. due to neighbouring hospitals nearby)

there was improved hospital management and higher performance in terms of quality, productivity and staff satisfaction (Bloom et al 2015). Authors noted that there may have been unobservable aspects of quality they were unable to account for, but they did not find negative associations between competition and any aspect of quality they observed. It is notable that they focussed on cardiology and orthopaedics, both specialisms of medicine cited by one of the participants in the current study as differing economically from stroke care, as they carry higher tariffs. Whilst patients in this study did not choose which SU to attend, patients are able to choose where to go for elective orthopaedic surgery. For these reasons, findings regarding cardiology and orthopaedics are unlikely to be applicable to acute stroke rehabilitation. Stroke practitioners do not expect individual patients to choose their services, so may not seek to attract them in the same ways as colleagues in other services may seek to demonstrate quality to the public. Additionally, individual performance measures and targets should be evaluated separately, as one may measure an aspect of care that is important to patients and can be measured with accuracy, whilst another may be vague, ill-founded and problematic in its measurement. They may also drive change through different pathways.

Exploring the literature regarding competition in healthcare, it is evident that much of it is based on ideology rather than evidence. This thesis, founded on ethnographic data, argues that marketisation of healthcare is a factor shaping the delivery of SU therapy, since SSNAP is used as a quality indicator to influence commissioners in their decisions about funding. There is no evidence to suggest that the leaders responsible for the introduction of the 45 minute standard and SSNAP intended it to be a tool of marketisation, and in some ways it has protected stroke services in a difficult economic climate for healthcare. Interviewees in the study discussed this, and also noted that this had led to tensions between stroke teams and other hospital teams that were short staffed. However, in other ways it has become a tool of marketisation. The perceived consequences of SSNAP discussed by therapists were less about whether patients get better, or have a better experience in hospital, or a better quality of life, and more about reputation, rivalries and the vulnerability of their commissioned services.

10.6 Strengths and Limitations

There is scant empirical evidence regarding the effectiveness of performance measurement in improving quality, and it has been noted that there is a need for studies that show the inner workings of policy implementation in practice (Fung et al 2008). The influence of evidence based guidelines and performance measurement has been explored in relation to medical practice, although more often in primary care than hospital settings (Harrison 2015). There is a lack of evidence regarding how therapists' interpret or apply clinical guidelines, or how audit may be changing the concept of therapy. This study addressed the research gap by revealing the inner workings of SU therapy practice and the influence of a newly audited national guideline on therapy delivery.

Forty-three participants were interviewed across three SUs. This yielded a large quantity of data from a diverse range of sources. Whilst this was intended to enable a view of stroke unit therapy from a variety of perspectives, it restricted the opportunity for in-depth analysis of any single profession. During data analysis it was apparent that OTs and PTs tended to have more in common, while SLTs encountered specific issues and sometimes were under the influence of different managers. Some of these distinctions were made when this seemed pertinent, but further exploration of the differences between the professions was beyond its scope.

I was limited in my ability to draw conclusions about whether therapy practice had changed as a result of SSNAP and the therapy intensity guideline, as I had not studied the sites before these were introduced. Thus my discussion of changes in therapy delivery is based on what participants told me and not on comparative observations over time. It is both a strength and a limitation of the study that it was situated in a specific point in time. Repeating the study at a later stage, when the guideline and audit may be more embedded in practice, would allow useful comparisons to be made. The changing landscape presented challenges when analysing the data, as things were rarely static or stable. This was also the case for the SSNAP scores, which were published on a quarterly basis and often showed movement in the ratings of SUs. Additionally, data analysis was complicated by the fact that many interviewees expressed mixed (and sometimes seemingly conflicting) feelings about the topic. Similar and different opinions were expressed at individual,

team and professional level. When analysing data, it was important to bear in mind that different views could be held by one person, and that similar statements could be made by different people. Although these conflicting perspectives and changes over time presented challenges when analysing the data, a strength of the design of the study was that it enabled these to be observed. Allocating three months to each site and using observation as well as interviews yielded rich, in depth data.

During the study I was very conscious of the potential for bias, particularly because of my background as an OT. I attempted to address this by writing freely in my reflexive diary and fieldnotes, and noticing when I was making judgements. I often found that where these judgements did occur, they were challenged by later experiences. Observing the contrasts in different sites forced me to compare them with each other rather than with any preconceptions I had about how SU therapy should or would be enacted.

Despite this, there is no doubt that my subjective values influenced the interpretation of the data. My interest was sparked by reading the theories I drew on to help me interpret the data, but another researcher may well have seen different meanings in the same data. I am confident that the conclusions I have drawn are well-founded, rooted in the data and contextualised by theory. But I am also aware that the data could have been interpreted differently, with emphasis placed on different findings. I was concerned about wasting data, aware that not everything could be included. In order to address these concerns, I presented and discussed my work-in-progress with others at many stages of data analysis. This included presenting preliminary findings to the SUs after fieldwork at each site and asking them if my interpretations resonated with their experiences, if they felt misrepresented in any way, and if there was anything they felt I had left out. I also presented the findings for discussion with former stroke patients.

Despite this study's specific focus, the findings resonate strongly with studies of the bureaucratisation and commodification of medicine (Harrison 2015; McDonald et al 2007; Timmins 2007). Quality improvement, the implementation of clinical guidelines, and evidence based practice, are all topics relevant to a wide and international audience of clinicians and policy makers, and the current study contributes to this broader field.

10.7 Recommendations and implications for future practice and research

The 45 minute guideline has been diversely interpreted, and there is little consistency in therapists' auditing practices regarding this guideline. This presents problems regarding the validity and reliability of audit data. Strategic leaders should consider how policy will be interpreted by practitioners, and whether it can be expressed in a way that will reduce variations in interpretation.

SU staff described a lack of joint working between nursing staff and therapy staff, a lack of team focus on rehabilitation and a belief that the nature of SU rehabilitation is changing. Whilst the benefits of early supported stroke rehabilitation are widely accepted, there are significant disparities in the availability of community services. Commissioning of stroke services should consider the whole pathway, including community services.

Therapists are concerned about the risk of standardising practice rather than treating people based on their individual needs, and of chasing ratings at the expense of providing good care. There is a risk that therapists new to stroke will follow the 45 minute guideline unthinkingly, rather than using their clinical judgement. Strategic leaders should be mindful when setting consensus-based guidelines of the possibility that these will be interpreted as evidence based, leading to confusion about best practice. Therapists should be encouraged to continue to focus on the specific and various needs of their patients, and should be supported by clinical leaders and managers in doing so. Clinical leaders are well placed to induct, direct, supervise and support new therapists to ensure they use their clinical judgement and understand the rationale for guidelines rather than over-interpreting them. Further investigation into what influences these leaders may be useful, as the leaders in this study had different mantras and priorities. Similarly, there is scope for investigating methods for increasing consensus and consistency between clinical leaders in different services. This study focused on the experiences and perspectives of therapists, and there were suggestions that higher level managers and commissioners had a

different perspective on the utility of guidelines and audit. Future research investigating this would enable a more comprehensive understanding of their utility in protecting and improving quality.

Focusing on audit performance is not the same as focussing on quality improvement. People at all levels, including policy makers, auditors, managers, clinicians and patients should be aware of this and not assume that the two are synonymous. Therapists consider it most likely that commissioners will use audit data to inform funding decisions. Strategic leaders should consider the likelihood that using audit as a performance measure in stroke will be used as a tool for the marketisation of healthcare, and will be more likely to influence commissioner choice than patient choice. Whilst patients and relatives do not necessarily feel best placed to make decisions about their care, they would like to participate in the conversation. In endeavouring to improve, maintain and measure quality, practitioners and strategic leaders should consider patients' and relatives' desires to be included in decision-making. It may be idealistic to expect any busy hospital therapists to have time to sit and listen to patients, but attending to a patient's personal journey, uniqueness and sense-making and being cautious of the risks of dehumanising practices are likely to improve quality of care. There is a risk of categorising patients in ways that may be objectifying and dehumanising, and of focussing on ratings rather than individuals. Further research is recommended to explore relationships between audit and humanising practice.

A consequence of auditing therapy practice is an attitude of rivalry between services. The concept of competition and its relationship to quality is complicated, and some have stated that competition drives quality improvement. This study did not find that to be the case, although it is situated at an early point in the auditing of therapy. Much of the literature on the topic of competition and quality improvement is based on ideology, and where empirical evidence does exist it is context specific. Competition is often used in economic terms, to signify the opportunity for choice between providers, rather than the sense of rivalry and disapproval that emerged as a bi-product of audit in the current study. There is much scope to explore the question of the influence of competition and hierarchical observation on quality in healthcare, and specifically in the areas of stroke, rehabilitation and therapy.

10.8 Conclusion

SU therapy is enacted differently in different hospitals, and the nature of SU therapy is changing. Therapists perceive themselves to be under increasing pressure, there is a growing focus on discharging patients, and the concept of an integrated 'whole team' approach to rehabilitation some therapists recalled as an aspiration appears to have been abandoned.

As observed by the member of the stroke patient research group cited earlier in this chapter, this study has shown what happens when a grand plan is set up with the best of intentions, but without due regard to the human nature of those involved in delivering or receiving care. Guidelines and audit in themselves contain no power, but carry the potential to change practice for the better or the worse. Therapy leaders are instrumental in shaping the way in which policy is interpreted and enacted at street-level. Positioned at the interface of policy and practice, they juggle and filter conflicting policy imperatives and ethical and professional values. Therapists did not believe the auditing of therapy time was a good reflector of quality, but whilst appearing to lack confidence in validity of the audit, many still reported it was important to them to do well. I have argued that in the wider context of healthcare marketisation, audit may become a tool of commissioner-centred, as opposed to patient-centred care. Further work is needed to identify quality improvement methods that encourage a focus on humanising practice in the delivery of SU therapy.

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The APA 6th Style was used for referencing, with the following resource used for guidance:

<https://blackboard.swan.ac.uk/bbcswebdav/institution/LibraryISSResources/Referencing%20Guides/Full%20APA%20referencing%20guide.pdf>

Appendix A: Sample Page of Publication

J Rehabil Med 2015; 47: 107–119

REVIEW ARTICLE

FACTORS SHAPING THE DELIVERY OF ACUTE INPATIENT STROKE THERAPY: A NARRATIVE SYNTHESIS

Elizabeth Taylor, MSc¹, Christopher McKeivitt, PhD¹ and Fiona Jones, PhD²

From the ¹Department of Primary Care and Public Health Sciences, Division of Health and Social Care Research, King's College London and ²Faculty of Health, Social Care Sciences and Education, Kingston University and St George's University of London, London, UK

Objective: To investigate factors shaping the delivery of acute inpatient stroke therapy (i.e. occupational therapy, physiotherapy, and speech and language therapy).

Data sources: A systematic search using electronic databases: AMED, CINAHL, Medline, Web of Knowledge and EMBASE.

Study selection: Qualitative studies ($n=31$) investigating delivery of inpatient stroke therapy, published since 1998, were included.

Data extraction: Narrative synthesis was used as the review method. Textual descriptions, tabulation and thematic analysis were used to categorize findings and explore relationships between studies.

Data synthesis: Data synthesis generated the following themes: the need for a therapeutic environment; power and decision-making; intensity, motivation and appropriateness for active therapy; therapy behind the scenes; the role of teamwork in creating a therapeutic environment. Delivery of therapy was influenced by conceptual, individual and professional factors.

Conclusion: Conceptual, individual and professional factors impact on the delivery of rehabilitation. Further research is needed to examine how therapists negotiate the sometimes conflicting factors shaping delivery of therapy.

Key words: stroke; rehabilitation; therapy; stroke unit; hospital; inpatient.

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Correspondence address: Elizabeth Taylor, Primary Care and Public Health Sciences, King's College London, SE1 3QD London, UK. E-mail: elizabeth.taylor@kcl.ac.uk

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INTRODUCTION

Stroke management underwent a paradigm shift at the end of the last millennium, from a prevailing attitude of passive pessimism regarding the fate of stroke survivors (1) to the emergence of stroke rehabilitation as an attractive and dynamic specialism with a growing evidence base (2). The value of stroke rehabilitation, provided by therapists to promote the restoration of lost function, independence and quality of life, was increasingly recognized and promoted (3–7).

Multi-disciplinary stroke teams typically include doctors, nurses, social workers, therapists, dietitians and psychologists. Occupational therapists (OTs), physiotherapists (PTs), and speech and language therapists (SLTs), are the primary members of the team concerned with providing therapy. Each therapy has different defining principles, but all share the aims of providing rehabilitation to maximize independence, reduce impairment and prevent further complications after a stroke (8). National guidelines in many countries recommend “increased therapy intensity” without further specification, whilst some specify a daily minimum (9–14). There is variation in the delivery of therapy internationally, and audits conducted in England and Wales suggest that the national standard regarding intensity is not being met (15–18). Quantitative studies investigating therapy delivery have focussed on quantifying time spent in physical activity or physical rehabilitation interventions (19–23). However, the varied content of therapy sessions cannot be captured by measuring physical activity, and the objectives of therapy sessions are not the same for all stroke patients (24). Qualitative studies lend themselves to investigating context and processes that may lead to variations in the delivery of therapies.

There is a need to improve understanding of the processes of stroke rehabilitation and contextual factors affecting the allocation of therapists' time (18, 25, 26). We sought to address this by reviewing qualitative studies investigating the factors shaping delivery of inpatient therapy for stroke patients.

REVIEW METHODS

Narrative synthesis was chosen as the review method, as this provides a systematic, transparent approach, with guidance on enhancing trustworthiness (27). Narrative synthesis involves developing a theory at an early stage of the review; developing a preliminary synthesis; exploring relationships in the data; and assessing the robustness of the synthesis product (27). The theoretical basis of this review is that delivery of healthcare is shaped by structure and process, and that asking “what goes on” enables critical enquiry into elements of structure, process or outcome (28).

Data sources

The following electronic databases were searched: AMED, CINAHL, Medline, Web of Knowledge and EMBASE. Search terms included: stroke, rehabilitation, therapy, stroke unit, hospital and inpatient. Where possible a filter was used to select qualitative studies. Table 1 sets out the

Appendix B: Interview topic guides (staff and patient)

Interview topic guide (staff)

- Can you explain your role?
- How long have you worked on a stroke unit for? (Different ones? Is this different from other ones?)
- How does your role on the SU differ from your role in other settings?
- Can you describe a typical working day to me?
- How do you manage your time? Do you use a timetable and plan sessions in advance? Is it up to you how you manage your time or are there structures in place?
- Are you aware of the guidelines regarding therapy intensity for stroke patients? (And SSNAP)
- Can you tell me your understanding of them? (What are they? What do you think the rationale for them is? Evidence based?)
- Do you think your practice has changed at all because of the guidelines or SSNAP audit? (How – trying to do a better job / pressure from above / reputation of hospital...?)
- What do you think about the 45 minute guideline? (Do you think the guideline is good / appropriate? Why / why not?)
- The SSNAP audit asks you to say whether you think a patient was appropriate / applicable / required therapy. Can you describe how you decide whether or not therapy is applicable?
- If you had unlimited resources, how would you decide how much therapy each patient should receive?
- Do you think your SSNAP score reflects the quality of your service?
- The audit data shows a lot of variation in the proportion of patients considered applicable for therapy, and the intensity provided. What are your thoughts about that?
- If you could change the therapy guidelines (if you wanted to), what would you have instead of the current 45 minute recommendation?
- If you could wave a magic wand and set up stroke unit therapy in the way you thought was best for the patients, what would that look like? What do you think prevents that from being reality?

Interview topic guide (patients)

- Can you tell me a bit about what happened to you and why you are on the stroke unit?
- What did you know about strokes /rehab / therapy before this happened to you?
- Have you seen an OT / PT / SLT on the stroke unit?
- What sorts of things do they do?
- How much therapy have you been getting?
- Do you think that is the right amount? Or too much? Or too little? Please explain...
- Do you know when you are going to be having therapy (i.e. do you have a timetable?)?
- Do you think most people get the same, or have you noticed that some patients seem to get more than others? Have you got any thoughts about that? Do you think everyone should get the same?
- Are you aware that there are guidelines regarding therapy intensity for stroke patients? (And SSNAP) [If not, I will explain]
- Do you think the guideline and audit is good / appropriate? Why / why not?
- How does it compare with your experience?
- Did anyone ever ask you what you thought you needed, in terms of therapy?
- If resources were not an issue, how much therapy would you want? What would you like it to involve?
- If you could change the therapy guidelines, what would you have instead of the current 45 minute recommendation?
- If you could wave a magic wand and set up stroke unit therapy in the way you thought was best for the patients, what would that look like? What do you think prevents that from being reality?

Appendix C: Fieldnotes from Jade Ward SSNAP meeting

The following extract is included as a sample of fieldnotes. I have chosen this entry because it gives an example of the role dilemmas I faced as an ethnographer with 'dual citizenship' to the world of therapy practice and the world of SSNAP. Despite wanting to observe therapists and have minimal influence, I was seen as an 'expert' on SSNAP, and was cautious about the implications of this. The extract also depicts the hazy muddle I perceived in stroke teams regarding SSNAP data, and gives an insight into sense of 'them and us' that I observed between the workers and the auditors.

10th Feb – SSNAP Meeting

Background

I did my fieldwork at Site A from September to November 2014. A few weeks ago I heard from [B7 OT]. She said Jade had done badly on the most recent SSNAP report (for July –Sept 2014), and she needed to meet up with the managers about it...

I then got this email:

Elizabeth Taylor has kindly offered to spend some time with us looking at our SSNAP data reporting.

That's all it said. It was one of those invitation emails, with a time and date, and had been sent to the relevant managers and the B7 stroke therapists.

I felt uncomfortable with this, because I had not intended to attend as an expert or advisor. I spoke to my supervisors who agreed it would be good to go to the meeting, and Fiona suggested taking my UKSF presentation to share with them. We agreed it might be good to talk to B [researcher involved in SSNAP] for a SSNAP perspective, so I had something useful to contribute.

Meanwhile, I looked into the SSNAP figures and was surprised to see the therapy domains were still looking good. I had the following email exchange with OT about this:

Me: I'm just having a look at the SSNAP data and Jade has As for therapy domains. I'm confused – what did you mean when you said Jade had done badly?

OT: Yes, despite the "A's" we've been pulled by SSNAP as we report much higher than the national average and therefore they think our data is botched. There were discrepancies in the data anyway... We have been sent a few emails with extracts from spread sheets etc., but it's difficult to read them out of context

Me: Ah, that's interesting.... So they think you're dodgy?!

OT: A-ha.

One of the dodgy-est apparently!

We have challenged them and will continue to do so (as per default position!!), and that's why casting your expert opinion would be really helpful for us.

Oh, and they apologised the other day, as apparently they marked us "RED" in audit compliance for 2 consecutive audits, only to turn round and say that there was an issue with their website which affected us and another team (dunno which one..)
Now.. who's dodgy?!

I spoke to B and he was very helpful. He reminded me that I needed to think about my role, and if I was attending as a PhD student / ethnographer who would be observing, taking notes, thinking about it and writing it up, then it was important to check they were all ok with that. He also said that SSNAP are definitely NOT checking if people are looking dodgy – it would take far too much analysis and isn't even possible. He was very interested in (me) picking apart that thought / paranoia... So, I emailed the group to clarify my role. :

Dear all,

Thanks for inviting me to attend your meeting about the SSNAP data. I'm very interested in attending as part of my observational fieldwork, to see how teams are using, interpreting and responding to the audit data. I just wanted to check I wasn't coming under false pretences and that you are happy for me to be there as an observer.

Please let me know if you have any objections. If not, see you next week!

Best wishes

Elizabeth

I think there is lots to reflect on in this regarding the tricky position of the participant observer; gaining and maintaining access; and other things like checking consent rather than assuming it. In the rest of these notes I want to focus on the meeting, which was very useful in itself.

The meeting.

Attending: Me, therapy services manager, divisional service manager for stroke, B7 PT, B7 OT, Head OT head.

We sat in the gym, in a semi-circle with the SSNAP website projected onto a big screen. It was a lunchtime meeting, so everyone ate their lunch at the same time except me, as I am a student so had eaten at my leisure beforehand.

OT showed us the hospital data for all reports displayed side by side, where it stood out that they had an E in red for audit compliance consistently since October 2013. They said this means results weren't submitted, but that didn't make sense because they had good results in the report. There was a bit of confusion because OT was saying that SSNAP had said this was SSNAP's error on the last report. It wasn't clear whether all the Es were an error, or just the latest one. The other scores all seemed good, with therapies always getting As or Bs.

Manager then explained to me that the hospital had been pulled up on their therapy intensity data and also queried the applicability data. There were queries because the SU was an 'absolute outlier' on the compliance score.

The nature of the meeting was that everyone there was trying to get to the bottom of what the problem was. They came up with ideas for different things they could check, and checked them. First, they discussed the fact they report 100% applicability. This was very interesting to me as it was something I had picked up on but nobody had seemed particularly aware of while I was doing fieldwork there. When they discussed it in the meeting, they justified it and thought it was right that everyone should be considered appropriate for something, but Manager wondered if they needed to think about doing it differently 'for the data'. She suggested that they could have an initial and not be considered appropriate unless they still needed therapy after that, but the therapists pointed out that that wouldn't make any difference because everybody needs something, even after the initial. Whether it's a home visit or some chest physio, it's very unusual for a patient to need nothing at all.

After looking at the SSNAP report, the slide deck was flashed up. (I was interested in seeing how they used the website and the data available). From the slide deck, they could see a graph showing their team's median minutes of daily therapy for each month. The medians were very high, from 53 in one month right up to 103 in another. Everyone acknowledged that must be wrong. Everyone wanted to work out where it was going wrong.

Questions were called out, like 'does it include students?'; 'does it include therapy assistants?'; 'are we counting family meetings and goal settings?'. If one person said yes, someone else said no, and someone else wasn't sure. Manager was saying no, you wouldn't count meetings as face to face therapy. PT was saying, well – we do. Head OT pointed out that even if family meetings were being included it still wouldn't explain the numbers, as you would not be likely to give someone a therapy session AND a family meeting in one day.

One issue seemed to be what goes into [the hospital stats system], then another is what goes from [that system] to SSNAP. They were able to flash some raw data up on the screen. One thing was the individual patient SSNAP data set for two different patients. Another was the hospital list of all contacts for the same patients. I knew both patients from my fieldwork, so was able to think about how well the data matched the intensity of therapy I had seen them receiving.

Patient A had this recorded on the SSNAP data set (completed by the team):

Days on which he received therapy: 14 (this seemed right. It comes straight off the hospital system for the days on which a therapy session was logged, rather than being the admission period. It also sounded right as he was in Jade for 20 days but was acutely unwell.)

Mins of therapy received: 1462 PT; 1212 OT; 500 SLT.

What?? So that's 104 mins of physio a day?? 86 for OT? And 35 for SLT.

I think that means that's the average they received on the days that they received anything.

People noted that a certain person used to do the SSNAP reporting with the help of therapists, and then this became the responsibility of someone else. They wondered if it had gone wrong when she took over. Division manager said he could copy the therapists into the hospital stats delivery reports for them to check.

SSNAP had sent a patient ID number as an example of strange data, but when they went to open it there was no such person. This exposed the fact that none of them had tried to look at this before the meeting, despite getting the email from SSNAP in December I think.

Patient B

I remember him. He was in for 4 months.

He had 111 days of PT; 64 OT; 54 SLT.

Total minutes: PT: 1136; OT: 8152; SLT: 5260 (which would be 90 mins a day – so there is definitely something wrong with the numbers!).

We got calculators out, tried to do maths, and whichever way we looked at it the long and short of it was that the data must be wrong. And we'd run out of time. Someone else needed the gym and everyone had places to go.

When we checked the raw data it was clear that TA and student time isn't being counted.

Manager wrapped up by asking Divisional Manager and B7 OT to take this forward. She said we need to make sure everyone's recording the same way so we are inputting good quality data, and we need to check the hospital stats reports to check if that's all ok.

When we were putting away our chairs and leaving I said something about it being interesting that SSNAP had spotted the anomalies. Divisional Manager said something along the lines of, "Well, I think they must have a lot of people working for them down there. If you ask them a question they get back to you in 10 minutes. So I think there is a lot of monitoring going on." I pictured the little office where we'd sat with [SSNAP lead], and the little team she's got, and didn't say anything.

Thoughts:

- People don't know what they're doing – inconsistent reporting and nobody's sure what data they are submitting off the tops of their heads, although they are able to look it up if they have a window of opportunity.
- Doing this isn't a priority in their busy day. In the brief time I popped in and saw various people, I noticed how exhausted everyone looked. When I spoke to Manager about this she said the problem is the way the NHS is now, you have to bid for business all the time and it takes up lots of time you haven't got.
- People think SSNAP is like big bro watching them. Despite OT's email which sounded a bit mistrustful of them, mostly people were open to believing SSNAP were right.
- I didn't get the impression any of this was going to change how people delivered therapy, just how they attended to the data.
- They're not intentionally 'gaming', they are muddling along.