The gap between public service theory and service user experience: An exploration of service users understanding of targets in New Zealand Emergency Departments

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Abstract

Demand for better public services, especially within healthcare, has been evident for decades. Practices and approaches from the private sector were posited as a solution to the ongoing failings of the public sector. The adoption of performance management and measurement was one, of many, private sector practices applied to public sector organisations. Targets, one performance management tool are examined. Targets were selected due to the media, academic and political attention they have received.

This exploratory research sought to develop an understanding of the effect of targets on public service delivery, specifically from a Service Users perspective. The findings indicate that within the New Zealand healthcare system, Emergency Department Length of Stay targets are not widely known by Service Users. As a consequence there is little impact on Service Users expectations of the service. There are, however, other factors which shape Service Users expectations. The lack of awareness of Emergency Department Length of Stay targets may lend evidence to the difference between citizens and Service Users. It may also support claims that the introduction of private sector practices has compromised the relationship between citizens and government. Areas for further research are identified.

Keywords: Public service, private sector, performance management, citizen, service user, New Public Management, managerialism, politics, healthcare, emergency departments, targets, measurement

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To my past self – the pain of being in the unknown was worth it. To my future self – always remember why you started: because it doesn’t have to be this way.

Ā tōna wa werohia tōu ao

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List of Acronyms

A&E	Accident and Emergency
DHB	District Health Board
ED	Emergency Department
GP	General Practitioner
IPA	Interpretative Phenomenological Analysis
NPM	New Public Management
NZ	New Zealand
NZHS	New Zealand Health Strategy
NZNO	New Zealand Nurses Organisation
LOS	Length of Stay
RTA	Reflexive Thematic Analysis
USA	United States of America
UK	United Kingdom

Introduction

“We hear about refugees, not from refugees” – Malala Yousafzai

We hear about Service Users, not from Service Users.

Background and Context: The Quest for Better Public Services

Dissatisfaction with Public Services

There is long-standing dissatisfaction with not only public healthcare services but government public services in general (Gauld, 2009). There are claims that bureaucracy is broken (Savoie, 1995) and unresponsive (Kettl, 1997). There have been calls for increased accountability, service delivery, efficiency, and effectiveness (Boston et al., 1996). This dissatisfaction, within the Westminster countries of the United Kingdom (UK), Australia (AU), New Zealand (NZ), and Canada has led to significant volumes of reform (Halligan, 2007). This has also been the case in the United States of America (USA) (Light, 2006). In addition to government level reform, dissatisfaction with the NZ healthcare system led to a series of healthcare-specific parliamentary reviews and reforms. Despite these reviews and reforms, there remains the perception that the NZ healthcare system is in “steady decline” (Gauld, 2009).

Business is Better: Managerialism and New Public Management

Public service delivery, via Public Administration, was seen to be fundamentally flawed (Pollitt, 2003). Private sector principles and practice were proffered as providing solutions to resolve these fundamental flaws and ultimately reduce public dissatisfaction (Pollitt, 2007; Terry, 1998). The position that public sector organisations should adopt private sector principles and practices is underpinned by the ideology that ‘business-is-better’. Business-is-better is the shorthand way of saying that practices typically associated with the private sector such as, but are not limited to, competition, cost control, disaggregation, output control and performance measurement (Dunleavy et al., 1994; Hood, 1991; Pollitt, 1995) are better at achieving desired outputs and outcomes than the practices and structures employed by Public Administration. Managerialism and New Public Management (NPM) became the terms used to describe the application of the market and private sector management practices to the public sector. In this research managerialism and NPM are used interchangeably. Managerialism and NPM are both underpinned by the belief is that business-is-better at achieving outcomes. For ease of reading the term NPM is prominently used.

NPM practices have been used in NZ since the early 1980s. Boston et al. (1996) argued that New Zealand had its own model of NPM. The unique articulation and ordered presentation of ideas and rationale behind the changes - warranting the label of ‘the NZ model’ - was driven by the “conceptual rigour and intellection coherence” (Boston et al., 1996, p. 3) of a post-election briefing to the incoming Labour government of 1984. The NZ model has been through several iterations since being introduced (Frederickson & Smith, 2003) and is now considered by some to no longer exist (Chapman & Duncan, 2007). However, despite contests around the continued existence of a NZ model, legislation and established government public service practices introduced during the 1980s reform remain.

NPM in NZ has evolved; as is expected with the natural development of a field (Hood & Peters, 2004). The initial changes to NZ public service delivery included a shift towards contracts, both for department heads and in service provision, accountability mechanisms, output measures, and a desire to improve efficiency. The approaches and practices implemented have been hailed as highly creative, innovative (Schick, 1996) and bold (Scott, 2001). Walker (1996) claimed the changes were successful while Easton (1995) and Kelsey (1995) claim the changes failed to achieve their promised results. It has been argued that the changes created issues of fragmentation, mis- or lack of alignment between political and managerial accountability, and variations in service quality (Boston & Eichbaum 2006; Halligan, 2007; Scott 2001). Since the 1980s reform, various additional waves of reform have sought to address both the initial concerns of a failing public service and or, the issues created by the ‘new’ approaches to service delivery. Duncan and Chapman (2010) claim that through these further reforms “some of the original NPM practices have been preserved, some refined and some improved upon; but others have been quietly abandoned, or even reversed" (p. 312). However, Halligan (2007) argues that there is a resulting sense of unfinished business. One area in which this unfinished business is highlighted is the continued development of targets, specifically within the NZ healthcare system.

Healthcare and Targets in New Zealand

NZ has, for the most part, a free-at-point-of-use healthcare system. The funding and structure of healthcare in NZ were initiated with the Social Security Act 1938 and “enshrined in the *Health and Disability Services Act* of

1993” (Brunton, 2017, p. 720, italics in original). These acts provided not only the legislative backing but embedded free healthcare as a social expectation (Brunton, 2017). The legislative backing for free-at-point-of-use healthcare has since moved to over 20 other acts (Ministry of Health, 2011). Alongside this long-standing belief in free healthcare, Brunton (2017) argues that the New Zealand healthcare system has been through significant “ideological shifts” (p. 719). These changes, significantly influenced by the prevailing NPM approach noted above, have played out at two levels: the structural level and service delivery level (Gauld, 2009; Pollitt, 2007). Targets are one way in which the business-is-better ideology has played out across NZ healthcare system.

Targets are purported by the Ministry of Health (2007) to be “one part of a comprehensive performance management and accountability system” (p. 2). The use of targets is posited as enabling accountability which in turn “builds the public’s trust and confidence” (Ministry of Health, 2016a, p. 25). Behind the accountability narrative is the idea that increased visibility of performance and improved information collection will result in better decision making. That is, resources can be directed to maximise the achievement of priorities in a resource-constrained environment. Targets are a tool used to enable, ensure, and verify that citizens needs are being met.

More specifically, Emergency Departments (ED) Length of Stay (LOS) targets are the focus of this thesis. ED LOS targets set a length of time, commencing on arrival, by which patients must be admitted (to hospital), discharged or transferred from the ED (Ministry of Health, 2009a, p. 3). Colloquially, they are known as the “door-to-departure time” targets (Weber et al., 2012, p. 700). In NZ, the ED LOS target is that “95 per cent of patients are admitted, discharged, or transferred from an Emergency Department within six hours” (Ministry of Health, 2009a, p. 1). ED LOS targets have been introduced in many English-speaking countries (Hoyle & Grant, 2015). They are a highly topical issue and have been reported and discussed in the medical literature for over 20 years (Moskop et al., 2009a) and in NZ since the mid-1990s (Tenbensel et al., 2017). In addition, ED LOS targets are part of broader conversations on waiting in ED, crowding of EDs, resource limitations in healthcare systems and indicators of overall healthcare system performance. Despite this, the effectiveness of ED LOS targets is questioned.

ED LOS target success has been described as “hitting the target and missing the point” (Bevan & Hood, 2006, p. 521). Hitting the target but missing the point is where a target is achieved, but with adverse side effects or no quantifiable effect on the desired outcomes. It is target success without outcome success. Research by Reddy et al. (2018) indicates that ED LOS targets improve health outcomes but do result in unintended consequences. Contrastingly, research by Weber et al., (2012) indicates that an improvement in performance (but not necessarily meeting the target) does not result in adverse effects. NZ based research indicates that the introduction of targets improved ED LOS times but that many hospitals still failed to meet the target (Tenbensel et al., 2017).

In addition to the target itself, secondary effects have been examined. Hoyle and Grant (2015) and Mortimore and Cooper (2011) have investigated the impact of targets on hospital staff. Their research indicates that staff, especially nurses, absorb the additional demands created by targets such as an increased workload and additional pressure. Research on patients' perspectives and experience of ED tends to focus on satisfaction. Taylor and Benger (2004) and Nairn et al. (2004) have identified aspects which drive patient satisfaction in ED. One component of satisfaction is waiting times. However, the research is unclear when referring to waiting time, what type of waiting is considered, or if it is an aggregate of all types of waiting. For example, a systematic synthesis of the qualitative research on the patient experience in ED by Gordon et al. (2010) found that patients' waiting time concerns were not only the total length of stay but the time to see a clinician for an initial assessment, the waiting time for tests and being informed about how long a wait would be as well as why there was a wait. It is evident that waiting time, in various forms, is critical to a satisfactory patient experience. However, how waiting time effects, or how different types of waiting impact the patient experience does not appear to have been examined. Overall the effectiveness and impact of targets on ED LOS is unclear.

Definition of Terms

There is debate over the distinction between citizen, customer, client, and Service User (Frederickson, 1991; Gray & Jenkins, 1995; Osborne & Gaebler, 1993; Roberts, 2004; Thomas, 2012). For the purpose of this research, the following delineations have been made. Citizens are deemed to have voting rights in government elections. They receive public value while clients/Service Users receive private value (Alford, 2002). A citizen may or may not ever need to use a public service, but they have a vested interest in how the public service is delivered, even if only by virtue of the outcome they expect for someone else using the service. Citizens typically demand accountability through voice (Quirk, 2005). On the other hand, Service Users, of which there are varying types (Alford, 2002) are those who consume a service. This research focuses on Service Users who do not pay at the point of use for the service (Alford, 2002). This research, therefore, assumes that Service Users are a sub-set of Citizens. The terms *client* and *customer* are considered terms used to view Service Users through an NPM lens. When quoting authors, their use of terminology is clarified with the use of the term as defined in this thesis. The use of these terms is examined further in the Literature Review.

Further, use of the term ‘hospital system’ refers to all services provided by the hospital which includes outpatient services and all hospital departments. The ‘whole system’, ‘wider system’ or ‘healthcare system’ includes hospitals and primary care services (such as General Practitioners (GPs)).

Research Overview

Broadly, this research sought to examine a perceived disconnect between macro-level policy ideologies and practices of public service delivery and the micro-level Service User experience of public service delivery.

This research explores the belief that targets improve public service delivery. The first premise is that Service Users want better service delivery. The second premise is that the business-is-better ideology can improve service delivery. The third premise is that targets are one way in which the business-is-better ideology is enacted. Therefore, the conclusion is that targets improve service delivery. This exploratory research sets out to examine this conclusion. Ascertaining if targets improve service delivery can be achieved by various metrics. The perspective adopted for this research is whether targets improve service delivery *from the perspective of a Service User.* In essence, we often hear about Service Users, but not from Service Users. This research seeks to add to bridging the gap between macro-level policy ideologies and micro-level experiences through an exploration of the case of NZ ED LOS targets.

However, initially, the following questions were used to guide the literature review, research design and data collection.

Guiding Question 1: How do ideologies about how to run public services filter down from idea through implementation to impact Service Users?

Guiding Question 2: How do Service Users perceive and experience the ideologies of public service delivery?

Guiding Question 3: Is there convergence between Service Users' understanding of the rationale and justification for public service approaches and the reasons purported by the government and its delegated agencies for said approaches?

The development of the research questions is further outlined in the Literature Review, Methodology, and Discussion.

Delimitations and Exclusions of the Study

The research does not delve into broader theoretical debates such as whether which services should be delivered by government (and to what degree), the complexity of the relationship between the citizenry and the state, the role of the state, or whether public and private organisations are fundamentally different (Alford, 1993). Where applicable, these issues are highlighted for reference.

Literature Review

Business is Better – An Ideological Position

The dissatisfaction with public services (Chapman & Duncan, 2007) and the quest of governments and the demand by citizens for governments to do better is not new (Boston & Pallot, 1997; Hood, 1995b; Savoie, 1995), and dates back to the pre-unification of China and 19th century Germany (Hood, 1995). This quest is also not likely to go away (Kettl, 1997; Osborne, Radnor, & Nasi, 2013). In the late 1970s and early 1980s, the business-is-better ideology was offered as a solution in response to calls for better public service delivery. The following reviews the intellectual and ideological development of the business-is-better ideology that was proffered as an answer to public dissatisfaction with governments provision of services. The development of business-is-better ideology is examined within the NZ context with a focus on the NZ healthcare system. Specifically, the use of targets, as a tool for improved service delivery, is explored.

Defining and Delineating New Public Management

The following does not aim to cover all the attempts that have been made to define and delineate NPM. An overview of the different ways NPM has been conceptualised, to highlight both the common underlying themes and variations in implementation.

NPM is a term that has been used to describe a collection of ideas about political and bureaucratic reform. Hood (1991) refers to NPM as an “administrative label” (p. 3) that is linked to four megatrends in public administration. Pollitt and Bouckaert (2004) further note that the term NPM is used in at least three different ways. Terry (1998), on the other hand, argues that NPM was simply a banner for two schools of thought: liberation management and market-driven management. Managerialism is the view that management is good and that the management practices of the private sector should be adopted (Terry, 1998). Conflictingly, managerialism has been identified as an ideology in its own right (Pollitt, 1990), while also noted as a common element across all NPM approaches (Terry, 1998).

Various components of NPM have been identified, with significant overlap emerging between authors. Hood (1991) identified seven “overlapping precepts” (p. 4), which he called doctrines. Along with this identification of each doctrine, he identified an associated meaning and typical justification he claimed appeared in most discussions of NPM. Similarly, Pollitt (1995) identified eight elements of NPM, noting that the elements often interacted with one another. Notably, both Hood (1991) and Pollitt (1995) clarified that not all components they identified were present in each ‘case’ of NPM, nor was there consistency in the application of ideas. Despite this, across both Hood and Pollitt, there are themes of cost control, disaggregation, output control, performance measurement and private sector management techniques as necessary to improve the performance of public services. These are summarised in a table provided in Appendix A. Similarly, Dunleavy et al. (1994) claimed that the components of NPM fitted into the categories of competition, disaggregation, and incentivisation.

Other conceptualisations of NPM include Terry’s (1998) position that NPM focused on freeing public servants from a system that prevented them from doing their jobs well. De Vries and Nemec (2013) further offer the perspective that NPM ideas have been either externally or internally focused. An externally focused NPM narrative is one which questions the role of the public sector and asserts that under neo-liberal views, delivery should be left to the private sector. An internal focus, in contrast, starts from the perspective of improved delivery for citizens, in which privatisation and market mechanism may be an appropriate tool to achieve these objectives. Whichever approach is taken, the underlying view is that practices and approaches from the private sector should be adopted in the public sector.

From a classification type approach, Pollitt and Bouckaert (2004) describe, based on their research, four types of NPM. They identified Maintainers, Modernizers, Marketizers and Minimalists. Each type has a slight variance in views on how involved the state versus the market should be – but overall, all still of the view that the involvement of the state should not be excessive (without being able to define excessive). In an alternative approach, Ferlie et al., (1996) derived an NPM typology made up of four models. The four models they identified were: 1) the efficiency drive, 2) downsizing and decentralisation, 3) in Search of Excellence, and 4) a public service orientation. In line with typology-building, these categories are deemed mutually exclusive. However, that does not mean that a mechanism used under one typology cannot be used in another. For example, performance management is found in all four typologies; however, there is variance in how performance management is applied. Ferlie’s typology offers one way to understand how the NPM ideology has played out across different countries and sectors.

NPM, therefore, is not a single a selection of ideas, instead, it is an ideological approach, with commonly associated practices, of how public services should be delivered. NPM is, from this stance, the prioritisation of practices of market-led behaviour (consisting of competition and the customer as central) and performance management. The above has provided an overview of the ways in which NPM has been defined and delineated from other approaches to public service delivery. The next section provides an overview of the ways in which these broad approaches have been implemented.

The Implementation of New Public Management

The NPM ideology has “manifested” (Steane, 1999, p. 134) through a variety of different practices now evident in public sector delivery. Tools and interventions include contracting or market testing (Rhodes, 1994) to create market-like conditions and cultivate competition (Brunton, 2017; Dunleavy et al., 2005; Hood, 1991; Hood, 1995b; Osborne, 2006; Osborne, Radnor, & Nasi, 2013) and show up through the privatisation of assets, contracting out of services and the creation of quasi-markets through the split of policy and delivery or the creation of the purchaser-provider split (Haworth & Pilott, 2014). A focus on performance management and explicit standards and measures of performance (Dunleavy et al., 2005; Hood, 1991; Hood, 1995b; Osborne, Radnor, & Nasi, 2013; Osborne, 2006; Pollitt, 1995; Pollitt, 2007; Rhodes, 1994) demonstrated through approaches such as pay-for-performance, league tables and output-driven funding or budgeting for performance (Steane, 2008). This also includes targets, indicators, and output objectives (Pollitt, 1995). A focus on cost management (Osborne,

2006) as demonstrated through both resource allocation based on required outputs (instead of inputs). The above certainly does not outline all the mechanisms for implementing the core NPM ideologies but instead serves to highlight some of the ways in which the NPM, business-is-better, ideology has been " bedded in" (Chapman & Duncan, 2007, p. 7) in political and public sector delivery across the UK, Australia, the USA and New Zealand.

Benchmarking of outputs, often through targets, allows government and public institutions to mould Service Users’ expectations, and simultaneously increase the acceptability of performance standards (Mathiasen, 1999). In this respect, targets, through the political lens, are “policy instrument[s]” (Tenbensel et al., 2017, p. 678). However, selection of a target may not be able to encompass broader elements of service delivery performance or neglect outcomes due to a focus on outputs. A target selected to aid Service Users’ satisfaction and outcomes may fail to encompass how Service Users assess value or if a service meets their needs. A target may also neglect the nature of demand of a service or be unable to account for factors outside the control of the organisation and neglect the view of wider stakeholders (Meekings et al., 2011). Further, as with any data, the results of a target can be used to both highlight success and failures. In the UK targets have been described as “political weapon[s]” (Hood, 2008, p. 7); the same data used by both the government and opposition to simultaneously ‘prove’ contradictory positions (Hood, 2008).

An additional NPM practice, relevant to this research, was the shift towards viewing Service Users as customers (Alford, 2002; Brunton, 2017; Dunleavy et al., 2005; Kettl, 1997; Pollitt, 1995) and a focus on service quality and customer responsiveness (Alford, 2002; Dunleavy et al., 2005; Kettl, 1997; Pollitt, 1995). This was the view that public service organisations should view Service Users *as though they were directly paying*, as in private business. This required, among other things, a shift to "quality as the customer [Service User] defines it" (Kettl, 1997, p. 447). It also assumed that dissatisfied Service Users could ‘vote with their feet’ and switch service providers (Pollitt, 2003). NPM implementation set about structuring a multitude of ways in which public service organisations had an "*operational* incentive to pay attention to clients' [Service Users] needs" (Alford, 2002, p. 344, italics in original). However, this is a complex and debated point.

Service Users are first and foremost a citizen[1] who directly consumes a service, but they do not pay for the service at the time of consumption. As noted in the Definition of Terms in the Introduction, for the purposes of this research, a Service User/client/customer is considered the same individual. Further, for this research, Service User is considered a neutral term that is not aligned to either NPM or Public Administration. Client and customer are ways in which NPM imposes the business-is-better ideology on public service delivery. The following provides an overview of the evolution in NPM.

Evolution, Variation, and the Validity of New Public Management

NPM has evolved (Dent, 2005; De Vries & Nemec, 2013; Ferlie & Andresani, 2006; Hood, 1995b; Terry, 1998). This is expected given that the

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[1] This discussion is underpinned by a long-standing debate about the relationship between the state and citizens (Osborne, Radnor, & Nasi, 2013). While there are claims that NPM fundamentally changes the relationship between the citizen and the state (De Vries & Nemec, 2013). It is outside this thesis to consider if this change has occurred.

intellectual development a field is a “normal process of scientific development” (Hood & Peters, 2004, p. 269). What is challenging, as there will rarely be a distinguishing time or action between dominant ideologies, is establishing when one ends and another one starts, or if it is the continued intellectual development of the ideology. For example, as early as 1998, Lynn (1998) argued that NPM was over and that a post-mortem could be conducted. Dunleavy et al. (2006) claim that NPM is “intellectually dead” (p. 7) and being replaced with digital-era governance. Others simply talk about being post-NPM (Christensen & Laegreid, 2005; Olsen, 2006). Osborne (2006) argues that NPM was a transitory state towards the now existing New Public Governance. Despite this, practices, and approaches to public service delivery, brought in under the NPM banner, remain (Dunleavy et al., 2005; Ferlie & Andresani, 2006; Halligan, 2007). It is outside the scope of this thesis to examine in detail the full lifecycle of NPM.

The, although expected, evolution of NPM combined with the inability to reach a single definition called into question the validity of the ideology. For example, Ferlie et al. (1996) take a cynical approach asserting that “NPM seems like an empty canvas: you can paint on it whatever you like" (p. 10), with Savoie (1995) adding that it is a poorly used label. Common (1998) argued that NPM was simply a title for a scattering of management techniques. There is also debate on whether NPM can be called a paradigm as some have tried to claim (Hood,1995). Whether or not NPM is its own intellectual paradigm is of little relevance here because of the position taken that NPM was at the very least, an ideology that was adopted. NPM may have been implemented in varying forms and to varying degrees, but none the less the ideology has had a lasting impact.

Variation in implementation is distinct from variance in the core NPM ideology; especially as ideologies are rarely implemented in full (Dunleavy 2006). The significant variance in the application of NPM (Pollitt, 1995; Pollitt & Bouckaert, 2004) is expected as change does not occur in a vacuum (Wong, 2013). Each country starts from a different place (Pollitt & Bouckaert 2004) with differing political influences, histories, and institutional features (Cheung, 1997) and is subject to different local configurations of power and knowledge (Dent, 2005) and culture (Bourgon, 2008). In addition to different starting points, countries have different visions for what they want to achieve overall (Pollitt & Bouckaert, 2004). Therefore, even between countries that choose to adopt the same mechanism the degree to which they apply it may vary, or how it can be implemented may differ.

Many authors have speculated why different countries took different routes (Boston & Pallot, 1997; Cheung, 1997; Hood & Peters, 2004; Pollitt, 1995; Hood, 1991; Hood, 1995b; Pollitt, 2007). It is not within the remit of this thesis to examine why and how the variance between countries came about. Arguably the analogy that ‘4+5=9, but so does 6+3’, is one explanation for why the variety in NPM implementation does not indicate a lack of consistency in the ideology. Nonetheless, this use of the ‘multiple ways to get to nine’ approach provided significant fodder to question the validity of NPM. The position taken here is that aspect of NPM continue to shape public service delivery.

The Remnants of New Public Management

Irrespective of where NPM is going, if still at all, NPM has left extensive deposits (Dunleavy et al., 2006), although in some countries more than others. Further, these remaining components have become normalised ways of thinking (Pollitt, 2007). The point of the discussion so far is not for or against the value of NPM in totality, nor is it around understanding if NPM was delivered as it was intended (if it ever was a coherent idea to begin with). The view taken here accepts that, like the ideologies before NPM and those that will/have come after it, additional components are often added during implementation which can ultimately change the core character of the initiating ideas (Dunleavy et al., 2005). However, despite this evolution, there *remains elements from the 1980s changes which drive how public services are delivered.* Further, whether NPM, either, academically, politically or in practice is a stand-alone concept is of minor relevance. Instead, what is of interest are the changes, in the form of legislation, organisational structures and processes, that came about through the ideas which dominated the public sector in the United Kingdom, United States of America, Australia and New Zealand in the 1980s and early 1990s and which left remnants identifiable at the time of writing this thesis.

To this end, irrespective of the agreement on whether the NPM ideology and practices should be used, the reality is they are used. Further, little is understood about the impact of these ideas and consequent, reversal, or refinement mechanisms from Service Users' perspectives. That is, we lack significant understanding of the effects NPM had on the *delivery* of public services *from a Service User's perspective*.

Business is Better in New Zealand

New Public Management in New Zealand: The New Zealand Model

New Zealand was said to have introduced its own NPM model. Boston et al. (1996) claimed that a NZ model emerged through unique and specific circumstances. This model of public management, while in broad alignment with NPM, they argue, is distinct due to both the “conceptual rigour and intellectual coherence” (p. 3) and “theoretical traditions, political imperatives, and pragmatic judgements by ministers” (p. 3) at the time of implementation. This coherence is attributed to a briefing prepared by the Treasury to the incoming minister and swift passing of four critical pieces of legislation which enshrined new ways of delivering public services (Boston et al., 1996). Further, and aside from ascertaining if NZ has a unique model, NZ said to have adopted NPM in a centralised manner (Chapman & Duncan, 2007; Steane, 2008).

According to Boston et al. (1996), NZ’s model of public management is characterised by the focus on performance management, contracts (in multiple forms), single lines of accountability, decentralisation of production and management decision making, the creation of a purchaser-provider split for service delivery and fundamental changes to the accounting mechanisms by government bodies. Halligan (2007) summarised NZs focus as on outputs over outcomes and ministerial performance over departmental performance. According to Kettl (1997), the model applied in NZ was a ‘make managers manage’ as opposed to ‘let managers manage’ version of NPM. Notably, in terms of a performance management approach, NZ took the outputs, over outcomes, approach to measurement (Kettl, 1997) and there was significant attention to department head performance over department performance (Halligan, 2007). Despite this, Halligan (2007) argues that in NZ "performance stands for a broad agenda as well as specific means of accomplishing improved services" (p. 228). There have been various critiques about these approaches.

NZ’s implementation of NPM resulted in issues of fragmentation (silos), a lack of accountability, and complaints about service quality (Boston & Eichbaum 2006; Halligan, 2007). One claim was that an "emphasis on output orientation and management accountability [was] at the expense of public and parliamentary accountability" (Halligan, 2007, p. 229). The NZ contracting approach, it was claimed: "radically transform[ed] the nature of democratic accountability" (Kettl, 1997, p. 456) by, ironically, making accountability lines unclear. This was publicly highlighted with the Cave Creek disaster in which accountability for 14 deaths remains unclear (Chapman & Duncan, 2007; Kettl, 1997). Furthermore, the focus on outputs over outcomes was prominently criticised in the Schick Report (1996).

There have been many attempts to address the concerns about public service delivery since the 1980s changes. These include, but are not limited to, various parliamentary reviews such as Review of the Centre and Better Public Services. Subsequent ‘reform’ has sought to counter the focus on outputs and shift it towards outcomes and address concerns around accountability (Chapman & Duncan, 2007; Duncan & Chapman, 2010; Halligan, 2007). While it is recognised that NPM evolved in NZ (Haworth & Pilott, 2014; Plimmer et al., 2017; Boston et al., 1996; Chapman & Duncan, 2007), it can be debated whether these changes are an evolution of improving NPM or and evolution of undoing remains unclear. For example, Chapman and Duncan (2007) argue that the NZ model has been “rebalanced” (p. 17), “*amended*” (p.18, italics in original), and “revised” (p. 21). However, Duncan and Chapman (2010) also offer a balanced perspective that "some of the original NPM practices have been preserved, some refined and some improved upon; but others have been quietly abandoned, or even reversed" (p. 312). It is clear that core tenants of the changes, implemented under the NPM banner remain. The following looks at the application of NPM within the NZ healthcare system.

New Zealand Healthcare System

An Overview of the New Zealand Healthcare System. The foundations for the NZ healthcare system trace back to the Hospitals and Charitable Institutions Act 1926 and Social Security Act 1938. The Hospitals and Charitable Institutions Act sought to bring together various acts which provided healthcare services and set up regional Hospital Boards. These Boards received funding from the Minister of Health to carry out various healthcare services for a population. These acts set the foundation for the existing healthcare system as one that is managed geographically. The Social Security Act of 1938 set out, amongst other benefits, to provide medical and hospital treatment to persons requiring it, in order to maintain and promote the health and wellness of the general community. Overall this set the foundation for ‘universal’ free-at-the-point-of-service healthcare.

NZ has seen a variety of different mechanisms introduced to achieve healthcare system performance. Some of these mechanisms have been at the legislative level, while other mechanisms have been in management practices. At the structural level, the NZ healthcare system was moved to a quasi-market with a purchaser-provider split (Boston et al., 1996; Gauld, 2009). Performance management and measurement approaches have been used since the 1990s (Chalmers et al., 2017). The changes in the NZ healthcare system structure are well studied. For example, Robin Gauld in *Revolving Doors: New Zealand's Health Reforms – The Continuing Saga* (2009) has extensively covered the changes in the NZ healthcare system. This thesis does not detail these changes. What is relevant here is that the NZ healthcare system has been subject to NPM ideologies through the application of market-type mechanisms with the purchaser provider split and the various application of performance management and measurement approaches.

Despite these changes, there has been the ongoing perception that the NZ healthcare system[2] is deteriorating and in need of fundamental reform (Gauld, 2009). This perceived failure and deterioration has been attributed to rising public expectations about the speed and quality of care of health services[3] which was an issue identified by the Department of Health (now Ministry of Health) as early as 1969. The system failures are 'demonstrated' through issues such as increased waiting time and lists

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[2] This paper adopts the following definition consistent with the Ministry of Health for referring to the NZ health system the as the "range of organisations contributing to the health of New Zealanders, including but not restricted to the organisations established through the New Zealand Public Health and Disability Act 2000, such as district health boards and other Crown entities" (Ministry of Health, 2000, p. 1).

[3] Consistent with the Ministry of Health "'health services' refers to services focused on improving health, including public health and population-level services as well as services for individuals" (Ministry of Health, 2000, p. 1).

(Gauld, 2009). Increased technology, higher population numbers and a disconnect between funding and local decision-making were put forward as reasons why this perception of failure persisted, despite increased funding. This public dissatisfaction lead to both numerous reviews and commissions.

The first New Zealand Health Strategy (NZHS) was introduced in 2000 by the Minister of Health, Annette King (Ministry of Health, 2000). The NZHS was a “framework within which District Health Boards and other organisations across the health sector will operate. It highlight[ed] the priorities the Government consider[ed] to be most important” (Ministry of Health, 2000, p. iii). The Strategy was based on seven fundamental principles which drove the development of 10 goals and 61 objectives. Most relevant here is that the strategy also included how the strategy was to be implemented. Implementation was to be aided through “toolkits to identify action…detailed action-orientated strategies…[and]… performance and/or funding agreements with the Ministry of Health, District Health Boards and providers” (Ministry of Health, 2000, p. viii). The NZHS made clear that the requirement for accountability through performance management. The refreshed NZHS was released in 2016 to set a “framework for the health system to address the pressures and significant demands on its services and on the health budget” and “sets the direction for development during the next 10 years” (Ministry of Health, 2016a, p. ii).

The introduction of the NZHS was a result of the first of many changes introduced by the Labour government which has been attributed to amending, reversing, and improving the ‘NZ model’. During this time, there were attempts to clarify the “links between outcomes and outputs” (Chapman and Duncan, 2007, p. 15). However, evidence of these issues had been present since 1991 when the NZ Government undertook a national engagement process to understand the needs of the public better, while simultaneously also trying to reinforce to them that are limited resources and 'decisions about allocation have to be made'. These changes eventuated and the development of National Health Targets.

The introduction of targets was a mechanism to focus attention (Ministry of Health, 2009); that is directing limited resources to those areas reflecting public priority. The Ministry of Health believe that targets would bring about a "significant impact" (Ministry of Health, 2009a, p. iv) on healthcare outcomes and were a mechanism to ensure continuous improvement through "steady and repeated improvements" (Ministry of Health, 2009b, p. 3) as they provide "indicators of progress" (Ministry of Health, 2008, p. v). This being a way to measure efficiency and effectiveness. Further, to demonstrate that healthcare services are meeting customer needs, the needs are translated into targets. "Delivering the priorities [set by customers] defined through the health targets" (Ministry of Health, 2009. p. iv) is the way in which it is shown to be taking action that is aligned with customers wants and needs. Targets are put forward as a mechanism to "provide clear and specific focus for action" (Ministry of Health, 2010a, p. 3) to meet the expectations that people have. The following provides an overview of the narratives in the NZ healthcare system.

Narratives in New Zealand Healthcare Service Provision. There are four narratives, put forward by Government that have remained consistent within the NZ healthcare system since the 1980's NPM-based reform. The four narratives are limited resources, a customer focus, accountability, and transparency, and finally, efficiency and effectiveness. The government has used these narratives to justify their decisions for organisational structures and mechanism for delivery[4].

Limited Resources. The NZ government and its delegated authorities repeatedly reiterate that the NZ healthcare system operates within a resource-constrained environment (Ministry of Health, 2000; Ministry of Health, 2016a; "*The Best of Health*", 1992). The limited resources' narrative starts with the premise that there is limited funding or budgets that must be adhered to and that needs are more significant than the funding pool allows. For example, the first NZHS makes clear on page two that the strategy and sector must uphold the principle of acting "within the money available" (Ministry of Health, 2000, p. 2, italics in original). The refreshed strategy in 2016 echoed these sentiments by highlighting the "fiscal targets" (Ministry of Health, 2016a, p. ii).

The limited resources narrative forces the identification of priorities and therefore, choices. The argument put forward is that "living within a budget means making choices. Money spent on one thing cannot be spent on anything else" (Ministry of Health, 2000, p. 2). Therefore, decisions must be made about what services are needed most – which becomes a discussion on what is valued most - and which choices will bring about the

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[4] It could also be argued that these narratives are used as a mechanism of control to narrow the public's discussions away from deeper fundamental issues of organisational structure, responsibility and accountability but that discussion is outside the scope of this thesis.

most significant benefit. The principle of choice is not just between where to spend money within the health sector but that more money spent on health means less money for other public services. Concluding that “it will never be possible for the Government to do everything for everyone” (Ministry of Health, 2016a, p. 2). Therefore, if one must make a choice, one then must determine what one values or what should be a priority. These priorities areas not only receive financial prioritisation but also attract targets and performance indicators. Targets become a means of demonstrating focused attention on these priorities (Ministry of Health, 2007) and provide justification for managing limited resources.

A Customer Focus. Customers, as service users, are touted as the guiding factor in the decision-making and actions in the delivery of healthcare. This consists of a focus on delivering services that place service users at the “heart of health care”, as well as a system that listens to and responds to “the messages that people have been sending” (Ministry of Health, 2000, p. iii).

The National Advisory Committee on Core Health and Disability Support Services was appointed by the Minister of Health in 1992 with the objective of providing support in determining which services should be funded and making the allocation of funding more “publicly obvious... [and to] …reflect community values” (“The Best of Health”, 1993, p. 7). The first NZHS reiterated this theme, stating that the strategy reflected the needs and wants expressed by citizens. The refreshed NZHS, 16 years later, echoed the same sentiment through the mechanism of collecting input from the public and the acknowledgement that “overwhelmingly…[citizens were asking for]…greater focus on people, how to engage better in designing services together and how to better understand people's needs" (Ministry of Health, 2016a, p. ii). There is, in the NZ healthcare system a precedent of citizen engagement and focus on delivering services that put the user front and centre

Accountability and Transparency. The first NZHS laid out that accountability arrangements for District Health Boards (DHBs) would be linked to "explicit performance targets… [which would] be benchmarked and publicised" (Ministry of Health, 2000, p. 26). Accountability for achieving targets is the "collective responsibility" (Ministry of Health, 2009a, p. iv) of the Ministry of Health and DHBs. Transparency was to be achieved through quarterly reporting of target achievement in major newspapers and on the Ministry of Health and individual DHB websites (Ministry of Health, 2018). This transparency was not only for the public but also for DHBs. Standardised reporting of targets was meant to enable the identification of success which could then be shared and use to support other DHBs who may not be performing as well (Ministry of Health, 2009a; Ministry of Health, 2008).

Efficiency and Effectiveness. Efficiency and effectiveness are closely related to the narrative of the limited resources. Reducing waste brings about efficiencies to deliver better, and more extensive services with the same resource allocations (Ministry of Health, 2016a). The inverse of efficiency – inefficiency – being "fewer health services available for each dollar spent" (NZHS 2000, p. 9). Being efficient if often referenced in the context of choices due to limited resources and comes as *quality and* *effectiveness;* as though when discussing increasing effectiveness, the consequence to be mitigated is lowered quality. Effectiveness is mentioned numerous times in the 2016 NZHS as both something the Ministry of Health currently does well and is looking to improve (Ministry of Health, 2016a).

The NZ healthcare system has strong legislative backing dating back before the NPM reforms in NZ. It has, however, also been subject to many iterations in structure in an attempt to resolve the dissatisfaction. The NZ Government has been consistent in its messaging that there are limited resources for health, that they will find ways to improve efficiency, effectiveness, and equity, and be more accountable. All while being more customer-focused. One way in which they have chosen to demonstrate their adherence to these commitments is through the use of targets. The following section examines the application of targets to the NZ healthcare system, their iterations, and current assessments of their success. This is couched in international research for context and comparability.

Targets as a Tool for Improvement

An Overview of the Targets in New Zealand's Healthcare System

Commencing with the goal-setting in the first NZHS, the National Health Targets have been through several iterations. The first NZHS in 2000 laid out 10 goals, with a total of 61 objectives shared between them. The objectives were assigned focus levels of 'ensure', 'reduce' or 'improve'. There was no quantification of how each level would be determined to have been achieved. Of the 61 objectives, 13 were selected as priorities for the short to medium term in order to "provide a direction for action" (Ministry of

Health, 2000, p. 13). The first NZHS did not set targets but laid the foundations for the introduction of national targets seven years later (in 2007).

In 2007, under a Labour Government, ten national health targets were set. The targets were first measured over the 2007/2008 year to determine a baseline. The targets were formally introduced, under a National Government, for the 2008/2009 year (Ministry of Health, 2007). In 2009 the National Government released a policy titled “Better, Sooner, More Convenient” and consequently for the 2009/2010 year the targets were reduced to six (Ministry of Health, 2009a). The consolidated set of targets were designed to show that the government was “committed to ensuring…effective and efficient” (Ministry of Health, 2009a, p. iii) service delivery (as summarised in Appendix B). The six targets comprised one new target, and five renamed and modified original targets. The ED LOS target was the newly introduced target. It was titled “The Shorter Stays in Emergency Departments” (Ministry of Health, 2009c). This target, for consistency with international literature, is referred to as the ED LOS target.

In the interests of accountability and transparency, the National Government committed to formally publishing the target results on a quarterly basis, online and in national newspapers (Ministry of Health, 2007). While the overall target goal was consistent across DHB’s, it was recognised that each DHB was starting from a different level of performance and resourcing and therefore the time taken for each DHB to achieve the target was varied (Ministry of Health, 2009). Between 2009 and 2017, the calculation methods for the other targets were amended while the ED LOS target remained the same.

In October 2017, Labour regained control through a coalition government. Within eight months, public reporting of the National Health Targets was revoked (Kirk, 2018; Ministry of Health, 2018). The Minister of Health, David Clark, justified the withdrawal of the reporting on targets as they created "perverse incentives" (Kirk, 2018). Clark went so far to argue that the current healthcare system was not “fit for purpose” (Kirk, 2018). Clark reiterated that it was the reporting of the targets, not the measuring that was ceasing (Bennett, 2018), reiterating that the ED LOS targets would remain being measured until “recommendations came back from clinicians who were developing the new measures” (Bennett, 2018). It is unclear how these new measures are being developed. Originating out of the first NZHS, the National Health Targets have been in place and measured since 2007. Initially implemented by a Labour government in a soft form they were applied and refined by a National government then withdrawn by a Labour government. At the time of writing the targets remain as unpublished[5], measures of performance.

Focus Target: Shorter Stays in Emergency Departments

Rationale and Justification for use of Emergency Department Length of Stay Targets. Discussions on ED waiting times and ED LOS are

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[5] The raw data is published quarterly the Ministry of Health website https://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing-2017-18

often combined with ED crowding. ED crowding is an internationally discussed issue which is associated with a negative impact on quality and patient safety (Tenbensel et al., 2017). Despite a lack of clarity around what ED crowding is or what the difference between overcrowding and crowding is (Moskop et al., 2009a) the idea of EDs which are ‘excessively full’ or ‘under-resourced relative to demand’ is associated with longer waiting time (Moskop et al., 2009a). Hoot and Aronsky (2008) using the American College of Emergency Physicians definition of ED crowding consider ED crowding to be a “phenomenon that involves the interaction of supply and demand” (p. 126-127). For simplicity of this discussion, crowding is synonymous with overcrowding. Further, crowding refers to times when care is *potentially* compromised due to the reality or perception of ‘fullness’ or ‘under-resourcing’ (Moskop et al., 2009a). Crowding considers regular, daily, and seasonal surges in demand and therefore excludes disaster events. It is both claimed that crowding causes excessive ED LOS (Moskop et al., 2009a) from an input perspective of excessive demand. Simultaneously it has been claimed that excessive ED LOS times create crowding (von Thiele Schwarz et al., 2016) and occurs due to output issues which is the inability to discharge or admit service users. ED Service User satisfaction has been linked to waiting in ED (Gordon et al., 2010; Nairn et al., 2004; Taylor & Benger, 2004). As a consequence, ED LOS use has been justified to manage ED crowding and function as an indicator of both wider hospital and healthcare system performance (Ministry of Health, 2009a; Ministry of Health, 2016a; von Thiele Schwarz et al., 2016).

One view is that ED crowding is representative of an overcrowded hospital (Moskop et al., 2009a). Therefore, ED LOS can be used as an indicator of hospital performance. A primary factor in excessive ED LOS times, therefore, is due to the inability for patients to be admitted, discharged or transferred. The ability to transfer or admit a patient is dependent on two things: the capacity of the receiving unit and the processes of enabling the transfer or admission (von Thiele Schwarz et al., 2016). A hospital that is not able to receive patients from ED will, therefore, contribute to ED LOS times.

Similarly, ED LOS times can be used as a proxy for wider healthcare system performance on the basis that higher input (ED demand) could be addressed in a primary care setting. Increased demand for ED is ascribed to several aspects. Two main issues causes are attributed to increased demand. The first is inappropriate ED use (Moskop et al., 2009a). However, research summarised by Moskop et al. (2009a) indicates that inappropriate ED use does not cause longer ED LOS times. Further, a systematic review of quantitative research on the cause, effects, and solutions of ED crowding by Hoot and Aronsky (2008) concluded that there was relatively little evidence to suggest that non-urgent and frequent-flyer ED visits - input factors - independently cause crowding. Instead, they conclude that there is a better indication that inpatient boarding (output issues) are the cause of crowding. The second attributed cause of increased ED demand is ageing populations and the increased complexity of presentations (Tenbensel et al., 2017; von Thiele Schwarz et al., 2016). Failure to manage these demand changes, either by planning for increased demand or improving primary care, is argued as a reason that ED LOS times are an appropriate proxy for wider healthcare performance. In these examples, inappropriate ED use can be seen as an issue for management by the wider healthcare system while genuine increased demand due to population growth or ageing populations or increase health presentation complexity can be seen as changes in demand which need to be addressed.

The rationale that crowding is due to failing primary care is echoed in NZ, where achieving ED LOS targets is seen as indicative of the availability of community care (Ministry of Health, 2009b). Further, the idea that ED LOS times are also an indicator of hospital performance (issues of patient flow due to the inability to admit or transfer) has been supported by the Ministry of Health (Ministry of Health, 2009b). In doing so there is the intention that issues of crowding will be managed. As a result, ED LOS targets, both internationally and in New Zealand, have been somewhat arbitrarily set as both a narrative and mechanism to manage crowding, wait times and indicate hospital and wider healthcare system performance. The following reviews the literature on ED LOS success.

Target Length. Given this, it might be reasonably expected that target length selection has a clinical backing. There is, however, no justification for the determination of ED LOS target lengths other than it is in line with international best practice (Ministry of Health, 2009c). There does not appear, however, to be a best practice, as identified by the variance in ED LOS targets. In New Zealand, the ED LOS target is that “95% of patients will be admitted, transferred or discharged within 6 hours” (Ministry of Health, 2009c). However, internationally there is significant variation in target times.

For example, in Canada, it is 12 hours while in Australia and the UK it is 4 hours (Weber et al., 2012).

Various narratives have been put forward to justify the implementation of these “arbitrary” (Mortimore & Cooper, 2007, p.402) targets. While the political justification for ED LOS is often to reduce ED crowding and reduce wait times the selection of the ED LOS targets lengths has little empirical evidence (Hoyle & Grant, 2015; Mason et al., 2012). While research that indicates that crowding and longer time spent in ED increases risks for Service Users (von Thiele Schwarz et al., 2016) there is little clinical justification for what the target length should be. Further, despite the claim that ED LOS targets are in place to reduce waiting, a pass/fail target of a Service Users journey time fails to differentiate types of waiting times. For example, total time spent in ED does not account for the time taken to see a clinician on arrival, which Mason et al. (2012) found to have minimally improved (by 1 minute) when a four-hour target was introduced, or the time taken between seeing a clinician and undergoing tests or receiving results. Therefore, while waiting has an impact on patient satisfaction (Nairn et al., 2004; Taylor & Benger, 2004), there is a lack of clarity around what type of waiting impacts satisfaction. Combined these factors have led to debate on the appropriate length for ED LOS targets. Despite this ambiguity the following reviews the achievement of ED LOS targets.

ED LOS Target Achievement

The success of a target can be assessed at two levels. The first level of analysis is of the target itself and whether or not it was met; a simple yes/no. With respect to assessing the first level of target achievement ascertaining adequate data to determine performance has proved challenging (Bevan & Hood, 2006). Additional issues have included questions of gaming and the fudging of figures. These are the secondary outcomes of the target. The second level of analysis lends itself to the unintended positive, and negative, quantifiable consequences of the target. For example this may include the use of additional resources, a reduction in care, higher reattendance rates at the ED, reduced ED Service User satisfaction and increased demands on medical staff. Achieving success at the first level of analysis, but not at the second level of analysis is referred to as “hitting the target but missing the point” as is Mason et al.’s (2012) aptly named paper which highlights that while EDs may be meeting at target, they may not be “improving overall care” (p. 347). The following provides and overview into these two levels of assessing ED target achievement.

Assessing the Achievement of Emergency Department Length of Stay Targets. There are mixed results on ED LOS target success. The first-year average across DHBs was 87% with 5 out of 21 DHBs achieving the target (Ministry of Health, 2010b). This was the only year the data has been aggregated. It has been reported on a quarterly basis only. Further, research on targets in NZ by Tenbensel et al. (2017) shows that despite continued improvements in the reported ED LOS total ED LOS only improved initially. Further, research in NZ by Tenbensel et al., (2017), indicates that while reported ED LOS continued to decrease during the study period (2008-2012), when accounting for the creation of short-stay units, and including patient time in these units, actual ED LOS time reduced only between 2008 and 2010. This indicates that the targets have some impact on improving the processes which support reducing ED LOS but that the benefit accrued is limited. This finding supports other work (Weber et al., 2011) which indicates that targets provide an impetus for making necessary structural and resource changes for improvements.

Gaming and Falsification. It has been observed that, where there are 4-hour targets, there is a spike in patients being admitted, transferred or discharged within the last 20 minutes (Mason et al., 2012; Locker & Mason, 2004). This gives the appearance that EDs are performing (according to their measure of performance) even though they might not be improving overall care. There is limited research available to indicate if this issue occurs with 6-hour and 12-hour ED LOS targets. Therefore, it may merely indicate that 4 hours is not a clinically appropriate target. Despite this, one concern raised is that the inappropriate application of targets leads to gaming of falsifying of data.

Gaming, cheating, effort substitution, and distortion of clinical priorities have been widely recorded as occurring with the introduction of 4-hour targets in the UK (Locker & Mason, 2005). Research by Locker and Mason (2004) showed that a “surprising proportion of patients appeared to leave the ED within the last 20 minutes before the cut off” (p. 342). While this itself does not prove gaming, it certainly brings into question the quality of the data. This research is further supported by British Medical Association surveys which highlighted other gaming responses such as adding extra staff to a roster and cancelling operations across monitoring periods (Bevan & Hood, 2006a). The Commission for Health Improvement (2003, as cited in Bevan & Hood, 2006a) also found that ED’s would require patients to wait in ambulances until they were confident they could treat them within four hours. Locker & Mason (2006) have also shown what digit preference bias occurred in UK EDs. While it appears, there may be gaming employed to achieve ED LOS targets there is also a lack clarity that these behaviours impact clinical are. There are notable exceptions (noted below) however, these issues do not necessarily warrant dismissing targets, rather they indicate that further investigation into both the clinical appropriateness of the target and the way the target is implemented are assessed[6].

Assessing the Secondary Outcomes of Emergency Department Length of Stay Targets. Targets drive behaviours (Bevan & Hood, 2006). There are contrasting and conflicting views and research results on the ways in which targets have impacted other related outcomes such as safety, quality, admission and re-admission rates, and resource allocation. This includes a lack of research on whether or not gaming has any impact on clinical outcomes. This level of analysis assesses the unintended consequences of targets. Despite the typical focus on unintended negative consequences, it is essential to acknowledge that there are possible positive unintended consequences.

Safety and Quality. One concern is that targets will drive behaviour and decision making that compromises patient safety or quality of care (Weber et al., 2012). Reddy et al.'s (2018) conclude that the claims of impaired clinical care is inconclusive or indeed absent. However, there are

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[6] Note that this data pertains to ED data. See Bevan and Hood (2006) for an overview of the noted consequences, largely due to gaming, in other healthcare targets.

notable examples of distortion of care, such as the case of a boy who died while waiting in an ambulance for two hours (“Two-hour ambulance delay”, 2004). Further, Mason et al. (2012) conclude that ideally, targets would have brought forward the treatment curve, yet they did not observe this pattern. This, however, does not mean that patient care was compromised. Further, Weber et al., (2012) conclude that the introduction of the four-hour target in the UK did not appear to have a negative effect on quality or safety using measures of admission rates, specific testing, deaths in ED and return visits within seven days. The impact of ED LOS targets on quality and safety remains unclear.

Resource Allocation. Another concern is that a focus on target achievement will change resource utilisation. For example, it is claimed that while ED LOS waiting times decrease, financial demands increase (Mortimore & Cooper, 2011). There is also evidence from departments that they received more resources in order to meet targets (Mason et al., 2012). Resources consumption may increase as staff ‘throw’ all the resources at the issue to achieve the target, or consumption may decrease as staff cut corners to get patients out the door faster. In contrast, research by Weber et al. (2012) assessed whether ED LOS targets impacted the quality of care (including safety) and resource utilisation. Weber et al. established first that the introduction of ED LOS targets reduced waiting time (performance improved according to the target) but noted that the majority of hospitals still failed to meet the target. Despite these improvements, the study did not identify any appreciable changes (positive or negative) in the quality of care and resource utilisation.

There remain mixed conclusions on the impact of targets on quality and safety between measures used in the research above and notable, highly emotive cases. Further, there appears to be no research into the trade-off between the “well-documented negative influences on quality and safety of care” (Weber et al., 2012, p. 699) and the increased costs and possible negative consequences of the targets. While there is a focus on the negative impact of ED LOS targets another aspect is the possible positive side effects. One secondary benefit of the targets is that they put pressure on management to address ongoing issues. Mortimore and Cooper (2007) note that nurses in ED report that they believe that without the targets issues such as unnecessary delays and gridlock systems, which had been points of complaint for some time would not have been addressed. Targets force management to take action.

Assessing the Impact of Emergency Department Length of Stay Targets. In addition to the above clinical and organisational outcomes, the introduction of targets may have an impact on ED staff and service users. There is research around the impact of targets on nurses and of the drivers of satisfaction for ED service users’, but there is little research on service users’ perceptions and understanding of ED LOS targets. The following looks at the literature on ED staff experience of ED LOS targets as a context for the type of research that may also be conducted with service users and to examine if there is any flow-on effect from the ED staff experience of targets to service users.

Emergency Department Staffs’ Experience of Targets. Staff, especially nurses, take the brunt of the impact when it comes to absorbing the additional demands such as an increased workload and additional pressure brought about by ED LOS targets (Hoyle & Grant, 2015; Mortimore & Cooper, 2011). Research by Hoyle and Grant (2015), in a study where nurses were interviewed to gain further understanding into the impact of targets on nurses, highlighted that nurses believed that the targets impacted patient care. From a positive angle, non-urgent cases were seen sooner, however, nurses reported being able to spend less time with sicker patients (Hoyle & Grant, 2015), it is unclear if less time spent with patients had any impact on the quality of care which contrasts with Reddy et al. (2018) but is consistent with colloquially known Francis Report into the Mid Staffordshire NHS Foundation (Francis, 2013). This finding is further echoed by a series of surveys by the British Medical Association which indicated that how the targets were implemented lead to effort being directed at achieving the target at the expense of staff well-being and clinical quality (Mortimore & Cooper, 2007). Hoyle and Grant (2015) further purport that this impact on patient care could lead to an additional emotional burden on nurses, particularly where there is active resistance against targets in cases of clinical need.

However, this perceived additional pressure should also be considered in light of the research by von Thiele Schwarz et al., (2016) which indicates that when ED throughput is low, (i.e. targets are more likely not to be met) staff perceive themselves to be more efficient. Further, the research that identifies perceptions of additional pressure by staff does not address whether the perception is temporary while nurses adapt to a new standard way of operating. The research by von Thiele Schwarz et al. (2016) does not state if targets were in place during the research.

Despite an element of negativity around ED LOS targets by staff, staff also report a desire for targets to remain (Reddy et al., 2018). Rationales include that targets prompted hospital management to address issues staff has been highlighting and the perception that less urgent service users were seen sooner with the targets than without (Hoyle & Grant, 2015). In summary, staff are not opposed to improving how they work nor are they opposed to new ways of doing things; they are merely trying to balance those improvements with a desire to maintain a standard of care. In trying to find this balance, possibly combined with a change to their way of working, they try to reconcile their values and beliefs of how services should be provided and in doing so take on an additional burden within the workplace.

Summary. Assessing the value and impact of ED LOS targets from a broader viewpoint indicates mixed outcomes. From a positive angle, EDs have been able to secure resources and address process issues that were not being addressed by management without the requirement to meet a target. Overall targets appear to have had an initial benefit in reducing ED LOS times. This should have been expected with a pass/fail target; however, the trajectory of improvement was bound to only ever get to the pass/fail mark and then level off. In reaching this level, there appears to have been some trade-off for increased cost and reduced. Therefore, what remains is a determination around what level of trade-off is acceptable. This, of course, means that there remains a political aspect to healthcare. The following looks at the impact of targets on Service Users experience of ED.

Patient's Experience of Emergency Department Length of Stay Targets. There is limited research on how patients' experience targets. In place of this research, the starting point becomes research focused on understanding the subjective experience of patients in ED. For example, work by Taylor and Benger (2004) concluded that the interpersonal skills and attitudes of staff, provision of information and waiting times (the type of waiting time undefined) are the most significant influences of patient satisfaction. The Commission for Healthcare Audit and Inspection noted that the sooner a patient is seen by a clinician, the more likely they are to rate the care they received as very good or excellent (as cited in Mason et al., 2012).

Similarly, Nairn et al., (2004), through a literature review, identified six elements of patients' satisfaction. These elements are waiting times (waiting time definition not defined), communication, cultural considerations, pain management, the environment and access. Further, Gordon et al. (2010) systematic synthesis of qualitative research on the patient experience in ED found similar results. Gordon et al. noted the different aspects of waiting but not how each waiting type may impact satisfaction differently. Evidence indicates that waiting time, in various forms, is critical to a satisfactory patient experience.

Summary of Emergency Department Length of Stay Targets

An ED LOS target was applied to the ED system in 2009 and is currently under review. While there was an initial improvement in ED LOS times this tapered off. From limited research, there is ambiguity around the impact of ED LOS targets on secondary health outcomes. The MoH rationale for implementing an ED LOS target was to reduce crowding and waiting times, which has been a highly topical media issues both in NZ and around the world. In line with international applications of ED LOS targets, they were also claimed to be an indicator for both hospital and wider healthcare system performance. However, there appears to have been little if any implications for these wider parts of the system as a result of failed performance; leaving EDs to bear the brunt.

Further, any claimed success of the targets is clouded with issues of gaming, data falsification and issues of resource substitution. Despite this, there appears to be a consensus that in some ways the targets have helped get management on board with changes that had been requested by clinical staff. However, it also appears that ED staff, in particular nurses, have taken on an emotional burden in balancing the trade-off that a target demands.

Gaps in the Literature

A review of the literature raises many questions. Several, which were factors in the research design and rationale for data collection are included here.

1. What are Service Users' and Service Providers' perceptions and understanding and experience of targets within ED's?
2. Is there alignment, and to what degree, between Service Users' and Service Providers' perceptions and understanding of the rationale and justification for ED LOS targets?
3. Given that the literature on ED LOS targets highlights that nurses take on an emotional burden and there is a spike in activity of admission or discharge within the last 20 minutes of the target (amongst other impacts):
    - Do Service Users pick up on these impacts, and how do they make sense of it?

    - What are Service Provider perceptions of how these impacts show up, if at all, in their nursing practice?
    - How do Services Users' perceptions converge or diverge from with Service Provider perceptions of ED LOS targets?

In conclusion, the gap identified in the literature pertains to the understanding and perception of Service Users of the role and function of targets not only in healthcare but specifically within the case of ED's with particular attention on the issues of crowding and waiting. This research seeks to commence gaining insight into how Service Users perceive and understand the role, function, and value of targets with EDs in relation to crowding and waiting. At a broader level, this research is also exploring Service Users understanding of both the justification and success of various mechanisms utilised to in, in theory, meet the Service Users' needs.

The following section outlines the research methodology.

Methodology

The following section first contains an overview of the strategy of enquiry applied to the research questions. The strategy of enquiry is the general “orientation” (Bryman & Bell, 2015, p. 37) by which the research is conducted. Secondly, this section describes the framework for conducting this research which results from the choices I, the researcher, made. This framework for collecting and analysing the data forms the research design (Bryman & Bell, 2015). Consistency between data collection, data analysis and research questions is important (Bryman & Bell, 2015; Creswell & Creswell, 2018). Finally, the research method, or manner in which the data was collected (Bryman & Bell, 2015; Hathcoat et al. 2019) and the procedure undertaken to reach the conclusions of the research is described.

Strategy of Enquiry

There are calls in research design and methodology textbooks and articles for improved transparency on the values and positioning of the researcher, and justification between research questions, methods, and analysis (Braun et al. 2019; Hathcoat et al. 2019; Nathan et al., 2019). Bryman and Bell (2015) note that the key influences on research are epistemology, ontology, values (of the researcher), theory and practical considerations. Hathcoat et al. (2019) conceptualise the combination of these factors as mental models, philosophical positions, and methodological decisions.

My acknowledgement, and belief, in my role as a researcher in shaping the research, does not discard the need for alignment between the theoretical framework, methods employed and research objectives (Braun & Clarke, 2006; Bryman & Bell, 2015; Braun et al., 2019; Hathcoat et al. 2019). In response to comments by Hathcoat et al. (2019), I have made explicit, best I can, considering my own limitations on awareness of knowing myself and space limitations, my mental models and philosophical position. Further, in response to concerns by Braun et al. (2019) and Braun and Clarke (2012) the approach adopted for this methodology sets out to describe the "active decision making" (Braun et al., 2019, p. 9) I undertook. The following provides some insight into the mental models, values, and philosophical positions I hold.

Mental Models, and Epistemological and Ontological Positions

I am of the belief that it is not possible for me to be value-neutral. In alignment with the values espoused below this section uses the first person and describes both the beliefs and values I am conscious I hold. I also outline several decisions, and often the process of making the decision, which I believe influenced the research. Through my previous work and study, I have adopted and become familiar with constructionism and social constructionism. I agree with Burr (2019), that "what we regard as knowledge is, therefore, one possible construction among many" (p. 122). This, in turn, influences not only the kinds of research interests I have but the angle from which I choose to understand those issues or phenomena.

I take a view similar to the fable of four people each with blindfolds on feeling a different part of an elephant and coming to a different conclusion about what it is they are feeling. I believe that a variety of research approaches applied to understanding a phenomenon all add to the collective understanding. I believe in the value of explicitly stating my perspective to allow the reader to make an informed assessment of the narrative/story/argument I put forward. This enabling them to make sense of new information within the context of other ‘descriptions of the elephant’ that have been put forward.

Finally, I note that I had three clear intentions when starting this research journey. First, I was frustrated at the lack of discussion and research on how theoretical ideas play out for individuals. These discussions (and the research) to me, while in theory for the people always seem so devoid of the people they were meant to be serving. With respect to public service delivery and society, how do things such as value[7], transparency, accountability or fairness translate for <u>an</u> individual – not <u>the</u> statistically average person. As a result, I wanted to increase the diversity of research outputs on public sector service delivery. The second, following on from that is that I wanted to hear from people who were recipients of these services. I wanted to understand what they understood and how they made sense of things. I knew I would not come out with a new theory or revolutionary way of changing how the public services are delivered. However, I had hoped I might begin to bridge gaps I saw between theory and practice; government and the people they serve; and academics/theorists and those that live in the environments created by their ideas. I sought to change the dynamic of hearing *about* Service Users and service providers (usually summarised as

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[7] E.g. Value for money or valuing the environment or valuing freedom of speech or even valuing democratic practices?

numbers) to hearing *from* Service Users and service providers. There was never an intention for this research to be theory creating or confirming a hypothesis. The intent was to add a new dimension of understanding by moving from a position of looking at the issue from arms' length to a position of being alongside those who are part of the organisation and system and directly experience the effects of the organisational structure. Finally, this research project was intended as a foundation for both further qualitative and quantitative research. The outcomes of this research would then guide what direction and in what format further research should take place. Specifically, with the desire to keep going with my own doctoral degree. In this respect, this work was considered an exploratory.

Decisions I Made in Research Design

Derived from the above positions I adopt, my approach to understanding the phenomena in question and formulation of the research questions can be understood as similar to Interpretative Phenomenological Analysis (IPA). Although I am not exclusively attached to one particular methodological approach, aligning myself with a guiding approach offered me, a novice researcher, a guideline to follow. It provided a common language as a starting point and a coherent narrative for me to, for the purpose of this project, see how all my own views integrated (or not!). It also provided structure as I document how I deviated. Therefore, my strategy of enquiry is guided by an Interpretative Phenomenological Analysis (IPA) type approach, but for reasons described below, uses a reflexive thematic analysis (RTA[8]) data analysis process.

The Decision to Align with and Integrate Interpretative Phenomenological Analysis and Reflexive Thematic Analysis. IPA is guided by three philosophical positions: phenomenology, hermeneutics and idiography (Smith et al., 2009). IPA preferences the lived experience of participants (Glasper & Rees, 2017; Smith, 1996; Smith et al., 2009) and acknowledges that people perceive the world in different ways (Smith & Osborn, 2004). Additionally, IPA is aligned to a form of social constructionism (Smith et al., 2009). Types of IPA have been used in healthcare literature since the 1970s (Glasper & Rees, 2017). The alignment of IPA to my values and its existing use in healthcare research lead to decision to use it as my guiding approach.

There is often an overlap in ontological and epistemological underpinnings in qualitative methodologies (Smith, 2004), most likely because, as argued by Braun et al. (2019) all qualitative research is interpretative. RTA is not a methodology but an analytic framework (Braun et al. 2019) or as they have described elsewhere[9] a “method of data analysis” (Braun & Clarke, 2012, p. 58). Although Hathcoat et al. (2019) point out that does not necessarily make RTA philosophically agnostic. Nonetheless, RTA overlaps with IPA by seeing the value in the subjectivity of the researcher

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[8] The current term adopted by Braun and Clarke to describe their approach to TA (Braun et al., 2019)

[9] See Braun et al. (2019) for a discussion on their evolution of their thinking and use of terms.

and as Braun et al. (2019) have noted is “compatible” with interpretative and phenomenological frameworks (Braun et al. 2019, p. 850). Further, both RTA and IPA recognise a dynamic research process (Smith, 1996). Finally, while IPA does offers a particular epistemological position, there is also the recognition that within IPA researchers may still take differing positions along a spectrum (Smith, 2004; Smith et al. 2009). Therefore, it is appropriate to combine IPA and RTA.

With respect to the exploratory research approach, both IPA and RTA are suited to novel and under-researched topics (Braun & Clarke, 2012; Smith & Osborn, 2004). Glasper & Rees (2017) noting that the findings of IPA based research is often used to guide further research. The combination of IPA and RTA is appropriate for a project which sought to ‘open the door’ on this topic and set the foundations for further research.

The Decision to Use a Case Study Approach. Despite the variety in defining a ‘case’ (Forrest-Lawrence, 2019), case study approaches are often ‘justified’ when intrinsically appealing (Platt, 1988) and used to “demonstrate existence, not incidence” (Smith et al., 2009, p. 32, summarising Yin 1989). The value of a case study is often in providing “a means of troubling our assumptions, preconceptions and theories” (Smith et al., 2009, p. 32). This research, seeking to examine a complex issue of connecting macro-level policy ideologies and practices of public service delivery and the micro-level Service User experience of public service delivery, needed an anchor point. However, a counter-argument to the idea that cases cannot be used for generalisation posited by Forrest-Lawrence (2019) is that by examining a ‘typical’ case the approach of ‘what is true of one is true of many’ is applied.

As an under-researched area, the intention was simply to start plotting points on a map. This map building exercise aimed to highlight key features of the landscape, including the parts of the horizon that are not able to be seen in full from the current position. As case approach was deemed appropriate to achieve this. Therefore, to anchor this research, the case of ED LOS targets was selected. ED LOS targets were selected due to the publicity and academic attention they have received both nationally and internationally.

Research Questions

The purpose of this exploratory research consisted of four broad elements:

1. To begin exploring the feedback loop between service users expressing their desire for an outcome and how Governments attempt to meet those needs. For example, Service Users' say they want X. Governments respond and say they will do Y to ensure X occurs. Much of the 'proof' of X being provided or that Y is what leads to X's occurrence is quantitative and is not confirmation from service users that they feel X is occurring.
2. To gain insight into Service Users and service providers experience, understanding, and interactions with the mechanisms, specifically targets, Governments implement in order to deliver policy.
3. To add another dimension to the discussion and literature on assessing the effectiveness of structures and mechanisms

used by governments to deliver public services by taking a Service Users perspective.

4. To bridge the gap between theory and lived experience; moving beyond ideas, theories and people reduced to numbers.

As exploratory research the questions evolved. As explained in the remainder of the Methodology and at the start of the Discussion elements of the research questions became more refined. The purpose of this research was to identify landmarks for further investigation within the arena of public service delivery when considered from the perspective of a Service User.

Research Design

The framework for collecting and analysing the data forms the research design (Bryman & Bell, 2015). The following provides an overview of the approach to data collection and analysis.

Data Collection

A qualitative, unstructured interview process was deemed appropriate for this exploratory research into the experiences of Service Users and providers. This is consistent with RTA and IPA (Braun et al. 2019b; Smith & Osborn, 2004). Further, interviews are an affordable and accessible data collection method (Nathan et al., 2019) appropriate for a novice researcher. An interview approach to data collection typically supports developing “context-bound subjective insight” from participants (Nathan et al., 2019, p. 392) and is consistent with interpretive research frameworks (Crotty, 1998). An unstructured (sometimes known as in-depth – see Nathan et al., 2019) approach often structures an interview with only one question and builds the interview around the stories shared by the participant. The purpose of the interview is not to accurately recall the past but provide an opportunity for reflection by the participant, acknowledging that “memories are reconstructions of the past, not simply retrieval” (Polkinghorne, 2005, p. 143).

Sample Selection. IPA typically focuses on small homogenous groups (Smith & Osborn, 2004). The approach employed was consistent with IPA as there was no intention to attain a random or representative sample (Smith & Osborn, 2004). However, it differs as I was not concerned with achieving a homogeneous sample to the extent typical of IPA. The degree of homogeneity was restricted to NZ citizens who visited publicly funded EDs (see Appendix G for the full eligibility criteria). I was not seeking to understand how particular groups experienced ED LOS targets. This is not ideographic in the strict sense but is aligned in the sense of the commitment to understanding the perspective of particular people (ED users) in a particular context (NZ EDs with ED LOS targets) (Smith et al., 2009). RTA does not offer any specific guidance on the appropriate sample size or selection (Braun et al. 2019). However, Braun et al. (2019) highlight that sample size is often constrained by practical issues. This is echoed by Polkinghorne (2005). One consequence of sample selection decisions is that one must be conscious of the types of claims that can be made about the themes developed (Braun et al. 2019). In doing so, accepting that generalisation may not be possible.

Participants were selected by a method of convenience and snowball sampling. Convenience sampling has been labelled as “the least desirable” sampling method (Polkinghorne, 2005, p. 141). Snowballing, a form of convenience sampling (Bryman & Bell, 2015), or asking participants to recommend others who may be interested and eligible to participate in the research (Nathan et al., 2019) was utilised. Despite the lack of desirability, the recruitment approach aligns with the research aims and research constraints.

Data Analysis

RTA, as the data analysis method was selected due to the acknowledgement that I, as a researcher, am active in the research process (Braun & Clarke, 2006). RTA provides a flexible method which is not theoretically bound and easily accessible to early career qualitative researchers[10] (Braun & Clarke, 2006). IPA acknowledges that attempting to understand what participants are saying cannot be done without interpretation by the researcher (Glasper & Rees, 2017; Smith & Osborn, 2004). The researcher is making sense of the participant whom themselves is trying to make sense of an event or phenomena (Smith & Osborn, 2004). Data analysis is not simply a discrete step in the research process. Rather, analysis occurs continuously, and it is not possible to separate analysis from interpretation (Sandelowski, & Leeman, 2012). Therefore, theme terminology should match the underlying philosophical approach to the research (Braun et al., 2019).

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[10] This is not to diminish the strength this method of analysis holds, it simply recognises that it is also useable by those starting out using these research methods.

Data analysis, therefore, is my attempt to make sense of how Service Users make sense of their experience. I then try and make sense of their sense-making within the context of the literature on service delivery. Researchers take active roles (Taylor & Ussher, 2001) in the analysis of data and theme development is an active process (Braun & Clarke, 2012). I agree with Geertz (1973) that “what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to” (p. 9). This view means that themes are not something to be discovered or uncovered. As Ely et al. (1997) highlight “if themes ‘reside’ anywhere, they reside in our heads from our thinking about our data and creating links as we understand them” (pp. 205–206). The researcher, therefore, is not a passive conduit through which participants’ views are given a voice (Fine, 2002). Therefore, I ‘own’ the narrative put forward in the following results and discussion.

Validity of Findings. The use of the term saturation has been called into question as researchers have used the term to infer quality and rigour while still failing to assure the reader how saturation was achieved[11] (Hennink et al., 2017; Nathan et al., 2019). Saturation is also a contested term within RTA (Braun et al., 2019). Noting that analysis is never finished, you simply choose to stop (Braun et al., 2019) and that this research sought to open the conversation on Service Users’ experiences of this research makes no attempt to reach ‘saturation’. Instead, I have adopted an approach called for by Nathan et al. (2019). They argue that researchers should be

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[11] See Hennink et al., 2017 for a review of this issue.

transparent around how and why sampling was undertaken; this is in line with my values of conducting and communicating this research in a manner in which enables the reader to make an informed decision about the research findings.

Reflexivity is the repeated act of reflecting on and being critical of the research process – specifically considering how my (as the researcher) subjectivity and experiences impact the study (Todres & Holloway, 2004). It is also, therefore, never-ending (Braun et al., 2019). However, Finlay (2003) outlines how it is used in a multitude of ways. As described by Finlay (2003), my approach to reflexivity is one of "confessional account" (p. 16) of my methodological process. This is aligned with Finlay's (2003) description that reflexivity through logging of the methodological approach enables (improved) scrutiny of research. In doing so, I hope to increase the trustworthiness of my data collection and analysis procedures (Polkinghorne, 2005). I am also aligning myself with Smaling's (2003) concept of "receptive generalization" (p. 18) in which the generalizability of the study is left to the reader (who is assumed to have the correct knowledge to determine if it is indeed transferable). With this, I note for the reader, that this qualitative exploratory research was not about understanding the average experience of ED Service Users but rather about describing aspects of that experience (Polkinghorne, 2005).

Usability of the Research Findings. The 'resulting analysis' does not sit on its own but within the context of other literature (Smith, 2004). Therefore, there has to be meaning or an argument put forward (Braun et al., 2019; Braun & Clarke, 2012) in relation to the data. Themes, then, should be in relation to the research question (Braun & Clarke, 2012). In RTA themes are the output of coding and development of an understanding of shared meaning across a data set (Braun et al. 2019; Braun & Clarke, 2012). Themes are developed iteratively, and codes may evolve (Braun et al., 2019). The aim of coding is not to summarise the data but instead provide a “coherent and compelling *interpretation* of the data” (Braun et al., 2019, p. 848, italics in original). This is consistent with the objective of IPA not to “generalise but to understand shared meanings” (Glasper & Rees, 2017, p. 79). Generalising is not prohibited – IPA researchers are merely cautious about how generalisations are put forward (Smith et al., 2009). There was no intention for this research to be generalisable. Instead the ‘meaning’ of this research put forward is to add nuance to the existing literature.

Research Method

The following section describes how data was collected and analysed.

Data Collection

Participant Recruitment

Two different recruiting flyers were drawn up to target each audience (Appendix C and Appendix D). Recruiting of participants took place over six weeks. Participants were advised of the study through social media, word-of-mouth, and snowballing (described in the Research Design section above). When asking for participants and individuals to pass on the information about the research they were advised that the researcher was not able to follow up on names and numbers provided directly to the researcher for privacy and ethical reasons.

Service Users and Support Persons. To target Service Users and support persons[12] short blurbs advertising the research were put on my personal Facebook page (publicly available) and posted in a social network forum called Neighbourly. The posts in each forum occurred twice. Once at the commencement of the interview stage and once again halfway through. The administrators of local groups on Facebook, e.g. “Wellington Residents”, were also contacted asking if they would allow me to post in their group advising of the research. There was no follow up with the local groups. Emails were also sent to various Rotary International clubs, requesting they share the research information sheet with their members. Two out of 30 clubs contacted advised they would share the information sheet. No follow up was conducted with any of the clubs.

Service Providers – Medical staff. Various nursing, doctors and emergency medicine groups’ administrators on Facebook were contacted asking if they would post in their group advising of the research. The *NZNO Members and Supporters* Group, an unaffiliated New Zealand Nurses Organisation (NZNO) Facebook page allowed me to post in their group (Appendix E). Subsequent communication with this group was through the initial post. An Editor of the nursing magazine Kai Take also offered space through a “Letters to the Editor” message, advising of the research and invitation to partake (Appendix F). I am not aware if this was published.

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[12] Service users’ support persons were also offered the opportunity to participate. This was done for two reasons: 1) it was considered that service users who had attended the emergency department in a serious condition may not be able to speak to the experience and 2) there was originally a concern that it would be challenging to recruit sufficient participants.

Participant Eligibility

Participants were deemed eligible if they were 18 years or older at the time of the screening interview, a New Zealand citizen or permanent resident and had visited or worked in an ED in the preceding twelve months. The full eligibility criteria is outlined in Appendix G. Participants who met the inclusion criteria were invited to participate. Individuals that wished to participate were described the research rationale, advised of ethics approval, and informed of their right to withdraw at any time. Participants were then again asked if they wished to proceed to arrange a time and place for the interview. Formal documentation was completed prior to conducting the interview.

Tangata Whenua

Māori, the tangata whenua, or NZ's indigenous people, rights are protected under the Treaty of Waitangi. Māori could choose to participate in the research. As there was no classification of respondents by ethnicity for this exploratory research, it was deemed this process did not unfairly exclude Māori. Therefore, there was no specific targeting of tiro ā-Māori ki tōna ake ao (the Māori world view) participants. Consideration of the tangata te whenua is not merely about ensuring adequate representation in research is it also about culturally appropriate behaviours. All participants were asked if there were any cultural practices that would be important for them to engage in before, during or after the interview. None were identified.

Interview Strategy

Initial concerns (raised by myself, my supervisors and peer reviewers during the proposal stage) were that participants would not have any awareness that targets were used within EDs. This led to a decision of whether to ask broadly about the experience of waiting times in EDs with the potential that participants would not bring up targets at all. An alternative approach was to ask participants directly if they were aware of the targets. If they were, the exploration would be directly around their understanding of the target. If they did not, then the interview could end, or participants could be asked, given the new information, what their thoughts were.

As exploratory research, grounded in IPA, it was important that the interview questions were non-directional (Creswell & Plano Clark, 2018; McCracken, 1988; Smith & Osborn, 2004) with no stance on participant perspectives was initially assumed. As a result, I determined that commencing the interviews with broad questions, not specifically pertaining to the length of stay targets or even waiting was the appropriate approach. Given the exploratory/iterative nature of the research and not wanting to ‘put words in participant’s mouths’ the most appropriate approach was to commence data collection broadly and allow the participants' responses to guide both the data collection and research. This approach allowed for the research to evolve depending on the data from the participants.

A question guide for each participant group was developed to formulate some general questions for the interview and also to check in advance for wording that may not be appropriate (Appendix H). This is a recommended practice to prepare for interviews (Glasper & Rees, 2017; Nathan et al., 2019; Smith & Osborn, 2004). Interviews were recorded (with permission) to allow for sufficient analysis afterwards (Smith & Osborn, 2004).

Interview Method

Participants were offered two means to participate in the research. The first was through a face-to-face interview, at a mutually agreed location. The second means to participate was via a phone call. Participants were not offered reimbursement for their costs, such as but not limited to, time, travel, and phone calls. I did offer to call participants when exchanging emails or text messages and at the start of phone calls so that they would not incur costs.

A total of 33 participants were interviewed. This consisted of 15 nurses and 18 Service Users. This further consisted of 6 males and 27 females. All 15 nurses were females. Five interviews were conducted face-to-face. Interviews ranged from 20 minutes to 90 minutes, with an average interview time of 45 minutes. More specifically, interviews with nurses averaged 62 minutes while interviews with Service Users averaged 32 minutes.

Participants were offered the option to provide written or verbal (recorded) consent. Eighteen participants chose to give consent verbally. Participants were also offered a copy of the recording. Three participants took up this offer and were sent an electronic copy of the interview. Participants were also offered the opportunity to provide follow up thoughts on the topic and interview. I encouraged this as my experience in working with individuals and groups on reflective topics often leads to thoughts after the fact. No participants provided comments after the interviews ended.

Service User interviews started with the same question, and then the interview developed from there. Each interview started with: “The interview today will start with one question, and from there I’ll ask questions along the way. There is no right or wrong answer; I am just looking to understand your experience at an ED. Please tell me only what you feel comfortable sharing. Could you please walk me through the timeline of your experience in the emergency department starting from the time you realised you needed to go to ED or someone else made that decision for you?” Service provider interviews were run similarity, with a single consistent question to commence. The prompt for these interviews was: “I’m going to ask a question that I’d like you to answer with the first thing that comes to mind. There is no right or wrong answer. Just say what comes to mind, and we’ll go from there. Can you tell me what it’s like to be a nurse[13] in ED?”.

Both these approaches are consistent with an IPA approach to stay close to the experience of the participant (Todres & Galvan, 2012). At the end of all interview’s participants were asked if there was anything they had thought of during the interview that had not been asked about that they would like to share. Several participants did this, either offering a summary of the aspects they felt most important that were discussed or offering further comments for reflection that the discussion had brought up.

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[13] Nurse is referenced here because all the service providers interviewed were nurses. This term would have been changed should the type of professional been different.

Ethics

The ethical considerations for this project were discussed with a primary and secondary supervisor as well as a third-party researcher who has completed research in EDs in NZ.

Research around public services, particularly healthcare and especially emergency department waiting times is political, topical, and personal. The study procedure was designed to mitigate risks arising from the following potential issues:

- Participants believing the interview offered an opportunity to make a complaint about a service
- Participants realising during the interview that they were not treated in accordance with the standards set through relevant legislation and protection bodies
- Re-victimisation or the arising of traumatic experiences which led them to be in the emergency department.

Participants were not recruited at hospitals to reduce the likelihood of connecting with participants who may be less emotionally vulnerable. This would reduce the likelihood of participants using the interviews as an opportunity to make complaints and increase the likelihood that they had time to process the event which led them to the emergency room. This decision also meant that the issues raised by the third-party researcher around the practical constraints of recruiting participants through hospitals such as research fatigue could be reduced.

Participants were informed on the participant information sheet of avenues they may pursue should they have concerns about the service they received while in the ED. These avenues included contact details for the NZ Human Rights Commission, NZ Health and Disability Commissioner and the advice that each hospital has its own complaints procedure. This information was included in the information sheet (Appendix C and Appendix D). This project was assessed as Low Risk through the Massey University Human Ethics Committee process (Appendix I).

Participants were also advised that, in addition to their right to stop the interview at any time, the researcher may stop the interview if they became agitated or appeared excessively upset. One interview was paused for a participant to take a few moments after becoming upset. The emotional distress was due to the situation that led them to the emergency department not due to their experience of the service.

Data Analysis Procedure

The method of analysis was based on the six-phase approach outlined by Braun and Clarke (Braun et al. 2019; Braun & Clarke, 2012). A table outlining these steps, and what I did in each step is included in Appendix J. During the interviews, initial transcription and initial coding processes, I stopped reviewing the literature. While it is not possible to undo any of the reading I had done, it was an attempt to focus on the data initially.

Immediately after each interview, several bullet points were made summarising the discussion. Between 12 and 48 hours after each interview, hand-written notes were reviewed where further notes were made, and reflections on the interview were noted. Every 3-4 interviews I would re-read all the notes from all interviews to date. This not only allowed for review of codes that were becoming more frequent, or new codes that had been added but also allowed for reflection on the quality of the interview itself. This allowed for the development of how I asked questions. It also allowed me to 1) improve the way in which I asked questions (reflecting on questions that had been awkwardly asked as in which participants had needed clarification on what I was asking) and 2) as themes began to emerge I could ask more questions around those aspects.

There are many different forms of transcription (Braun & Clarke, 2012). Service User interviews were transcribed by myself. Nurses interviews were initially transcribed by Nvivo transcription software and checked for accuracy by myself. Coding initially occurred in two ways. One, keywords (and synonyms or phrases) were written out alongside the transcriptions. Two, sentiment or elements expressed but not explicitly stated were coded. Codes were then written out away from the transcriptions. A research diary was also kept during the interview, analysis and write up stages. This captured reflections and thoughts about data and literature and allowed for reviewing during each stage.

Analysis is an answer to a question (Braun & Clarke, 2012). Nonetheless, the question may develop during the analysis, especially when the research aims are exploratory (Creswell & Plano Clark, 2018). One time of notable evolution was during data collection. The evolution of data collection was primarily around the development of what follow-up questions were asked. As themes began to develop my questioning evolved. This also influenced the concept of ‘what question am I asking?’ at the research aims level. This eventually led to the reduction in data used for analysis. During the data analysis and discussion component of this research, it was determined to place aside the service provider data. The results, therefore, consist of data collected from 18 interviews (12 females, 6 males). To this end, the focus on the service provider aspect of the above questions was dropped. Given that service providers were still interviewed they are still referenced as part of the methodology, but no result data is included.

Findings

The findings from the interviews with Service Users are detailed below. As described in the Methodology, no data or findings from interviews with nurses are included here. Themes have been grouped into four elements of ED sense-making. The elements are 1) Service Users expectations of ED, 2) Service Users relationship to waiting in ED, 3) Service Users satisfaction of their ED experience and 4) Service Users awareness of and thoughts on targets. The first three themes emerge from Service Users understanding and sense-making of ED visits while the fourth, from Service Users reflections on targets in ED.

Service Users Expectations of Emergency Department Visits

Service Users have several expectations about how their ED visit will go. Service Users expect to wait when attending ED, but many feel they would be treated faster if they were in a serious condition. Service Users develop their expectations of waiting in ED from previous experience, stories from others and media coverage. Their expectations include beliefs about the ideal time to attend ED and of what the outcome of the visit will be. Combined, these expectations feed the decision-making process services users make when deciding whether to attend ED and their assessments of events during the process.

Service Users Expect to Wait While at an Emergency Department

Service Users expect to wait when going to ED. Service Users who knew they were not ‘life or death’ know that going to ED means there will be waiting involved. Service User (018) said that "I knew going in that hospitals are a place where you go and wait” while Service User (017) noted that “obviously [I] came in knowing there will be a wait”. However, the length of the wait is often unpredictable: "you never know when you turn up at these places how long you're going to be there" (003).

In addition, there is a general awareness of the process of ED and where in the process the waiting component occurs. Service User (004) summed this up saying: "I thought that was kind of a normal thing [waiting[. You see the nurse. They take bloods. They give you a pain killer. And then tell you to wait for the doctor." However, Service Users also believe that they would be seen faster if they had the need.

Most Service Users Feel They Would Be Treated Faster If It Were More Urgent

For the most part, Service Users appear to trust and have faith in the system in that if they were more urgent then they would be seen sooner. For example, Service User (007) noted that: "I certainly felt at the time that had it been more urgent then it would have been treated as such. I had the confidence in them. … they gave me confidence to know that had it been urgent they I would have got exactly what was needed". Service Users are also aware that how they describe their ailment influences how they get prioritised. For example Service User (002) who had an injury that required stitches was able to apply basic first aid before attending ED to stop the bleeding felt that "if I'd said it was bleeding I probably would have gone straight through". Service Users seem to have an awareness of the process of ED and also a sense of fairness about being seen based on need.

How Service Users Develop Expectations of Waiting

Service users develop expectations of waiting in ED from previous experience and third-party sources such as hearing about others' experiences or hearing about wait times issues in the news. Sometimes this information come via the media: " nationwide hospitals are saying how busy they were. Which is part of the reason I went in expecting to wait" Service User (018). While others have heard about it from people they know: "I've heard other people who have been in hospital everyone says there's a wait, especially in emergency" Service User (011). Therefore, one of the expectations Service Users develop about ED, before they even have the need to attend, is that ED is a place where you wait. Layered over this are perceptions on when is better to attend ED to minimise waiting.

Service Users Have Expectations About Ideal Times to Attend Emergency Department, or The 'Luck' of the System

When Service Users talk about the wait they experience, whether they categorise it as 'good' or 'bad', they tend to refer to 'the luck' of the situation. This can be anything from the day and time of the week upon which they happened to attend, for example, "it was Sunday night; fortunately, ED was really quiet" (003) or "it was a really crazy night actually, there was something specific about it….something was on, or it was a holiday, a special kind of day. …and, there was a reason why it was particularly bad" (026). Alternatively, whether there were the resources available that they needed, such as, "there just happened to be on duty that night an orthopaedic surgeon" (003). Often people just accept that their wait time was simply because "the hospital was just really busy that day" (030) or that "in the meantime, a couple of ambulances came in and the helicopter came in twice, so that was probably unfortunate" (002). For the most part, this luck is attributed to factors outside the control of the hospital.

However, a few Service Users wondered whether this was because of understaffing. Service User (018) assumed that "they were understaffed I guessed, so they just sat me down". Even then, that there is understaffing Service Users do not seem to attribute blame to those working in the ED. Service User (017) captured this with: "I think they were doing as well as they could in terms of the amount of in terms of the amount of people they had on" (017). In addition to these expectations about waiting Service Users have expectations about what the outcome of the visit will be.

Services Users Have an Expectation of the Outcome

This theme highlights that on arrival, Service Users have already anticipated the result of their visit. Service Users make assessments of the event that has led to their trip to ED and have may have a fair idea about what the outcome will be. For example, "I knew that I wasn't going to be admitted. I knew that I was going to get stitches…I knew I was going to be walking out of there. At what time I didn't know" (002). Sometimes, this need is not about a specific procedure but being provided with reassurance. Service User (030) had the need to be checked over: "just being a neck injury you sorta want to rule out everything possible really...and just make sure you're on the safe side. You just hear all these bad stories [around neck injuries]". This theme highlights that Service Users attend ED to have a specific need met. Importantly, this is a need as articulated and understood from their perspective.

The combination of expectations that Service Users have about waiting times in ED, how the visit will pan out, the timing of their visit and the needs they have all feed into the decision-making process to attend ED.

Services Users Expectations Feed the Decision to Attend the Emergency Department

Most Service Users go through a process of trying to determine whether to attend ED, seek care elsewhere or if they even need care. This may include calling their GP, friends or family, or the national helpline. For example Service User (025) discussed with her husband whether they should go to ED now or wait for the GP to open in the morning, while Service User (018) called the helpline who advised them to attend ED. Service Users weigh up the anticipated wait to see if attending is worth it and often try other measures before resorting to ED. For example, Service User (031) tried to avoid a trip to the ED by taking pain medication and trying other things to help manage the pain.

Service Users reflected on the use of an alternative medical facility as an option *after their visit.* The cost was never mentioned as a reason for choosing not to attend a private facility. It is more that, in an emergency, ‘you just go to the ED’. Service User (002) sums this up: "I did think afterwards I should have gone to [private clinic Accident and Emergency (A&E) name] and paid for it, and I would have been in and out. I knew that I wasn't going to be admitted. I knew that I was going to get stitches…I knew I was going to be walking out of there. …I don't know why [we didn’t go to the private A&E] if we'd thought about it a bit longer we maybe would have. But maybe my wife panicked a little bit…and my first thought was just 'straight to A&E. I never even thought of [private clinic A&E name]" (002). Service Users are aware of alternative approaches to care, but the decision is predominantly between ‘going to ED or not going to ED’ as opposed to where to seek care.

Service Users have a variety of expectations when it comes to visiting ED; waiting and the factors related to waiting being a key expectation. The following focuses on, and explores, Service Users relationship with waiting.

Service Users Relationship to Waiting in the Emergency Department

Service Users understand their length of wait is partially dependent on their level of severity. Their own assessment of their level of priority comes from what nurses’ say to them and their observations of what is going on around them. With these observations come judgements of the severity and validity of other Service Users use of ED. At times, these observations lead to the assumption that ED is understaffed or mismanaged. Patients assess their level of priority based on the severity of their injury and what they observe around them.

Given Service Users expect some level of waiting, frustrations with waiting appears to, somewhat, be a symptom of unmet needs. Waiting becomes less of an issue when they have pain relief and are informed of the process (have access to information). The need for information about the process and anticipated length of stay is important because Services Users either have the need for reassurance that they the wait is simply the wait and not because there is something more serious going on or because they have an outcome they are specific need they want met. Furthermore, Service Users still have lives outside ED; they may have children that need caring for, or they may need to be picked up from the ED. Overall Services Users do not seem to associate waiting with the quality of the care they receive, but the quality of the waiting experience does impact their overall satisfaction of the experience.

Services Users Sense-Making of Their Wait

Service Users are aware that the length of their wait is relative to their severity. They also know that their position in the queue is not fixed. Some Service Users come in at a higher priority but an initial assessment and pain relief results in them being re-prioritised. Service User (007) was well aware of this: "I was no longer an urgent case which I fully understood because I was feeling good. I wasn't in pain". While Service User (017) knew going in that they were not going to be a high priority. For example, on arrival Service User (017) further assessed their potential wait: "we just looked around and saw that it was full….I wasn't dying. And there was lots of babies and little children…[so] we just sat and waited our turn". While others observe other Service Users coming into ED and realise that they are being re-ordered “you might sit in that waiting room and think how come that person came in after me, and they've gone through first. But you know what that person could be having a heart attack, and you've just broken an arm in a hockey game" (Service User, 005). Service Users are continually re-assessing their position in the queue and using explicit and implicit information to validate the waiting experience.

Information and Pain Management Make Waiting More Tolerable

Service Users generally accept that waiting is required when visiting the ED. Waiting becomes, acceptable or tolerated when distress is managed. Distress is fed from two main factors: (1) a lack of information about their medical complaint and the process, and (2) the need to manage pain.

A Lack of Information. The theme of expectations is also entwined in this theme as Service Users expect to have information not only *about the medical issue* but also *the process of ED*. Service User (018) noted that: "I thought I was going to get information I guess. Even if there was going to be long waits, I would have thought I'd be told; not 'wait here until you see a doctor', even if that's going to be a few hours. That extra little bit of information can make a hell of a lot of difference”. Further, Service User (011) explained that "I don’t mind waiting, it's more about feeling like when you do see someone, just not really knowing what you're supposed to ask or what's supposed to happen". For Support Person (025) it was not only about having information but having access to information when they needed it: "even if we did feel something was off we had the ability to get in touch with her [the nurse]". In feeling able to reach out to a nurse, the anxiety of the unknown is reduced. Being given specific enough information or believing they had access to information should they want it appears to mediate the waiting experience.

Another driver of the need for information is because Service Users have lives outside the ED. When people seek care at an ED, that is, they are not taken to ED in life or limb-threatening manner, there is a trade-off between visiting the ED and managing their lives outside of ED. Service

Users may need to co-ordinate being picked up from the ED once treated or be trying to determine whether a support person should remain with them. They may want a support person there to receive the information on their behalf, or the support person may have other commitments to attend too. They may also be trying to co-ordinate children or other dependants who need to be looked after. This aspect of ‘lives outside ED’ drives their need for information, and a lack of information makes them frustrated because they cannot plan and let others know what is going on. For example, Service User (018) was frustrated because they felt they needed a support person there to advocate on their behalf. "When I was put out into reception … they said the next step would be to see the doctor, but they didn't say that was several hours away. That would have been good to know because I had people with me who could go and do stuff and they were kinda wanting to see the doctor with me because I'd lost time [the Service User had blacked out during their injury] so I wasn't sure I'd remember stuff so I kinda couldn't trust [myself to remember]". Another Service User (025) had children that needed to be looked after, while Support Person [026] had arrived at ED in an ambulance was trying to co-ordinate how she would get home with her child under the age of one. When attending ED for a non-life or limb-threatening medical complaint, life goes on, and responsibilities still need to be managed.

For other Service Users, it was a conflict between their need to ‘be checked’ and being able to go on with life where waiting frustrated them. Support Person (010), while away travelling, wanted her son’s symptoms checked to ensure it was not more serious. Her assessment of the situation going into ED was that he could be checked, “you want to be seen straight away, quick in and out, and that was what I was hoping. And when we first arrived there didn't seem to be anybody". While Service User (007) had a flight for an overseas trip and simply wanted to check everything was ok before travelling. The lack of information about the process combined with the expectation that they would be ‘checked out quickly’ contributed to frustrations with experience.

The need for information is not just about being told what is going on. It is about being given the right level of information at the right time. Participant (013) summed this up as information that was "to the level probably that we needed at the time".

Pain Management. In addition to information, Service Users have the need to have their pain managed. For the most part, Service Users are more satisfied with waiting when their pain is being addressed and managed. Again, Service Users have expectations about what will happen while at the ED. One of these expectations is about pain relief: "the thing about going to ED is you straight away get some pain relief" Service User (003). Service Users believe that ED is the best place to be when you are suffering. Service User (026): "If you're there you kinda feel like you're in better hands than being there. So if you have to wait 6 hours, I don't know why people complain so much. I just feel comfort that if I feel discomfort, I can get help" (026). It is not necessarily about the wait; it is about getting their needs met.

For example, Service User (007) reported that there was "quite a bit of waiting in between, but it wasn't of a concern to me at all, simply because I was no longer in pain". While Service User (003), on arrival at the ED was explained that there was going to be a delay in seeing a doctor, but they were informed that they would still be able to receive pain relief. Distress about waiting also impacts Support Persons. Support Person (013) said that in being advised, there was a wait that “we weren't worried because she was comfortable (once she had the pain relief)". This is consistent with comments such as the one made by Service User (029) who had to ask for pain mediation also reported that "it wasn't nice just sitting there, waiting, waiting [without pain relief]". Managing pain appears to be linked to the tolerability of the wait.

Service Users Assess the Level of Severity and Validity of Other Service Users

Service Users observe who else is in the ED and make assessments as to the validity of that person’s visit to ED. They are assessing if there is an unnecessary demand on the service, which is preventing their needs being met and causing a wait. Service User (002) noted that "I think it was unfortunate that because there were other people there using the system as a doctor. That is what it boils down too. I reckon a lot of those other people shouldn't have been there." (002). This sentiment is echoed frequently with comments such as the one made by (011): “People go to hospital that don’t need to”.

The other side to these observations made by others is the awareness Service Users have of their own validity for attending ED. Service User (025) noted that they did not have access to after-hours medical care, which is not always cost driven. “The Doctor kinda mentioned there was no need to come to ED…and when she said that I understood obviously it was not an ED problem, but I explained to her that we don't have after-hours services. So anything like this happens for a first-time parent you kind of can rely on your family and friends, but we don't have anyone, and that's when you panic, and you think it's better to be safe than sorry. That's why you come to ED. Just to make sure that everything is ok" (025).

Service Users are using visual information to assess the validity of other users use of ED and determining if they should be there. They are assessing whether or not these users are contributing to the waiting unnecessarily.

Service User Sense-Making of Their Experience

In addition to the role of expectations in mediating a Service Users' (dis)satisfaction the provision of information, as described above, and other Service Users mediates their experience. Feeding into the Service Users experience of medical staff busyness and how they attribute negative engagements with medical staff.

The Role of Information in Mediating Service Users' Experience

Being informed calms anxieties Service Users may have. The information provides Service Users with "reassurance, just providing reassurance to the patient and letting them know what is going to happen…"you're not just lying there wondering what's going to happen. Oh, when is the nurse going to turn up, or the doctor turn up. Or what's happening with me" (025). Service User (026) noted that being updated often was reassuring and "it felt really helpful when you're in distress". Service users want information, so they do not "end up so that your mind doesn't wander off, and you start doing Google searches" (025). Overall, those that are informed of the process, and have explained to them what is going on seem much more responsive and feel more positive about not only the overall experience but are more tolerate of the waiting. While there are multiple dimensions to patient satisfaction, positive communication appears to play an important role by making Service Users feel in control. This indicates that Service Users have broad expectations of communication because they do not know the process. In an already heightened state of emotion, they are seeking reassurance of what is going on and how it is going to happen. When this need for reassurance was met, they spoke more positively of the experience.

The Impact of Other Service Users

Some Services Users express dissatisfaction not because of any action or inaction by the nurses and medical staff, but because of other Service Users. Service User (026) rated the care and process a 10/10, but when considering the whole experience – and seeing people be disruptive in the ED – would rate the experience an 8/10. Other Service Users believe they would have been seen sooner if “a lot of those other people shouldn’t have been there…when I got my treatment that was good, that was 100%, but it was quite a circus really” and summed it up by saying "nothing [about the care received] turned me off [going to ED], just the other patients" (002). This suggests that the experience of ED, and overall satisfaction, is mediated by other Service Users.

Service Users’ Awareness of Staff Busyness

Service Users are aware of the busyness of nurses and to some degree, doctors. In addition, Service Users are empathy towards staff mediates negative interactions to some degree.

Service Users observe that nurses and doctors are “run off [their] feet” (Service User, 017) and that they “on a mission…with a hundred things to do” (Service User, 011). Through observing how ED staff move about and overhearing conversations Service Users pick up that ED staff are under the pump. Service User (030) sums this up: "you'll catch the occasional angry whisper about someone not getting back to them in a hurry…and just the speed at which they're moving and the way that they're trying to shuffle patients around and manage it. You can sort of sense they are very stretched for time". It is not only the volume of work that ED staff have to deal with but the content of the work which Service Users are cognizant of. Several Service Users commented on observations of ED staff dealing with other disruptive or rude Service Users.

Service Users wondered whether the busyness was because of understaffing. Service User (018) assumed that "they were understaffed I guessed, so they just sat me down". Even then, that there is understaffing Service Users do not seem to attribute blame to those working in the ED. Service User (017) captured this with: "I think they were doing as well as they could in terms of the amount of in terms of the amount of people they had on". While Service Users pick up on ED staff’s busyness, for the most part, they also believe that ED staff are not “being rude. They were genuinely wired and stressed and exhausted. I feel sorry for them. I don’t think they are bad people wanted to do more, but they just had a hundred things to do" (Service User, 011). Service Users expressed empathy via acknowledging that working in ED is not an easy job. Where the medical staff are under pressure "in terms of numbers of patients that needed to be seen" (Service User, 017). Although some there appears to be more goodwill towards nurses than doctors. Service User (026) summed this up with "nurses make the hospital… doctors, I don't know, maybe their understaffed and not enough of them but they not that pleasant".

Service Users Sense-Making of Negative Experiences

There is an indication that Service User empathy for ED staff working conditions mediates the shortfall in experience. Service Users either counterbalance the experience of a negative interaction with a comment on the character of the nurse, such as, "I could tell she was on a mission, but she was really nice" (011). Alternatively, they counterbalance negative interactions by justifying why a nurse would behave in such a manner. For example, "so while it was frustrating it was understandable [not getting enough information was frustrating but understandable because they were so busy]" (Service User, 010) and "I understand they are in a rush and they have a lot of things going on in their mind, I understand that" (Service User, 008). Service Users recognise that "It's a tough job for them because they have to prioritise…you have to work who the one that needs the care first given the limited resource" (Service User, 005). Some of this is attributed to the nature of the job. At other times it is attributed to management or 'the system' be it resourcing or fluctuations in demand. Despite Service Users feeling at times that they the quality of their experience could be better, they do not seem to hold the nurses and doctors to account.

Service Users' Awareness of, and Thoughts on, Targets for Emergency Departments

Most Service Users are not aware there are length of stay targets in pubic EDs in NZ. Services Users ultimately want a quality service, so while they think there should be some mechanism for ensuring quality, they do grapple with trying to find the balance between keeping efficient service delivery and not letting a target compromise care.

One sub-theme that does not fit within any of the main categories is necessary context for this section. Service Users seem to distinguish between waiting and the quality of the medical care they receive. This could be in part due to the expectation of waiting described above.

Service Users Awareness of Targets

Most Service Users were not aware there are length of stay targets. The Service Users, who were aware target existed, knew either through the hospital having signs up advising them, previous experience in ED where the target had been discussed or because they had a personal connection with someone in the workforce. While this is not a representative sample, nor is it quantitative research of the 13 individuals asked whether they knew there were targets, only three knew. Only one individual knew about the targets from signs within the ED.

Service Users Thoughts on if There Should Be Targets

Participants in the Service Users group were advised by the researcher that “public hospital ED’s in NZ have length of stay targets. That is they have a goal to get 95% of patients admitted, discharged or transferred within 6 hours of arriving at and ED”. Service Users were then asked, “what are your thoughts on this?”

Service Users had internally conflicted views on whether there should be targets. Often, they could see both positives and negatives to the use of targets. One concern was that targets would get in the way of care, but simultaneously there was an expectation that there needed to be some level of quality or accountability. Service User (003) "yeah I guess I think that's a good idea… I guess it is reassuring that they do have some targets; standard operating procedure type stuff". Even Service User (001) who had a strong view against targets saw that it was not straight forward: "in general I vehemently object to [targets in healthcare], but I understand that quality metrics have to start somewhere. So, I think there is two sides to this".

Service Users’ Thoughts on The Length of the Target

Service Users were also not sure about the length of the target. Part of this stemmed possibly from a lack of understanding about a target and the difference between waiting to be seen and the total length of time spent in ED. Service User (017) summed this up with "I guess they gotta have some sort of target, but I don't know if that's reasonable or not". Some immediate reactions cautioned the use of a fixed target around the varying demands across the week (e.g. a busy Saturday night) and wondered if the target should be varied across the week. Others worried that a target might mean that they wouldn’t get seen urgently. Many Service Users ended up concluding that they wanted an ED where they could go to for assurance that “everything is ok…[and if it’s urgent that you are]… fixed right away” (025).

An additional observation made was a discrepancy between individual experience and view of the target. As the research was conducted by asking Service Users to go through the timeline of their ED visit, before each participant was asked if they were aware of the target, an approximation of their ED LOS was discussed. Service Users were asked if they felt this was acceptable. Most said the length was acceptable and referenced back to other elements of the satisfaction or dissatisfaction of the visit. Several Service Users who met the target and were satisfied with their visits then expressed that they felt the length of the target was too long.

Overall, the sense is that Service Users want a service that runs effectively and efficiently, but they are also cautious of decisions that may get in the way of proper care. There also appears to be a dissonance between the individuals' experience and their ideal standard for the experience.

Summary of Findings

Service Users have both clear and conflicting expectations about visiting an ED. There appear to be several factors that mediate their waiting experience. This further impacts their satisfaction. However, waiting, itself, may not be a significant issue when other factors are managed sufficiently. Additionally, Service Users, while they may not be satisfied with the experience often satisfied with the quality of medical care. They also engage in sense-making processes to justify any negative experiences, particularly pertaining to interactions with staff.

For the most part Service Users were not aware of the ED LOS targets. When introduced to the targets, they had mixed views, mainly within themselves about their position on targets. Service Users grappled with how to balance efficient care and management of resources with not compromising care. The Discussion below explores these aspects in more detail and links these micro-level findings back to the macro-level theory of public service delivery.

Discussion

If a discussion were happening in real-time (i.e. a conversation) there would be a back and forth of ideas and positions. There would be a development of ideas. Someone says X, which makes the other person take an idea down a new path and so that part of the topic is explored. Research discussions are typically 'arguments', and positions put forward or answers to questions (Braun et al., 2019b). As an exploratory piece of work, trying to examine a phenomenon in a new way, this 'discussion' does not aim to put forward an argument or position in the typical sense. This Discussion instead lays out a series of points which invite the reader (and other researchers) to take the ideas down new paths. However, these are not paths on a well-defined map; they are paths yet to be established. The points made in this Discussion serve to identify key features of the landscape and include identifying the parts of the horizon that have not been able to be seen in full.

In exploratory research aims often evolve (Creswell & Creswell, 2018; Polkinghorne, 2005). Evolve can be taken to mean developed and considered at a more nuanced level. For example, someone discovering new land for the first time. Their first questions may be ‘can we get all the way around it?’, ‘what does the landscape look like?’. Once they either identified all the way around and have an idea of the shape, they may choose to go ashore. Alternatively, they may choose a landing spot without fully outlining the new land. Then they can mark out significant points of interest in the land such as mountains, valleys, and bodies of water. Further levels of examination are then possible – from how the climate is different to what makes up the soils and what grows on the land. Each layer of investigation adding a layer to the understanding of this new land. Their aims evolved to get a more nuanced understanding of the land.

Evolution of research aims may also develop through improved articulation. The ability of the researcher to articulate the aims may be both a combination of discovering a shared jargon or the development of language in general. For example, before one can articulate the concept of gravity, one is familiar with it. Even without trying to communicate with others, one can have a sense and understanding of the phenomena they are observing (and experiencing). They may also come to learn the shared language and the terms gravity, force and friction and discover the theories and principles behind it. With this research, there were both aspects of evolution in the aims of the research. Over time the level and aspects of what was pertinent to focus on developed as well as my ability to articulate what I had been observing from the beginning.

Another aspect of the development of the aims of this research is entwined with both a guiding practice of qualitative research and a decision made in the research design stage. That is asking opened ended questions (Creswell & Creswell, 2018). With the broad aim to understand ‘what is this?’ the focus was shifted away from ‘is this here?’. As described in the Methodology, the decision was made to assume that Service Users *did* not know about targets. Further, and in alignment with the research questions, to seek to ‘understand what Service Users think about targets’, there remained the possibility that Service Users did ‘not think anything / would not be aware of the targets’. However, the crucial aspect here was also the context. Service Users are not only Service Users. They are also citizens. I was asking participants to put on their ‘Service User’ hat (or glasses) over top of their citizen core being.

As a result of the above evolution, the research questions can be more appropriately articulated as:

- Do Service Users have an awareness of ED LOS targets while they are in ED?
- If yes – what does this awareness look like, and how does it interact with their experience?
- If no – what insight can be gained into how Service Users make sense of the ED visit, with respect to satisfaction and waiting?
- When introduced to targets in ED, what are Service Users initial thoughts?
- If ED LOS targets were, partly introduced to reduce waiting time, what do Service Users understand about waiting?
- How does what Service Users understand about their ED experience relate to macro-level policy on how to operate public services?

The Service User Experience

The following discusses the above findings in relation to the research questions and the broader theoretical literature on NPM.

Do Service Users Have an Awareness of Emergency Department Length of Stay Targets While They Are in the Emergency Department?

For the individuals interviewed for this study, a non-representative sample, there was a general lack of awareness of ED LOS targets. Only three individuals were aware of the targets, and only two people brought them up voluntarily during the discussion on their experience. Given the government's rationale and justification for implementing and publicly reporting on the targets as part of a "performance management and accountability system" (Ministry of Health, 2007, p. 2) designed to build "trust and confidence" (Ministry of Health, 2016a, p. 25) the absence of knowledge of the targets indicates a possible lack of accountability and absence of trust and confidence.

The lack of awareness of targets, as indicated by this research, is further interesting because it is of a similar nature to research, both in NZ and overseas, which indicates that most people are unable to approximate the spend on various public services (Kemp, 2009). The commonality across these situations is the lack of awareness by citizens and Service Users on what really goes on with public service delivery. It, therefore, also adds to the conversation around the discrepancy between what government does to affect outcomes and what it does to get votes. The finding that Service Users are generally not aware of ED LOS targets warrants further investigation because it will add to the body of knowledge on whether or not actions taken by the government are for the benefit of the Service User or a political tool for gaining votes. This finding should also be considered in light of the broader discussions on the difference between the needs of citizens and Service Users (Podger, 2012; Thomas, 2012).

What Does Service User Awareness of Targets Look Like and How Does it Interact with the Service Users' Experience?

Service Users who are aware of targets had become aware of the targets either through seeing signs up in the waiting room or having previous experience or a personal connection of someone who was involved in the target. The awareness, by Service Users, of ED LOS targets, appears limited to knowing the targets exist. There does not appear to be any connection made by the Service Users between the target and how it will affect their visit.

The lack of awareness of targets and the apparent integration of what these targets mean for the Service Users is notable. It would seem, that quarterly publishing in local and national newspapers and being available permanently online has likely not led to a general awareness of the targets. In light of the Minister of Health, and subsequent Ministry of Health documents advocating the use and publication of targets amongst other things, in the interest of transparency and accountability, this lack of knowledge of targets brings about questions of the value in both the use of targets and public publishing of the results or the effectiveness of their approach to publication. The lack of awareness of the target, and therefore subsequent implication of the target effect, is that the target has failed to filter through and *shape the expectations of NZ ED Service Users.*

When Service Users Are Not Aware of The Target, How Are Service Users Making Sense of The Emergency Department Visit with Respect to Satisfaction and Waiting?

In the absence of awareness of targets by Service Users three themes became evident when engaging with the data. These can be helpful in understanding ED Service User satisfaction and experience. First expectations, of various kinds, mediate the experience and therefore mediate levels of satisfaction. Second, waiting, in and of itself, is not the issue. Finally, when Service Users are frustrated or dissatisfied, the blame is shifted away from ED staff to management and other external factors.

Expectation Mediates Experience and Therefore Satisfaction

What is revealed through this research and adds to this body of work on ED Service User satisfaction is that *expectations mediate experience and therefore mediate satisfaction.* Service Users are focused on issues such as getting their needs met and making sense of why they are waiting for the length of time that they are waiting. They are also attentive to the quality of care that they receive, somewhat independent of the length of waiting.

These findings add to the existing body of literature by indicating that 1) the ED satisfaction factors, previously identified in the literature, themselves mediate each other, and 2) that the value of satisfaction on each of these measures is mediated by the expectations held by the service users. That expectations mediate service level satisfaction has been identified in the literature (Osborne, Radnor, & Nasi, 2013). However, to my knowledge it has not yet been examined in the context of ED patient satisfaction.

Waiting, in and of itself, is not the issue

Waiting is highlighted in the literature as a factor in ED satisfaction (Gordon et al., 2010; Nairn et al., 2004). Various types of waiting have also been described, such as the time to see a clinician and waiting to undergo tests as well as receive the results (Gordon et al., 2010). The research so far has suggested that, therefore, to increase ED Service User satisfaction, these waiting times should be minimised. This has, inter alia, been used as a justification for ED LOS targets and target lengths.

Service Users were generally aware of the process of ED and how waiting is an integral part of that process. However, waiting appears to be less of an issue when they received pain medication and information about the process. Their focus is not necessarily on avoiding waiting but having their needs met. While the fundamental need is to resolve their medical complaint, intermediary needs of pain management and information about the process become their dominant focus. The elements of pain management and the need for information are consistent with the literature on ED satisfaction (Nairn et al., 2004; Taylor & Benger, 2004). What these findings add to this literature is *how* managing aspects such as pain management and information are linked to waiting and satisfaction, not just that they are part of satisfaction.

Further, Service Users believe that should their needs be more urgent they would be seen sooner and seem to assume fairness in the process. As identified in the Findings, Service Users are making judgements and re-assessing where they think they are in the queue to be seen. These judgements are based on what they know about the ED process (or think they know as information is sometimes gathered from television shows) and cues in their environment. Environmental cues include, but are not limited to, observing others in the waiting room talking and overhearing medical staff. Service Users attention to prioritisation would indicate an element of fairness. The Findings indicate that once Service Users pain needs are met, they are more tolerant of some level of waiting. This, however, is also entwined with their expectation that they will be seen to in an order that is fair.

The findings of this research indicate that within the NZ context, there appears to be a built-in ‘expectation of waiting’. This implies that *some* level of waiting is acceptable. However, for this waiting to be acceptable, certain needs must be met. When the need for pain management and information about the ED process are met, and Service Users believe they are going to be seen in fair order, they are tolerant of some level of waiting. This finding adds a layer of nuance to the claim in the literature that waiting negatively affects satisfaction (Moskop et al., 2009a; Moskop et al., 2009b). It does so by highlighting that the claim is not nuanced enough. While more research is necessary, these findings indicate that the following is more likely to be accurate: under some conditions, waiting negatively effects satisfaction. The value in this finding is that governments and practitioners can develop interventions aimed at the holistic experience of the Service User rather than at an isolated element of the experience. It may also explain why the improvement in ED LOS via target achievement or improvement has not been reflected in overall ED Service Users satisfaction.

Finally, from both the review of the literature and Findings, ambiguity around the difference between ED LOS and waiting time was identified.

While this needs further examination, the disconnect is present in the literature where the ED LOS targets are referred to as “waiting time targets” (Hood, 2008, p. 9). While it may seem like semantics, failing to make this distinction, is worthy of further examination in light of the finding above that *waiting time, in and of itself, is not the issue.* The following looks at how ED Service User dissatisfaction is rationalised and understood.

Service Users Shift the Blame away from Emergency Department Staff

One of the research questions that evolved from the Literature Review and is specific to EDs was whether Service Users experience a flow-on effect as a result in the spike in activity observed within 20 mins of the ED target deadline or as a result of ED staffs’ additional emotional burden in managing the demands of the target.

While Service Users are aware of staff being busy and stressed as Service Users are not aware of the targets, they are not able to attribute any perceived busyness or lack of care to the targets. Still, Service Users do make attributions about why medical staff are busy and stressed and rationalise any gap in the care they may have received. Service Users make some attempts to justify why they received the (poor) service they did, such as the attribution of staff burnout, excessive demands on resources (including inappropriate ED use[14]) and a lack of resources in the system. Notably, though, in doing so, Service Users also *shift the blame away* from ED staff. Primarily Service Users shift the blame on to management and

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[14] Inappropriate ED use covers both going to ED for something that is perceived could have been dealt with at a GP and poor treatment towards staff.

other Service Users. Even the individual experience of burnout of an ED staff member is noted to be *caused* by management, or a failing in the system. This attribution does not necessarily justify or make it an acceptable service quality gap, but Service Users do shift the blame away from those who provide the care.

The shifting the blame onto management is interesting in light of the criticism of NPM on accountability within public services. In shifting the blame to management and other Service Users, Service Users seem to be missing a level of accountability towards Government. As highlighted by Pollitt (2003) contracting out (including creating quasi-markets) has, contrary to claims that NPM would increase accountability, arguably reduced accountability. While the discussions on accountability shifting have mainly been theoretical, these findings indicate that there may be some evidence to this claim. However, a counter-argument is that this shifting of accountability may not be an issue if management is, in fact, the best party to be accountable. This is akin to the concept of appropriate risk-sharing in the contracting out approach (Pollitt, 2003). A corollary is whether or not there is sufficient accountability of management to Government. Alternatively, there is also the consideration that given Service Users are a sub-set of citizens each group may have different accountability requirements. Does this raise questions of who should be accountable to Service Users? Moreover, how is accountability managed when Service Users are also citizens? This indication of blame-shifting combined with the questions of accountability under NPM, is a landmark identified by this research and requires further examination.

Yes, But…. No, Maybe? Service Users Response to Targets

Service Users had varying, and contradictory, positions on whether there should be targets in ED. Sometimes these contradictions were present within one person's own position. Service Users also grappled with determining what the difference between performance and quality assurance measures were. Service Users, prima facie, seem to be grappling with the issue of how to determine and then measure what is systematically important (Meekings et al., 2011).

Some Service Users were concerned about demand fluctuations of EDs. They are grappling with how targets could fit within the ED without compromising care. One Service User suggested that targets be adjusted to accommodate known busier times. This, to some, may seem to defeat the point of a target, but it is consistent with the view that Service Users are aware of busier times in ED (and how lucky or unlucky they are to end up in ED at this time) and have an expectation of some amount of waiting. Overall, though, Service Users want assurance that there is some management of ED to ensure they received 'good' service, but not at the risk of compromising quality clinical care. Services Users conflict around the appropriateness of, or manner in which to implement targets, speaks to the concept of a trade-off.

Trade-offs occur at various levels. They may occur at the level of values (e.g. equity versus efficiency) or budgets (e.g. health spend versus education spend) or at the operational and individual level (e.g. quality versus cost). Given the option, most people would desire less waiting. However, most options are rarely a simple get-more-for-nothing; they involve a trade-off. This is exemplified by U.K. Passport Agency case where an attempt to reduce the cost of passports by £1 resulted in a failure to deliver services for a time (Dunleavy et al., 2005). Dunleavy et al. (2005) claim that the “resultant political row made clear that the reliability of the service is actually a quality far more important to passport holders than a small cost reduction” (p. 476). We can assume that people desire a cheaper passport if the question was one dimensional, i.e. do you want a cheaper passport? Yes. However, as extrapolated from the passport example while Service Users would like a cheaper passport, they do not wat it *at the expense of quality and timeliness.*

In the case of ED LOS targets, Service Users appear to be trying to balance a desire for less waiting with possible decreases in clinical care. This issue is also described by Gray and Jenkins (1995) as "the underlying problem with an emphasis on quality is that no-one is against it but definitions depend on values and circumstances (e.g., what is a quality health service?)" (p. 91). These findings echo this sentiment. A Service User may indeed prefer less waiting but not if that means trading the quality of medical care. While the NZ Government, notably with respect to healthcare narratives, has focused on a trade-off at the resource (money) allocation level, they have neglected the discussion around other trade-offs that occur. Considering the trade-offs Service Users are willing to make is another landmark identified by this research.

The Gap Between Theoretical Discussions on Public Service Delivery and Service User Experience

This part of the Discussion links the research findings to broader issues of public service delivery.

Ideas matter: they have consequences (Terry, 1998). The idea that business-is-better, or NPM, which permeated the public sector from the late 1970s is one of those ideas that had consequences. NPM was a response to “a profound public dissatisfaction with government, its programs, its performance, and its governance." (Kettl, 1997, p. 460). The business-is-better ideology, proffered as a solution to these ills, has been “extensively institutionalized" (Dunleavy, 2006, p. 218) having left “deposits” (Pollitt, 2007, p. 113) on public institutions. One aspect that remains is the focus on performance management (Halligan, 2007) and the identification and measurement of Service User requirements (Mathiasen, 1999). In its current form, this is the focus on “developing better performance measures” (Mathiasen, 1999, p. 103). The implementation of targets in the NZ healthcare system commencing in 2007 until present demonstrates a reinvigoration of the quest for better performance measures. This holds, even as the targets are no longer published as the targets have not been withdrawn for removal; rather, the targets have been sent back for improvement (Bennett, 2018).

The following discussion is underpinned by the theme of the difference between Service Users and citizens. As discussed in the Definition of Terms in the Introduction, this research defined Service Users as those who consume a service directly. For the purposes of this research, Service

Users had to be citizens (defined as having voting rights in government elections). This research, therefore, assumes that Service Users are a sub-set of citizens.

Targets: An Answer to The Question of Performance or the Question of Meeting Needs?

Organisational performance is complex and multidimensional (Amirkhanyan et al., 2008). Further, service quality, as opposed to quantity, is hard to measure (Hood, 2008). While all stakeholders in the NZ healthcare system may share the same overarching goal of improved health services (Brunton, 2017) determining improvement to what level will undoubtedly be different between stakeholders. Therefore, depending on which stakeholder you ask, and how you ask, may garner differing answers. With respect to the NZ government's approach for engagement, which arguably focused on citizen stakeholders and clinicians, it may mean that for Service Users targets have no direct value. What this issue possibly highlights is the issue any researcher can find; the wrong questions lead to inappropriate findings. The government, by focusing on what citizens and clinicians wanted, got answers on what citizens and clinicians wanted. This is not wrong, but it is critical context. For simplicity, and congruence with the research focus, the disconnect is discussed in terms of citizens and Service Users.

A disconnect in needs may occur between a Service User and citizen. Asking a citizen who has had no ED experience of their requirements for ED will result in a conceptual answer. An answer that anticipates what ED is like and should be like. Asking a Service User, someone who has been to ED, will most likely result in a different answer because they have an experience to reference against. This is aligned to Alford (2002), who argues that we must recognise that “sometimes what clients [Service Users] want may be at odds with what citizens want” (p. 344). Quirk (2011) argues that citizens prefer cheaper services, while Service Users want better and faster services. The application of an ED LOS target, in response to, inter alia, waiting time complaints may well be evidence that the citizens' needs have trumped the Service Users’ needs. In this case, citizens claims have taken priority over Service Users (Alford, 2002). The focus on citizens needs and therefore, the focus on waiting times and ED LOS may also be explained by Public Goods theory which posits that governments will produce the quality and quantity of goods and services which are aligned to the median voter (citizens) (Amirkhanyan et al., 2008). To this end, we could say that citizens need a government to perform, while Service Users want their needs met.

One key aspect of the difference between a citizen and Service User may be what they are willing to trade-off. The findings indicate that Service Users appear hesitant to be willing to trade quality of care with waiting. Preferring a longer wait rather than reduce the quality of care when acknowledging that it is not possible to have both. This is similar to the UK Passport example described in the above portion of the Discussion. Of course, a Service User would like a shorter ED LOS. Never mind hitting-the-target-but-missing-the-point – *maybe the NZ Government missed asking the right questions to the right parties.* An appreciation for soft information and soft analysis “which seeks to pose the right questions rather than find the right answers” (Boston & Pallot, 1997, p. 401) may be of critical use here if traction is to be made in keeping both citizens and Service Users satisfied.

However, a cynic may take the view that the government is purposefully avoiding asking some stakeholders specific questions because they do not want to know the answer.

These findings highlight one of the possible differences between citizens and Service Users. Raising the question of ‘who is this target serving?’. These findings indicate that the target is most likely serving the government-citizen relationship. The targets serve the government by completing the ‘we ask, you told, we delivered’ narrative. In this manner, the targets become a political weapon (Hood, 2008) that has nothing to do with delivering healthcare services. Alternatively, from a more neutral stance, in Kettl’s (1997) terminology, the use of targets as part of a performance management approach is about “*political communication* [and] it only has value to the degree to which it improves that communication (p. 457, italics in original). In this case the communication is still focused on citizens not Service Users. Alternatively, linking the use of targets as a means of communication back to these findings, targets can be used by government to mould both citizen and Service user expectations of public services. More research is required.

It is also worth noting that, while not the focus of this research, as identified in the literature, targets may have value to other stakeholder groups. There is reported evidence elsewhere that the introduction of targets brought about changes that ED staff had been requesting, changes which they believed would not have eventuated without this pressure on management (Mortimore & Cooper, 2007; Weber et al., 2011). Whether this is the target or a form of observer paradox (Hood, 2008) is up for debate and does not yet appear to have been researched. This research did not examine this aspect but give the connection to stakeholder groups acknowledges that stakeholder groups are wider than simply citizens and Service Users.

Who is Responsible to Whom? Is There an Accountability Disconnect?

Accountability is being answerable to someone for a defined objective (Deber & Schwartz, 2016). The business-is-better answer to public discontent was intended to put in place “greater accountability and transparency through requirements to report on results” (Holmes & Shand, 1995, p. 551). However, Kettl (1997) argues that the NZ model’s demand for results shifted the responsibility for outcomes to government managers and away from politicians. Ryan and Gill (2011) add to this with the claim that in NZ through a range of reforms (of which targets have been part of) politicians have been pushing the blame from themselves to the executive arm of government. Elected officials were able to create a “'blame free' zone, leaving administrative actors in the front line" (Gray & Jenkins, 1995, p. 92). The question then arises, in light of these findings, is Service Users blame shifting towards management and other Service Users early, indicative evidence that NZ elected officials have been successful in distancing themselves from the responsibility of outcomes? The nature of this research is not in a position to answer this question but does provide another landmark for further investigation.

Although requiring further consideration, these findings indicate a level of attribution of blame for poor service delivery by Service Users towards management instead of government. This can be considered alongside Dunleavy and Hood’s (1994) assertion that NPM may reduce citizen understanding of the system. This concern is echoed elsewhere in the literature (Dunleavy & Hood, 2004; Rhodes, 1994). Is this blame-shifting another one of the effects of NPM? Is the system so complex and confusing that Service Users fail to understand who is accountable for public service delivery? While this research cannot give a definitive answer, it does provide possible on-the-ground insight, compared to the generally speculative claims made by those against NPM. In this sense, this research further bridges the gap between theory and effect. An alternative perspective is that management is duly accountable for the outputs (in this case, the experience of a Service User) while outcomes are the responsibility of the government. This determination is, however, ultimately to be negotiated between the government, citizens, and citizens-as-service-users. Either way, these findings serve to highlight the potential differences between Service Users and citizens.

One criticism of NPM is that market-type mechanisms and quasi-market approaches have resulted in a loss of control and influence by government (Kettl, 1997). Targets, although being an NPM tool, may also be a counter-balancing tool for unintended consequences. Irrespective of a service being contracted out or provided via a quasi-market, targets offer Government a tool to intervene in public service delivery indirectly (Baggott, 1994). While this intervention type is not cost-free (there are, unintended positive and negative consequences and costs for collecting the data) for a government that has gone down the ‘hands-off service provision’ via a contract-based approach targets, provide government with one more touchpoint. Meekings, Briault, and Neely (2011) put forward the challenge that target setting should move beyond the “simplistic adage of ‘what gets measured gets done’ towards the concept of ‘what gets evaluated gets improved’” (p. 92). However, this comes with the caveat of is what is getting improved the *right* thing to improve. As highlighted in the ‘flattening out’ of target achievement in NZ and when considered in through the context of systems theory that improvement cannot be infinite (Gharajedaghi, 2011) we can see that targets serve many different means. Targets can be used by the government to compel public entities to take action or re-direct their priorities when they are not otherwise compelled to make changes.

While the NZ governmental service provision structure may create a disconnect for accountability, it is not to say that removing the quasi-market approach would resolve this issue. Because structurally, irrespective of who does the delivery, there still is Government ->Management ->Frontline staff. So speculatively, this issue will remain because Service Users interact with frontline staff who are directly accountable to management. It is citizens who hold Government accountable. Further research is needed on how individuals, when taking different positions, vary how they assign accountability and blame.

Noting that it is possible to get caught up in ideologies at a values and principles based level, this research can serve as a reminder that there is no one right way to be found. Decisions around public service delivery, quality, and quantity will ultimately be both context-dependent and politically determined. The answers to the problems articulated here, after all, are “fundamentally political judgements” (Kettl, 1997, p. 458). Targets are one answer (of many) to one question: there are also other questions.

A Final Comment: Reflections of a Researcher

This section contains a final reflection, I, as an active sense-maker, made throughout this process. It is not directly connected to a theme but is connected to the overarching research purpose of understanding how ideologies entwine with everyday action.

This research is not placed to answer the question of does business-do-it-better as that was not the remit of this research. However, it does add to the discussion of does-business-do-it-better' by better describing how structures and mechanisms have various effects. More pertinent questions, however, may be: does it matter if the technique applied to service delivery originates from the private sector? Should public service delivery improvement not be focused on if what is being done is working? Some may say that there is a risk in adopting practices from the private sector that will not work and therefore waste taxpayer money. However, doing nothing, while dissatisfaction mounts is not a solution either. Arguing over where a method came from does not determine its effectiveness; only evaluating its effectiveness verifies its effectiveness. To this end, maybe rather than focus on the origins of a mechanism, we can note that performance measures have become used for control rather than learning (Bourgon, 2008) and that progress in public service delivery is more likely to progress when a learning stance is adopted.

While the use of targets in NZ was linked to organisational incentives (Boston et al., 1996) the approach has been less strict than the application in the UK which came to be known as the “targets and terror system” (Hood, 2008, p. 8). The Minister of Health, David Clark, noted, on withdrawing the targets, that the national health targets created perverse incentives (Bennett, 2018). This is aligned with international experience (Dunleavy et al., 2005; Pollitt, 2007). However, Clark does not outline what these perverse incentives are, other than highlight a few cases, outside of ED, where the provision of healthcare was compromised. Noting that no performance system is perfect, and systems continue to need improvement (Kettl, 1997) it is somewhat unsurprising that the targets are once again subject to a re-do. However, the government may be wise to consider, in light of these findings, and commentary in the literature by Kettl (1997), that the problems they are trying to solve may be better addressed by looking at the *connections between things* rather than seeking “greater goal specification” (p. 452). As further highlighted by Kettl (1997): “the fundamental purpose of the process [of performance measurement], is not to produce measures but to improve results” (p. 457). With respect to this research that means considering how expectations mediate Service Users experience and how different stakeholder roles influence expressed needs.

This section concludes with a note directed to the Minister of Health who appears to have handed the development of the targets back to clinicians. The Minister must take the time to understand that there is both the Service User and citizen as crucial stakeholders in the application of these targets. Preference towards one, without meeting the needs of the other is likely to continue to result in political discontent. Discontent most likely expressed in the form of continued dissatisfaction with the healthcare system and waiting times. So while there has been a temptation, somewhat successfully, of elected officials to distance “themselves from the chain of responsibility and the unforgiving implications of clear output measurement. Successful performance management systems hinge on careful integration of politics and management" (Kettl, 1997, p. 458). Clark must also keep in mind that one impact of the contract model in NZ is that "at some point the state loses its operational capacity to determine standards or service quality expectations or reasonable outputs in negotiating the contract" (Steane, 1999, pp. 139-140). Even if that contract is within a quasi-market environment. Handing the target development back to clinicians is firstly risks privileging one stakeholder group over another and secondly may reduce the ability of government to use the target as a means of control over service provision.

Limitations of the Research

There are practical limitations when conducting research (Bryman & Bell, 2015). One limitation of this research is that, being completed within a master's degree programme, time and scope limitations existed. These limitations were a factor in the number of iterations of data collection and analysis. Another limitation was that the research invitations to participate were only offered in English. This potentially excludes ED users who may have difficulty reading English. This is an acknowledged limitation of the research; however, as the research is exploratory, it is not considered detrimental to the research objectives.

One challenge in seeking service users' experiences is in seeking Service Users. Without recruiting directly in EDs (for reasons discussed in the Methodology), the sample self-selection bias is further amplified. While this is not as significant for exploratory research, it is worth noting that only those whom themselves were not experiencing life, or limb-threatening experience participated. Further, when seeking to understand users experience, it can be challenging to differentiate between the satisfaction of the service and the satisfaction of the health outcome. While, to a large degree, they are related, this body of work was not suited to further understanding this dynamic. Finally, and in part due to the research methodology, there were challenges in participants understanding of terminology. In presenting participants with the ED LOS target, it became apparent that Service Users were not aware of the difference in ED LOS versus waiting.

The findings here are context-dependent. Limited, amongst other things, to the New Zealand political landscape, which includes how public services are funded and delivered. As noted in the Methodology there was no intention from the outset for these findings to be generalisable. The findings are landmark indicators for further research.

Further Research Opportunities

Designed as exploratory research, this work marks out several landmarks for further investigation. Further, as expected with exploratory research, there are more questions than answers. Many of these questions have been posed throughout the Discussion. Therefore, only a brief overview of future research directions is highlighted here. First, there is significant scope at the ED experience level to examine in more detail Service Users expectations and understanding of waiting and how this interacts with satisfaction of both the medical care and overall experience. Second, this research points towards the need for greater understanding, as opposed to theoretical positioning, of the differences between Service Users and citizens. This can also be expanded to other stakeholders, such as taxpayers. Future research will need to be both qualitative and quantitative. While this research has indicated that expectations mediate ED experience only some factors related to expectations have been explored. For example, the noted increasing expectations for service levels (Plimmer et al., 2017; Quirk, 2005) and the expectations of free medical care (Ashton, 1996), or general dissatisfaction with the government of the time were not examined.

Conclusion

There is the demand for Government to confirm that it does what it says it will (Kettl, 1997) and widespread debate over the way in which public services should be delivered (Ferlie & Andresani, 2006). Despite this pressure and attention, public sector performance remains hard to measure (Noordegraaf & Abma, 2003) especially when attempting to measure the quality of public service, as opposed to the quantity (Hood, 2008). These issues are particularly prevalent in terms of healthcare delivery. The business-is-better ideology, under the label's managerialism and NPM, was extended as a solution to these challenges and issues. The questioning of how to better deliver public services is not new. The 'new' of NPM was about the packaging of these ideas (Boston et al., 1996). Rather, in the late 1970s and early 1980s there began a specific discourse around improving public services that was grounded in the ideology that business practices would enable the better delivery of public services (Hood, 1995b; Osborne, 2006; Pollitt 1990; Pollitt, 2007; Savoie, 1995; Terry, 1998).

The business-is-better ideology, under the banners of NPM and managerialism, brought into public service delivery various practices and approaches typically associated with the private sector. It also pushed the creation of organisations to mimic private sector organisation with the underlying belief that markets drive better service delivery due to competition, performance management and a focus on Service User requirements. There was the supposition that Service Users should be viewed in the same way private sector customers are (Kettl, 1997). Although there is debate around whether public sector and private sector organisations are similar enough to transfer these practices (Alford, 1993; Chapman & Duncan, 2007; Hood, 1995b; Savoie, 1995 ;Terry, 1998), the attempt to impose market-type mechanisms and private sector practices on public services prevailed.

NZ was identified as an early adopter of the business-is-better approach. NZ's NPM 'model' labelled such for its intellectual coherence and implementation was solidified through a wave of legislative reform in the early 1980s. New Zealand's public service was significantly "redesigned, reorganised, or reconfigured" (Boston & Pallot, 1997, p. 382). Overall, the NPM reforms in NZ brought in a focus on performance management, accountability, efficiency, and a customer focus (Boston et al., 1996; Haworth & Pilott, 2014) in the delivery of public services. As a result, the tool of targets has become deeply entrenched in the delivery of public services, particularly healthcare.

The NZ healthcare system operates via a quasi-market structure, with entities that are performance managed through both departmental head performance management and organisational performance mechanisms. Targets are an organisational performance mechanism. Introduced in 2007, the National Health Targets have been through several iterations. ED LOS targets were introduced in 2009 and have been highly public and topical; including their withdrawal from public publishing during this research period. Targets have been justified by government as a means to ensure performance, accountability and provide transparency. The targets were also meant to address issues of poor service, crowded EDs and long ED waits.

Broadly this research sought to understand further how ideologies filter down and impacted Service Users. More specifically, it sought to gain an understanding of how Service Users make sense of targets. The research taking an Interpretative Phenomenological Analysis approach and utilising Reflexive Thematic Analysis for data analysis did not seek to measure the quality of public services but rather understand the service delivery from a Service Users perspective. There was not any intent for generalisation. Instead, as exploratory research, the objective was to identify landmarks for further investigation.

A Reflexive Thematic Analysis approach guided the data analysis. Reflexive thematic analysis is a method (Braun & Clarke, 2006; Braun et al. 2019; Braun & Clarke, 2012) for analysing and reporting data. A rich description of the data set was sought as opposed to a detailed account of an aspect of the topic. This is appropriate given that the area is under-researched and that the research sought to explore broadly the complexity and variance in factors and views held by participants (Creswell & Plano Clark, 2018).

The findings indicate that within the NZ publicly funded ED context, Service Users have expectations of the experience. These expectations mediate their experience, particularly their assessment of satisfaction. During their ED visit Service Users are going through a sense-making process. One of which is to rationalise and justify ED staff busyness and negative staff interactions. In doing so, Service Users shift the blame away from ED staff to management and other Service Users. With respect to waiting, and within the NZ context, the findings indicate that most Service Users expect to wait while in ED.

The concept of satisfaction, even when limited to an ED experience, is complex. In addition to the components of ED satisfaction identified, which are consistent with previous literature, these findings further identify that 1) expectations mediate experience, 2) that waiting is not, in and of itself, an issue, meaning that satisfaction factors mediate each other and 3) the nuance between the satisfaction with the quality of care and the quality of the overall experience. With respect to targets, Service Users are generally not aware they existed. They also have conflicting views on whether or not there should be targets, and in what form.

As exploratory research the conclusion that targets improve service delivery is investigated. By reviewing the existing research on targets' role in improving service delivery it is apparent that there is a lack of understanding of from the Service Users' perspective. This research adds to the literature on the role of targets improving service delivery by exploring service delivery from a Service Users perspective. Existing research on targets examines if a target is achieved and if there are any unintended side effects. However, this research posits that ED LOS targets, although meant to be a means to improve the Service User experience, run counter to this in two ways. The first way is that the target most likely meets the needs of citizens not Service Users. The second, is that targets become divorced from the overall user experience.

These findings further add to the literature on both the ED context of satisfaction and public service delivery. The findings highlighted above are, prima facie, relevant to hospital management and frontline staff in addressing the experience of individuals. At the service delivery level interwoven across the discussion points linked to the macro-level discussion is the distinction between citizens and Service Users. This research highlights a potential disconnect between which stakeholders performance measures serve. In this case of ED experience stakeholders, they most likely directly serve citizens as they do not appear to serve Service Users *directly*. They may *indirectly* serve Service Users, in theory, through improved ED throughput performance. This is because the targets do not appear to have shaped Service Users expectations about visiting ED. It is hypothesised that they directly serve citizens through the way in which government use them to communicate performance. Overall this highlights the difference between the needs of citizens and Service Users. Further, the findings of this research and the discussion moves away from the appropriateness of applying targets, as assumed to be a private sector practice, to the public sector towards a focus on how targets provide value and to who.

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Appendices

Appendix A

New Public management Content Themes

Hood (1991) – Table 1 p. 4-5	Pollitt (1995) – Table 1 p. 134
'Hands-on professional management' in the public sector	Cost cutting, capping budgets and seeking greater transparency in resource allocation
Explicit standards and measures of performance	Disaggregating traditional bureaucratic organisations to separate agencies
Greater emphasis on output controls	Decentralisation of management authority *within* public agencies
Shift to disaggregation of units in the public sector	Separating the function of providing public services from that of purchasing them
Shift to greater competition in public sector	Introducing market and quasi market-type mechanism
Stress on private sector styles of management practice	Requiring staff to work to performance targets, indicators and output objectives (performance management)
Stress on greater discipline and parsimony in resource use	Shifting the basis of public employment from permanency and standard national pay and conditions towards term contracts and local determination of pay and conditions
	Increasing emphasis on service ‘quality’, standard setting and ‘customer responsiveness’

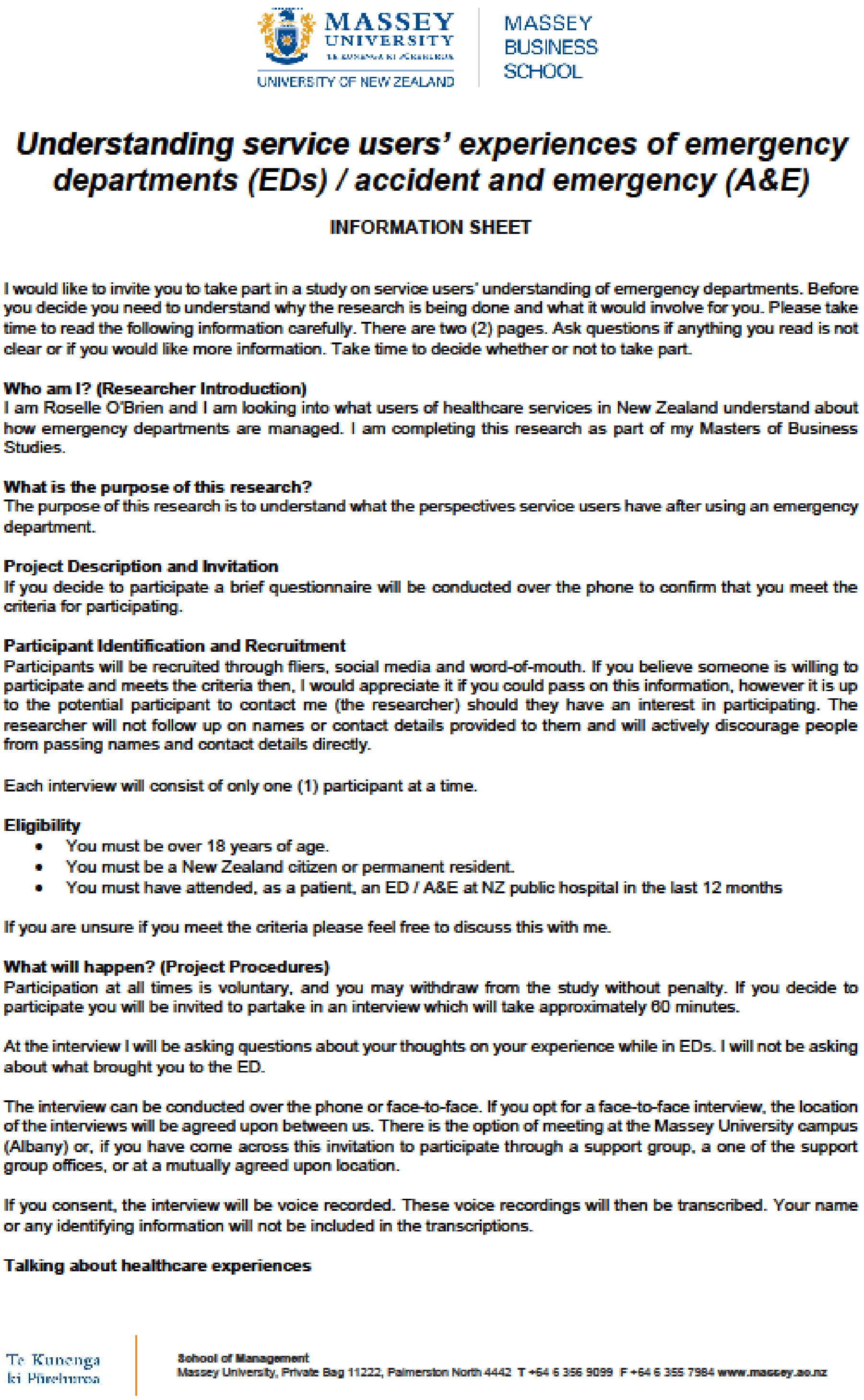
Appendix B

Change in targets

Targets in 2007/2008 & 2008/2009	Targets in 2009/2010	Type of change
Improving Immunisation Coverage	Increased immunisation	Renamed; New staggered timeline to achieving the original 95% rate introduced (i.e. achievement set for 85% then 90% and finally 95%)
Improving Oral Health	-	Discontinued
Improving Elective Services	Improved access to elective surgery	Renamed; Changed from agreement on compliance with Elective Services Patient Flow Indicators and an agreed discharges to a national average of increased discharges.
Reducing Cancer Waiting Times	Shorter waits for cancer treatment	Renamed; Change from only certain categories of patients receiving care within 8 weeks to all patients requiring radiation treatment only within 6 weeks as an interim time frame and 4 weeks as a final time frame.
Reducing Ambulatory Sensitive (Avoidable) Hospital Admissions	-	Discontinued
Improving Diabetes	Better diabetes and cardiovascular services	Renamed; Expanded to include cardiovascular services and changes to what is measured and how.
Improving Nutrition, Increasing Physical Activity and Reducing Obesity	-	Discontinued
Reducing the Harm Caused by Tobacco	Better help for smokers to quit	Renamed; Changed from measure of outcomes to services conducted.
Reducing the Percentage of the Health Budget Spent by the Ministry of Health	-	Discontinued
-	**Shorter Stays in emergency departments**	**New**

Appendix C

Service Users Information Sheet



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

MASSEY
BUSINESS
SCHOOL

Understanding service users' experiences of emergency departments (EDs) / accident and emergency (A&E)

INFORMATION SHEET

I would like to invite you to take part in a study on service users' understanding of emergency departments. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. There are two (2) pages. Ask questions if anything you read is not clear or if you would like more information. Take time to decide whether or not to take part.

Who am I? (Researcher Introduction)
I am Roselle O'Brien and I am looking into what users of healthcare services in New Zealand understand about how emergency departments are managed. I am completing this research as part of my Masters of Business Studies.

What is the purpose of this research?
The purpose of this research is to understand what the perspectives service users have after using an emergency department.

Project Description and Invitation
If you decide to participate a brief questionnaire will be conducted over the phone to confirm that you meet the criteria for participating.

Participant Identification and Recruitment
Participants will be recruited through fliers, social media and word-of-mouth. If you believe someone is willing to participate and meets the criteria then, I would appreciate it if you could pass on this information, however it is up to the potential participant to contact me (the researcher) should they have an interest in participating. The researcher will not follow up on names or contact details provided to them and will actively discourage people from passing names and contact details directly.

Each interview will consist of only one (1) participant at a time.

Eligibility

- You must be over 18 years of age.
- You must be a New Zealand citizen or permanent resident.
- You must have attended, as a patient, an ED / A&E at NZ public hospital in the last 12 months

If you are unsure if you meet the criteria please feel free to discuss this with me.

What will happen? (Project Procedures)
Participation at all times is voluntary, and you may withdraw from the study without penalty. If you decide to participate you will be invited to partake in an interview which will take approximately 60 minutes.

At the interview I will be asking questions about your thoughts on your experience while in EDs. I will not be asking about what brought you to the ED.

The interview can be conducted over the phone or face-to-face. If you opt for a face-to-face interview, the location of the interviews will be agreed upon between us. There is the option of meeting at the Massey University campus (Albany) or, if you have come across this invitation to participate through a support group, a one of the support group offices, or at a mutually agreed upon location.

If you consent, the interview will be voice recorded. These voice recordings will then be transcribed. Your name or any identifying information will not be included in the transcriptions.

Talking about healthcare experiences

Te Kunenga
ki Pūrehuroa

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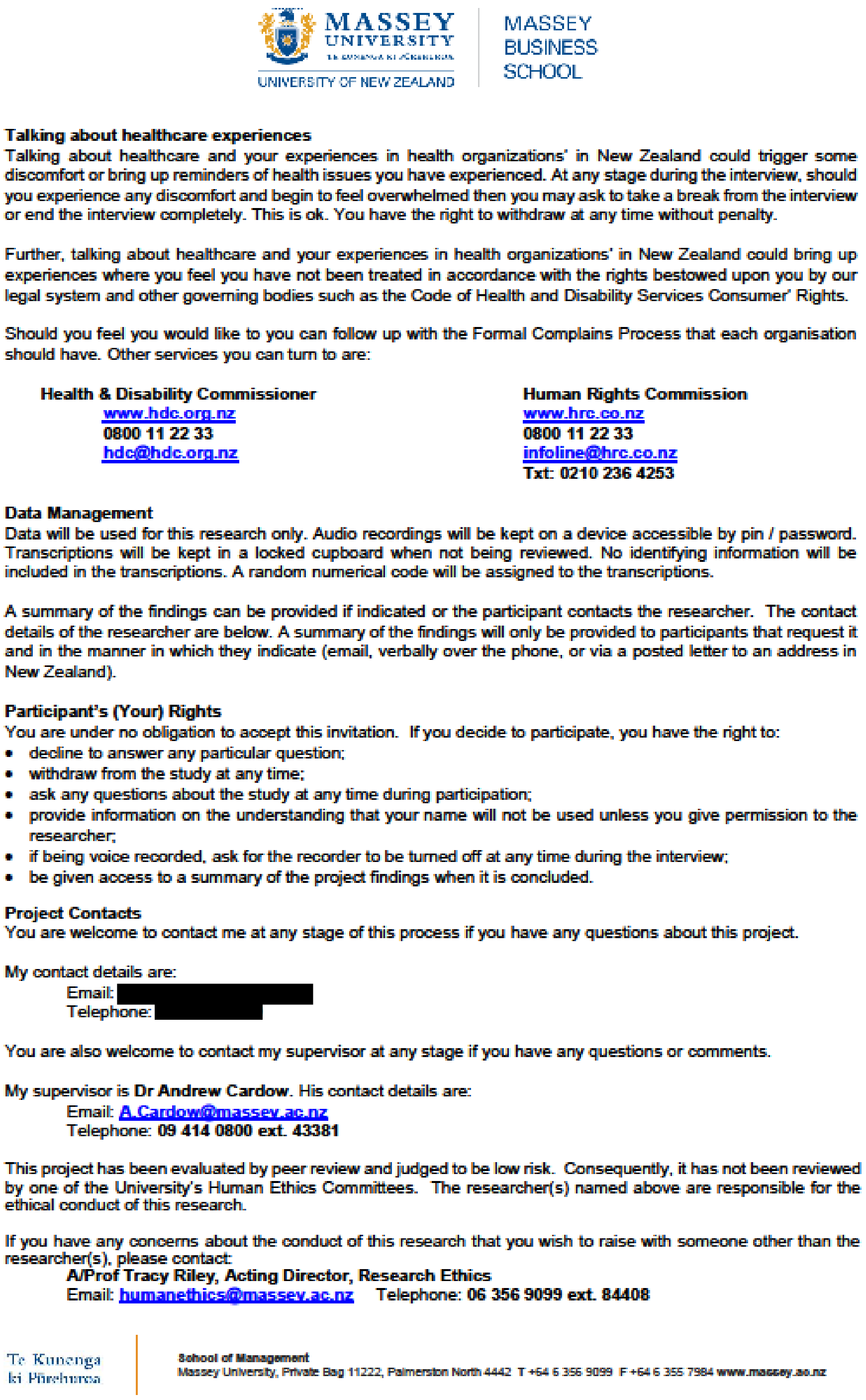

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TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND
MASSEY BUSINESS SCHOOL

Talking about healthcare experiences
Talking about healthcare and your experiences in health organizations' in New Zealand could trigger some discomfort or bring up reminders of health issues you have experienced. At any stage during the interview, should you experience any discomfort and begin to feel overwhelmed then you may ask to take a break from the interview or end the interview completely. This is ok. You have the right to withdraw at any time without penalty.

Further, talking about healthcare and your experiences in health organizations' in New Zealand could bring up experiences where you feel you have not been treated in accordance with the rights bestowed upon you by our legal system and other governing bodies such as the Code of Health and Disability Services Consumer' Rights.

Should you feel you would like to you can follow up with the Formal Complains Process that each organisation should have. Other services you can turn to are:

Health & Disability Commissioner	**Human Rights Commission**
www.hdc.org.nz	www.hrc.co.nz
0800 11 22 33	**0800 11 22 33**
hdc@hdc.org.nz	infoline@hrc.co.nz
	Txt: 0210 236 4253

Data Management
Data will be used for this research only. Audio recordings will be kept on a device accessible by pin / password. Transcriptions will be kept in a locked cupboard when not being reviewed. No identifying information will be included in the transcriptions. A random numerical code will be assigned to the transcriptions.

A summary of the findings can be provided if indicated or the participant contacts the researcher. The contact details of the researcher are below. A summary of the findings will only be provided to participants that request it and in the manner in which they indicate (email, verbally over the phone, or via a posted letter to an address in New Zealand).

Participant's (Your) Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- if being voice recorded, ask for the recorder to be turned off at any time during the interview;
- be given access to a summary of the project findings when it is concluded.

Project Contacts
You are welcome to contact me at any stage of this process if you have any questions about this project.

My contact details are:
Email: [redacted]
Telephone: [redacted]

You are also welcome to contact my supervisor at any stage if you have any questions or comments.

My supervisor is **Dr Andrew Cardow**. His contact details are:
Email: A.Cardow@massey.ac.nz
Telephone: **09 414 0800 ext. 43381**

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

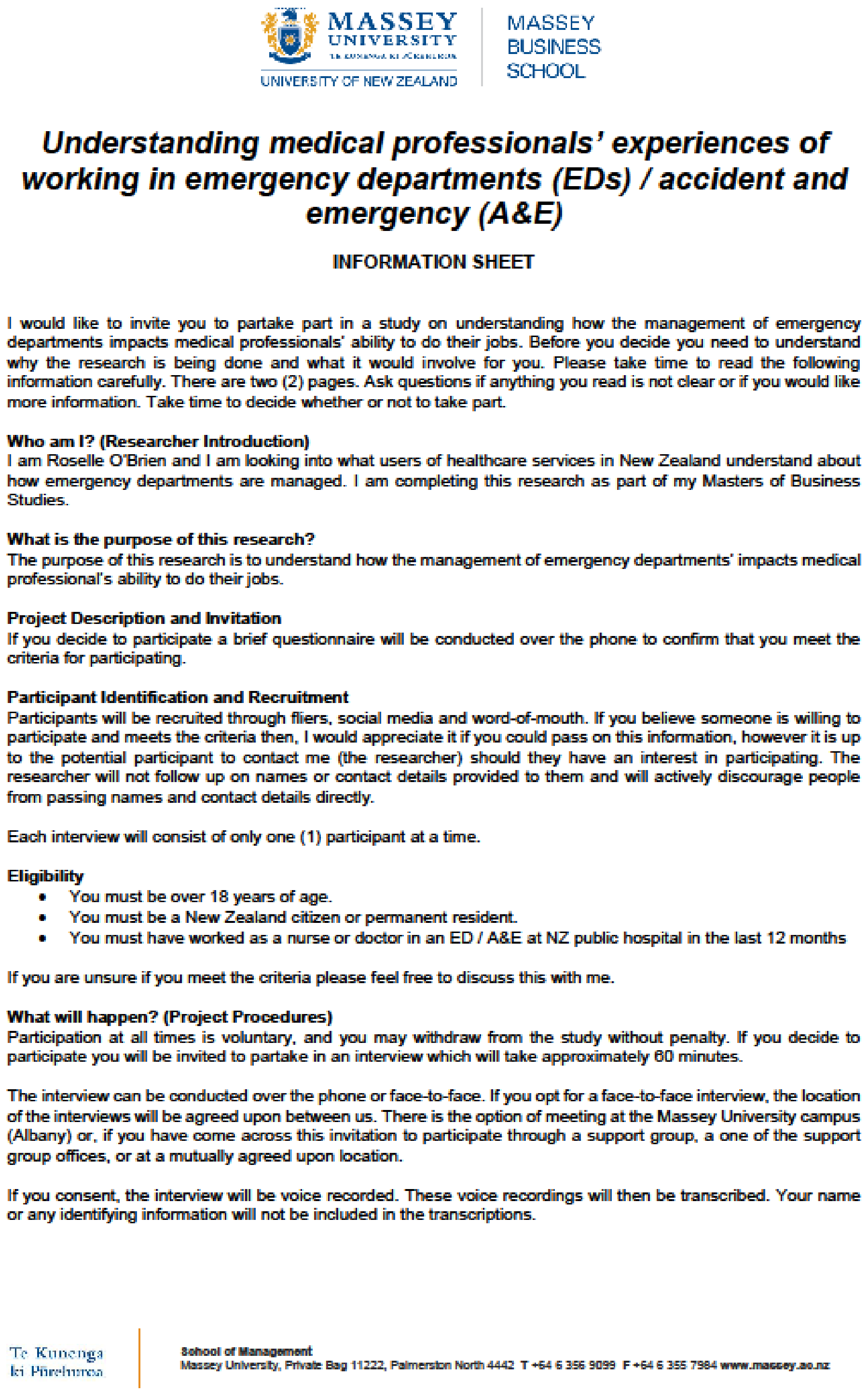
If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact:
A/Prof Tracy Riley, Acting Director, Research Ethics
Email: humanethics@massey.ac.nz Telephone: **06 356 9099 ext. 84408**

Te Kunenga ki Pūrehuroa

School of Management
Massey University, Private Bag 11222, Palmerston North 4442 T +64 6 356 9099 F +64 6 355 7984 **www.massey.ac.nz**

Appendix D

Medical Staff Information Sheet



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

MASSEY
BUSINESS
SCHOOL

Understanding medical professionals' experiences of working in emergency departments (EDs) / accident and emergency (A&E)

INFORMATION SHEET

I would like to invite you to partake part in a study on understanding how the management of emergency departments impacts medical professionals' ability to do their jobs. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. There are two (2) pages. Ask questions if anything you read is not clear or if you would like more information. Take time to decide whether or not to take part.

Who am I? (Researcher Introduction)
I am Roselle O'Brien and I am looking into what users of healthcare services in New Zealand understand about how emergency departments are managed. I am completing this research as part of my Masters of Business Studies.

What is the purpose of this research?
The purpose of this research is to understand how the management of emergency departments' impacts medical professional's ability to do their jobs.

Project Description and Invitation
If you decide to participate a brief questionnaire will be conducted over the phone to confirm that you meet the criteria for participating.

Participant Identification and Recruitment
Participants will be recruited through fliers, social media and word-of-mouth. If you believe someone is willing to participate and meets the criteria then, I would appreciate it if you could pass on this information, however it is up to the potential participant to contact me (the researcher) should they have an interest in participating. The researcher will not follow up on names or contact details provided to them and will actively discourage people from passing names and contact details directly.

Each interview will consist of only one (1) participant at a time.

Eligibility

- You must be over 18 years of age.
- You must be a New Zealand citizen or permanent resident.
- You must have worked as a nurse or doctor in an ED / A&E at NZ public hospital in the last 12 months

If you are unsure if you meet the criteria please feel free to discuss this with me.

What will happen? (Project Procedures)
Participation at all times is voluntary, and you may withdraw from the study without penalty. If you decide to participate you will be invited to partake in an interview which will take approximately 60 minutes.

The interview can be conducted over the phone or face-to-face. If you opt for a face-to-face interview, the location of the interviews will be agreed upon between us. There is the option of meeting at the Massey University campus (Albany) or, if you have come across this invitation to participate through a support group, a one of the support group offices, or at a mutually agreed upon location.

If you consent, the interview will be voice recorded. These voice recordings will then be transcribed. Your name or any identifying information will not be included in the transcriptions.

Te Kunenga
ki Pūrehuroa

School of Management
Massey University, Private Bag 11222, Palmerston North 4442 T +64 6 356 9099 F +64 6 355 7984 www.massey.ac.nz

Data Management

Data will be used for this research only. Audio recordings will be kept on a device accessible by pin / password. Transcriptions will be kept in a locked cupboard when not being reviewed. No identifying information will be included in the transcriptions. A random numerical code will be assigned to the transcriptions.

A summary of the findings can be provided if indicated or the participant contacts the researcher. The contact details of the researcher are below. A summary of the findings will only be provided to participants that request it and in the manner in which they indicate (email, verbally over the phone, or via a posted letter to an address in New Zealand).

Participant's (Your) Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- if being voice recorded, ask for the recorder to be turned off at any time during the interview;
- be given access to a summary of the project findings when it is concluded.

Project Contacts

You are welcome to contact me at any stage of this process if you have any questions about this project.

My contact details are:
Email: [redacted]
Telephone: [redacted]

You are also welcome to contact my supervisor at any stage if you have any questions or comments.

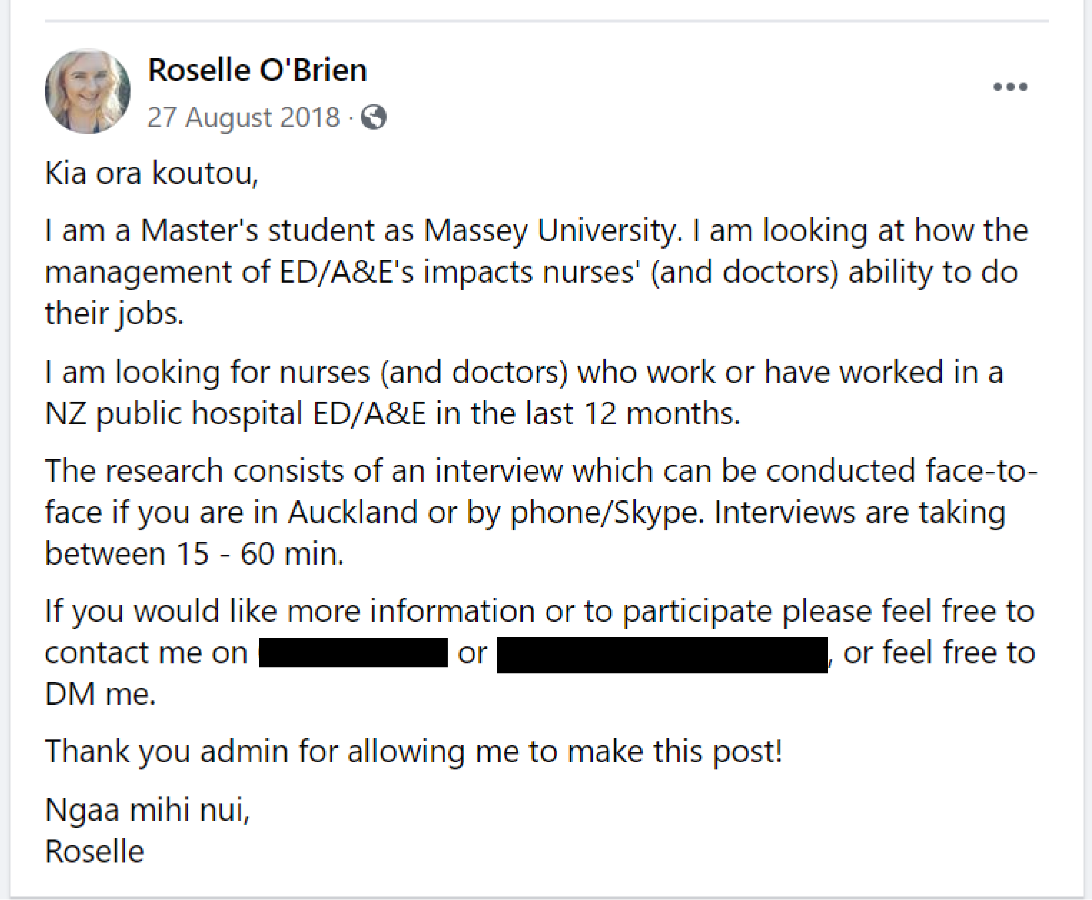
My supervisor is **Dr Andrew Cardow**. His contact details are:
Email: A.Cardow@massey.ac.nz
Telephone: **09 414 0800 ext. 43381**

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact:
A/Prof Tracy Riley, Acting Director, Research Ethics
Email: **humanethics@massey.ac.nz**
Telephone: **06 356 9099 ext. 84408**

Appendix E

NZNO Facebook Post



Roselle O'Brien

27 August 2018 ·

Kia ora koutou,

I am a Master's student as Massey University. I am looking at how the management of ED/A&E's impacts nurses' (and doctors) ability to do their jobs.

I am looking for nurses (and doctors) who work or have worked in a NZ public hospital ED/A&E in the last 12 months.

The research consists of an interview which can be conducted face-to-face if you are in Auckland or by phone/Skype. Interviews are taking between 15 - 60 min.

If you would like more information or to participate please feel free to contact me on [redacted] or [redacted], or feel free to DM me.

Thank you admin for allowing me to make this post!

Ngaa mihi nui,
Roselle

Appendix F

Kai Tiake Letter to the Editor Text

Research participants wanted: Understanding medical professionals' experiences of working in emergency departments (EDs) / accident and emergency (A&E)

Kia ora, my name is Roselle O'Brien and I am a master's student at Massey University. I am looking at how the management of emergency departments impacts medical professionals' ability to do their jobs.

I am looking for nurses (and doctors) who work or have worked in a NZ public hospital ED/A&E in the last 12 months who would be willing to have a chat with me about what it's like to work in ED/A&E.

The research consists of an interview which can be conducted face-to-face if you are in Auckland or by phone/Skype. Interviews are taking between 15 - 60 min.

If you would like more information or to participate please feel free to contact me on [redacted] or [redacted].

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact:

A/Prof Tracy Riley, Acting Director, Research Ethics

Email: **humanethics@massey.ac.nz**

Telephone: **06 356 9099 ext. 84408**

Appendix G

Participant Eligibility and Screening Questionnaire

<u>These questions must all be **yes** to proceed.</u>

- Are you older than 18?
- Are you a New Zealand citizen or permanent resident?
- Have you attended, as a patient, an A&E at a public hospital in in the last 12 months? **OR**
- Have you worked in a medical capacity in an A&E at a public hospital in in the last 12 months?

Hospital List

- Auckland City Hospital
- Tauranga Hospital
- Whakatane Hospital
- Ashburton Hospital
- Burwood Hospital
- Chatham Island Health Centre
- Christchurch Hospital
- Darfield Hospital
- Ellesmere Hospital
- Kaikoura Hospital
- Oxford Hospital
- Rangiora Hospital
- The Princess Margaret Hospital
- Tuarangi Home
- Waikari Hospital
- Kenepuru Hospital
- Wellington Hospital
- Middlemore Hospital
- Hawke's Bay Hospital
- Wairoa Hospital & Health Centre
- Hutt Valley Hospital
- Rotorua Hospital
- Taupo Hospital
- Palmerston North Hospital
- Nelson Hospital
- Wairau Hospital
- Bay of Islands Hospital
- Dargaville Hospital
- Kaitaia Hospital
- Whangarei Hospital
- Timaru Hospital
- Dunedin Hospital
- Lakes District Hospital
- Southland Hospital
- Wakari Hospital
- Gisborne Hospital
- Hawera Hospital
- Taranaki Base Hospital
- Matariki Hospital
- Rhoda Read Hospital
- Taumarunui Hospital and Family Health Team
- Te Kuiti Hospital
- Thames Hospital
- Tokoroa Hospital
- Waikato Hospital
- Wairarapa Hospital
- North Shore Hospital
- Waitakere Hospital
- Grey Base Hospital
- Whanganui Hospital

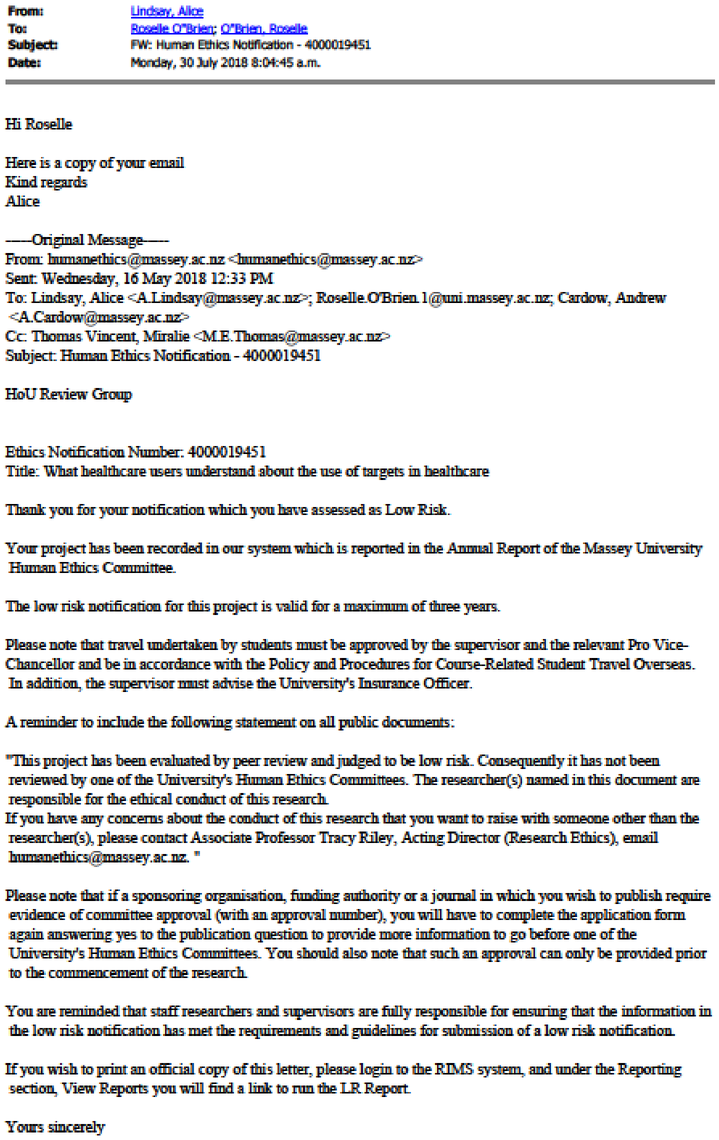
Appendix H

Interview Prompts

1. **Are you aware of any targets used in healthcare in New Zealand?**
   - If yes – please explain.
   - If no – next question.
2. **Are you aware of any targets used in the [refer to healthcare service that qualified them for this interview]?**
   - If yes – please explain.
   - If no – explain targets in place.
3. **Who do you think sets these targets?**
4. **Why do you think this / these targets are set?**
5. **What do you think is achieved by setting this / these targets?**
6. **Who do you think is responsible for ensuring targets are achieved?**
7. **Does the use of targets install a sense of trust in the system?**
8. **What does a customer focus in healthcare mean to you?**
9. **What does equity in healthcare mean to you?**
10. **What does accountability in healthcare mean to you?**

Appendix I

Ethics Approval



From: Lindsay, Alice
To: Roselle O'Brien; O'Brien, Roselle
Subject: FW: Human Ethics Notification - 4000019451
Date: Monday, 30 July 2018 8:04:45 a.m.

Hi Roselle

Here is a copy of your email
Kind regards
Alice

-----Original Message-----
From: humanethics@massey.ac.nz <humanethics@massey.ac.nz>
Sent: Wednesday, 16 May 2018 12:33 PM
To: Lindsay, Alice <A.Lindsay@massey.ac.nz>; Roselle.O'Brien.1@uni.massey.ac.nz; Cardow, Andrew <A.Cardow@massey.ac.nz>
Cc: Thomas Vincent, Miralie <M.E.Thomas@massey.ac.nz>
Subject: Human Ethics Notification - 4000019451

HoU Review Group

Ethics Notification Number: 4000019451
Title: What healthcare users understand about the use of targets in healthcare

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Associate Professor Tracy Riley, Acting Director (Research Ethics), email humanethics@massey.ac.nz. "

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish require evidence of committee approval (with an approval number), you will have to complete the application form again answering yes to the publication question to provide more information to go before one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

You are reminded that staff researchers and supervisors are fully responsible for ensuring that the information in the low risk notification has met the requirements and guidelines for submission of a low risk notification.

If you wish to print an official copy of this letter, please login to the RIMS system, and under the Reporting section, View Reports you will find a link to run the LR Report.

Yours sincerely

Appendix J

Reflexive Thematic Analysis – Self Developed Guide

Step	Name	What it is / My Notes	How I did it (and any variance)
1	Familiarisation	• Getting to know the data; making notes; initial reflections from engaging with the data • Not coding the data • Messy, stream of conscious notes	• Initial notes • Re-reading notes • Self-transcribing or reviewing transcribing • Re-listening to interviews
2	Generating codes	• Inductive / latent (what meaning may be below the surface) • Semantic / descriptive (what is the participant saying) • Beginning to label • May stay close to participant language or be put in a theoretical, academic or other jargon-based phrase • Code everything (you can discard later) • " but there is no right or wrong way to manage the physical process of coding. Work out what suits you best. What is important is that coding is inclusive, thorough, and systematic" (Braun & Clarke, 2012)	• I took an inductive approach - codes beside interviews both transcribed interviews and notes of interviews) • Both semantic and latent identified - some are words said - other are summaries of what phrases of words said that often aligned to single words said • However, I did this concurrently not sequentially

3	Constructing themes	• Creating coding blocks • A theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82) • Themes do not emerge - they are actively generated and constructed • Themes like a jigsaw - and start to tell a story • Keep a miscellaneous theme section • "Remember, your job in analyzing the data, and reporting them, is to tell a particular story about the data, that answers your research question. It is not to represent everything that was said in the data" (Braun & Clarke, 2012, p. 65)	• Transferred themes to paper away from the interviews • This was both in textbook form and 'mind-map' form (similar to the thematic maps highlighted by Braun et al. 2019 p. 856); Braun & Clarke, 2012 • Moved themes around, drew lines, amended words chosen to describe themes
4	Revising	• Review themes in line with whole data set • Is this a theme (it could be just a code)? ■ If it is a theme, what is the quality of this theme (does it tell me something useful about the data set and my research question)? ■ What are the boundaries of this theme (what does it include and exclude)? ■ Are there enough (meaningful) data to support this theme (is the theme thin or thick)? ■ Are the data too diverse and wide ranging (does the theme lack coherence)? (Braun & Clarke, 2012, p. 65)	• Themes were adjusted and re-ordered and 'tired on for fit' • Re-read notes and re-listened to interviews (interviews listened to either in sections, or in full without taking notes to simply - 'take in the whole conversation'

5	Defining themes	• A good thematic analysis will have themes that (a) do not try to do too much, as themes should ideally have a singular focus; (b) are related but do not overlap, so they are not repetitive, although they may build on previous themes; and (c) directly address your research question. (Braun & Clarke, 2012, p. 66) • The difference between steps 5 and 6 can be blurry	• Commenced writing paragraphs to unite the themes • This process of articulating that the theme was and how it related or contradicted another theme lead to going back and forth through stages 1-5 in an iterative process
6	Producing the report	• Not simply a writing up exercise • Seeking to answer the research question • "(your research question can be “tweaked” for better fit at this point" (Braun et al. 2019, p. 857) • What about the theme is interesting and why; still need to form an argument to answer the research question • Is part of the analysis	• Merged two sub-themes for ease of reading • Did not refer back to the initial data collected (audio) or notes. Only reviewed from written up themes in Findings section