Supplementary material 7. Framework analysis of telephone surveys and case study interviews

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
Outer setting				
Patient need	"The population is becoming older. For every year that passes, the proportion of people over seventy-five goes up by one or two percent. So we're seeing a gradual, but sustained, demographic shift." [5]	"Patients are more complex than they ever were, but crucially the expectation is entirely different to what it was when I was a kid. And I think that's a really big issue." [1]	"…it's a shame we weren't having these conversations 10 years ago, when we could have already developed a service to pre-empt this', because we've known about the demographic time bomb for a long, long time" [1]	"Our challenges are really around that and deprivation, and therefore a reliance on... well a borough that has had its resources severely curtailed over the last five years" [3]
			"Life expectancy still goes up two months every year, so it's going to continue, and there's no signs of the long term trend changing, so it's going to be a problem. " [1]	

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
Networking with other organisations	"I don't think we do enough of that, I think, … that's perhaps a symptom of our location, so really any other hospital is almost twenty miles in any, any direction from here." [1]	"One of the stroke consultants has the most onerous job plan of all of us. It's been at times up to 14 PAs a week –" *Oh gosh, right.* Because he covers stroke at X Hospital as well. It's a sore point because they don't necessarily cover us to the same degree." [2]	"We've tried to do some networking based upon the STP footprint with colleagues …, who are the two other EDs that are in our slightly geographically challenging area." [1]	"We have the cancer network, we have the allergy network, we have the asthma network." [1 and 2]

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
			"there's a significant programme of work across multiple organisations in terms of improving and standardising our frailty pathways" … "We are also having some conversations with other local organisations about shared rotas, so in some cases we have rotas which with the very small numbers of people on them which is obviously quite demanding on people's time and not really sustainable, so where we've got smaller specialties we are having conversations about having joint rotas." [2]	"We've never done rotational posts, no. And I think we do struggle a little bit. I think they'll come here, get their first post, get their bit of grounding and then they go off ..." [5]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
	"The cardiologists also don't provide overnight on-call: that's provided from X as well. So if we had somebody with primary PCI, they'd go straight to X; if somebody is seen in the ED and needs to be transferred, they'd go straight from there. We've got three of our cardiologists are joint posts with X." [5]			"I think for us possibly more than other organisations, joint working is probably a key element. From our perspective we're a very small player and so our ability to extract competitive prices from suppliers is reduced. … On the clinical services piece the issue for us is around scale, particularly in certain specialties and the solution to those issues lie in partnership or networked arrangements." [6] "Things that have been very integrated for a long time are falling apart: like ENT and neurology and things, with people at [other hospitals] going, 'We don't want to provide the specialist service'." [7]

Site:	**Site A**	**Site B**	**Site C**	**Site D**
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Peer or external pressures	"Locally the experience of accident and emergency and acute medical services in X which have had to take on a lot of X's work have been quite negative from what I understand from colleagues at X, they're a lot more busy, their waiting times have gone up." [2]	"The STP and the county-wide sustainability and transformation plan is necessitating us looking at … consolidation of services perhaps but certainly looking at certain services. You know, does a little hospital like this need to have all the services that we currently have? Rheuma-holiday, derma-holiday, those sorts of things, do we really need them here?" [1]	"The trust won't offer up-front, lump sum payments for people to come and work here, as other places do, and it's a shame the NHS doesn't have a joined together view on that …[1]	"I think we are a niche. We advertise ourselves, A: that we are pretty consultant-positive, so-to-speak as in, we are a group that wants to teach people about EM; we're big on teaching and training; we'll be present on the shop floor to provide the support so, hopefully, it's not a complete 'Oh, my God!' zone. We'll offer them something different." [4]

Site:	Site A	Site B	Site C	Site D
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	"The anxiety there that's articulated by MDs and chief executives is, 'What are you going to do to our A&E?' Because, it's a badge of honour, having and A&E because one of the things that NHS Improvement measure you on is your A&E performance. And then the local politicians who are, 'What are you going to do our population's A&E?' because, again, it's a badge of honour to have a hospital that's fully functional." [5]			"It's clearly a threat on paper; I think touch wood and thus far both our financial and operational performances are strong enough to provide a counter balance to that direction of travel." … "The key thing for us is to have a counter narrative which probably lies in two ways. One is around our integration into the local health and social care economy, so we provide community services in X as well as acute services, so the more we can embed ourselves into a X narrative that is a story. And the second point is the one I was just making around networks, so if we were already networking effectively into tertiary centres and having those pathways working efficiently, again that's quite a neat story." [6]
				"The bickering between us and the specialist centre about where the trainees go, I think is an active issue in that." [7]

Site:	Site A	Site B	Site C	Site D
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Local external landscape	"If we had better wrap around services in the community we would have better options for our patients, so pre-admission, to avoid admission, if we had more responsive services in the community." [3]	"X, Y, who was the previous medical director, and myself to a lesser degree spent a lot of time visiting every single practice and spending, you know, an hour or so a number of times with them talking about the kind of the burning platform, but also our vision. So there's an awful lot of groundwork and that is bearing fruit now. It was very difficult just to try and jump in bed with the GPs." [1]	"We'd really like an urgent care centre but we can't make that decision in isolation of the commissioners and they don't really want an urgent care centre." "The relationship with the commissioners is challenging and we've had some issues as well around ambulatory from a commissioning perspective because the commissioners basically don't want to pay what it's currently costing." [2]	"The other big advantage we have is that we do run the intermediate care, we do run the district nursing, we do have very good links with our GPs, so the vertical integration stuff I think is probably the way to go, and then there is increasing talk about integration between social and healthcare." [3]
	"One of the disappointing things about this organisation: that it's got itself into a very difficult situation with the local CCGs. They're at arbitration about money and it's not a good place to be. And I've seen things deteriorate in terms of the language on both sides and the behaviour between the two of them. It's a great shame."… "And it's a reflection of NHS England on one hand and NHS Improvement on		"We had really good buy-in from the CCG, regarding the ambulatory care centre when it first opened. I'm not sure them relationships are as good now as they were in the beginning." [5]	"The STP thing is quite interesting; it's still probably a bit unclear as to where that will go and what that may mean. Given our size we have to be an active participant in that process and we have to be an engine for solutions because otherwise, if we retreat into a shell and try and be obstructive because of our size, that's not going to work, so I think the strategy for us, if you can call it a strategy, is to try and be both engaged and

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
	the other hand, bearing down on the two separate organisations. It isn't helpful towards joint working." [5]			proactive and by doing so try to extract selfish benefits for ourselves from it." "It's also the way we've approached general relationships over the last few years, to try and be as engaged as possible, both because it's the right thing to do, but also because that's the only way we're going to potentially resolve some of the conundrums we face." "Some fairly active work was done, and it's still going on but it was done more actively probably four or five years ago, around joint pathway development. So over a period of years we did have GPs and consultants sitting down to design clinical pathways that they both felt comfortable with, ending up with things like referral criteria etc, but more around elective and out-patient flows than emergency stuff. But the act of people sitting together to work through the pathway engenders a bit of trust." [6]

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
External policy landscape	"What I would change here: I think there's something about the regulatory regime. And that's not the organisation: that's probably NHS Improvement and CQC: is that I think too much of our time as an organisation is spent giving assurance to external bodies and spending a lot of time on it."… "I would say the… Ninety-day programme for NHS Improvement North that X was leading was refreshing in that. And I think it was as near to inspirational as you'll get." [5]	"We're involved in these NHS England 100 day projects. We're a week into it now. The whip's being cracked. What's your goals, what have you done today, who have you phoned. But we've revolutionised, trying to revolutionise this sort of primary care, secondary care management referring patients follow up model." [2]	"We've just had our CQC now and we had one two years ago, whereby one of the things that they found that the trust needed, that requires improvement, was leadership, so as a result of that there's been pretty much a complete transformation in medical and other leadership in the trust." [1]	"If you can meet the criteria for seven day services the NHS London criteria, , if you can meet them with a model that has 15 consultants on it, also doing other stuff, then it seems to make more sense, and people seem to get less burnt out." [3]

Site:	Site A	Site B	Site C	Site D
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	"The Safer Flow Bundle has had a really big effect and of that one of the things to my mind that's had the biggest effect is the weekly review of patients over seven days." [6]	"From a government point of view in the last 10 or 15 years, they slashed the nursing budget for training. So I think it'd be naive for any of us to think that wasn't going to have an impact at some point." [5&6]	"At the moment we are on track to deliver our planned control data which means that we'll get an extra £8 million from NHS Improvement which is quite frankly amazing." [2]	"Sometimes a number of those standards don't seem to have clinical respect on the ground, so that is always interesting where you've got clinicians responding against recommended numbers and against recommended numbers and recommended standards. The other big issue is the disconnect between those kinds of guidance documents and financial reality, so how are we meant to afford them." [6]
			"If we can then get a Good from the CQC I think that will then change the perception to encourage people to want to come and work here" [3]	
Inner setting				

<u>Site:</u>	**Site A**	**Site B**	**Site C**	**Site D**
<u>Consolidated Framework for Implementation Research Domains and Constructs</u>				
Structural characteristics	"The registrar room's quite useful. Well, that certainly helps massively: if you can just walk into a coffee room – and, actually, it's in a closed, four-walls and confidential environment – and just go, 'Can I just show you this X-ray?'" [4]	"This place is a very, very different place now than it was five six years ago, sorry ten years ago. Before it was managed very tightly. Our budget was bang on, fiscally we were fine but there wasn't much energy. We did an okay job. What X did and he's got his faults – and I say this to him because I'm not betraying any confidences – he's incredibly enthusiastic. He wears his heart on his sleeve and he's really quite visionary." [1]	"Parts of it are really old and someone told me today that a fuse went and it cost £16,000 to get the lights working again because the lights are so old, but all of the electrics are so old that it's much more expensive to repair stuff when things go wrong." [2]	"We don't have any space here. And I think, if we could just have more space ... our patients are in a bay with six beds , most trusts only have four. And I think that does make it feel quite crowded. And I think, if you have more space, the patients would probably feel a bit more relaxed." [5]
Culture	"We're very lucky here with the culture in that, certainly my experience – clinical or non-clinical – is that it's very much about patient care here. And I think that the consultants, in the main, are very patient-focussed and that feeds down throughout all levels." FGS	"We're open for new ideas and realising that we can't stay still and very much working with our community colleagues, looking for change, so it punches above its weight from that point of view." [FGS]	"We needed to meet the target for A&E this month. We had a lower target of 90%. We started off the month quite badly. It was really, really challenging. And then, over the last two-and-a-half/three weeks, we've just all pulled together and it's absolutely amazing what you can do as an organisation when everybody's on the same page." [5]	"It's enabling of innovation from the top down and it's good relationships and size of the hospital that really, that enables the bottom up, both together." [FGS]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
	"The consultant body that we've got at the moment is fantastic, it's the best it has been; we've lost one consultant to retirement recently, another one who's left, but the ones we've got, we're solid, we're a really tight, cohesive team, we're all on the same page, so work life is very easy and enjoyable because of that, and the team's good." [7]	"I know this Trust is not perfect but we do care about what we do, we do care about the patients. And if someone doesn't care, you can make something about that and you can improve things which is one of the things that makes me believe in what I do here and what we do here." [3]		"People get on with each other, by and large, I think there's a general idea that if you come and work here you're going to do general medicine, not just be a superstar specialist, and people are interested in it and people have good ideas, and people are constructive." [3]
				"I think we're also quite open. So, actually, if somebody came to me and said, 'I'd like to do this', I'd have a jolly good think and, if it was going to give me something and give them something, I'd be completely open to it." [4] "That's another thing I do think is a real factor here: we never lost everyone." [7]

<u>Site:</u>	**Site A**	**Site B**	**Site C**	**Site D**
<u>Consolidated Framework for Implementation Research Domains and Constructs</u>				
Leadership and climate change	“The problem is having the time to focus on that area of what you need to do next because you’re so busy, in our division, with the operational, day-to-day, getting through the day, that, actually, you don’t have that time to step back and think, ‘Let’s just think about how we can do that a bit different.’” [FGS]	“We’ve always had a fairly open door up to the chief exec policy. I think it’s because we’re small.” [FGS]	“The appetite for risk needs to change and that does apply all through the organisation, including at board level.” [2]	“This hospital does facilitate development and innovation, which is why we are so far ahead, basically.” [FGS]
	“I think when you’re focusing on improvement and change you do have to pull on a lot of personal skills, trying to bring the staff with you and develop a culture within the workplace, and I suppose that’s the real sort of success of what you do, it is to develop that culture where everybody feels part of it.” [3]	“You can see here that if you empower people to do things, then that’s the kind of most important thing.” [2]	“We also get a newsletter that comes out, with all the information on as well. So I think we are very up-to-date with things that are going on. We work in a very open and transparent trust, which is great.” [5]	“I’m unaware of a single member of my team that hasn’t got the same ethos that I have. So I think we try to lead by example. We do talk about it and we talk about it to the juniors.” [4]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
	"There's a willingness to try things, and I think part of that is accepting when they don't work, but you've got to have the ideas in the first place."	"People are doing it because they believe in it as opposed to doing it because they've been told to do it. I think somebody may sow a seed from up high but actually the way it grows and develops into what it turns out to be is very much done by the people on the ground floor and how they choose to interpret that and make it happen." [4 and 5 nurse]		"I do feel that, here, you are listened to if you raise an issue or you raise a concern or you make a suggestion. And I think, in lots of organisations, that isn't the case. And I think that benefits us – the staff – and it benefits the patients. I do love the fact that… our chief exec, will go for a wander round the wards and is in at the weekend." [5]
		"The thing that we probably need to be better at is going back and checking that things have been sustained." [5 and 6]		"We're now making much more proactive change and we've got the right leadership group who, thanks to our Chief Executive nominating us for a leadership course, a quality improvement course, which we've done over the last year, which has really helped consolidate a leadership team who is incredibly proactive in improving how we work, how we measure what we work with and developing different ways of working." [8]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
Drivers and imperatives for change	"If you are faced with a situation where it's pretty much a done deal that two specialties are coming off the general medical rota. If you're then faced with an organisation which has failed to recruit very well over the last few years at consultant level – for all the reasons: geography, reputation and things like that – you have to manage colleagues." [5]	"We have a very proactive, good CEO, and we had a bit of a crisis as well because a lot of our surgeries are running out of GPs and we didn't have enough consultants here for all specialities, so I guess there was a bit of push and pull." [FGS]	"We've just had our CQC now and we had one two years ago, whereby one of the things that they found that the trust needed, that requires improvement, was leadership, so as a result of that there's been pretty much a complete transformation in medical and other leadership in the trust." [1]	"We all have the trust set targets anyway, which never existed 20 years ago, and they just had to add in, they have to worry about all these two week waits and so on, the objectives, so clearly that's kind of a quality related issue anyway." [1 and 2]
				"Some of the financial challenges, and this is relevant to all trusts, are around how do you extract the level of savings you need to deliver, and I think for us possibly more than other organisations, joint working is probably a key element." [6]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
Organisational incentives and rewards	"We've given recognition as well, so, for example, the therapists were very much involved in the enhanced therapies on Ward 7 and they came and presented at the acute medical workshop that I facilitated, so it's giving recognition for people's value." [3]	"I feel, personally I can influence care and that I'm respected. And I suppose that's probably what's important to me. If I thought I wasn't and couldn't make a difference, then I don't think I'd want to be here." [5 and 6]	"…finally got buy in from management as a whole to construct a different type of job description which offers more opportunity, because the trust won't offer up-front, lump sum payments for people to come and work here, as other places do." [1]	"There is also the fear of if we don't deliver on X, Y and Z what will happen to us,. So that fear piece also comes into it around they do value the independence of the organisation and what that means for them as individual practitioners, and many of them will go the extra mile purely to support that." [6]
	"As people left and we had to re-look at what we were doing for on-call, we had to – as a temporary measure – shore up the on-call with additional duty payments which were relatively expensive but, at least, encouraged people to view on-call – being present in the evening, being present at the weekend – as something which was important because we paid money for it." [5]			

Site:	**Site A**	**Site B**	**Site C**	**Site D**
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Available resources	"You have that vision – that idea – but we're short-staffed so you're working on the shop floor for twelve hours. So, at the end, you take time back. So the days that you think you might be in the office, you end up not." [FGS]	"So people have an obsession with 'if you gave us more staff and if you gave us more beds, it will be fine.' And it's like 'if I gave you more staff and I gave you more beds, you'd just fill all the beds and then you'd just want more staff again." [4 and 5 man]	"There isn't a body of acute physicians in this trust, and that is probably one of the single most biggest problems in this hospitals." [1]	"You have to show that something works, often quite rapidly, and it's quite a dirty pilot in the sense that you're doing it without any extra resource initially, and that bit's hard and there's a limit to how many times people can do that." [3]
	"If I had a magic wand there would be more of what we need really, but then it's not an empty bag, it's the financial side of it, isn't it. So it's about how we use the resources we've got smarter." [3]		"So we have been filling the rotas but with agency staff which obviously isn't very sustainable." [2]	"The biggest change is we don't have the paper notes. So nobody uses anything ... There's nothing written down so that makes a big, big difference. Yes, it does because enables us to look at how we manage and record things." [5]

Site:	Site A	Site B	Site C	Site D
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	"If you asked the junior doctors at this hospital what they would like to make their day better, Wi-Fi would come, almost certainly, at the top." [4]		"Our workforce is hugely dependent on the locum workforce so we've spent a lot of time working with our locums team to negotiate rates to try and get as many as we can onto our own bank and to offer them substantive contracts but we're still at the mercy of the agencies and locums." [3]	"We've kept a fairly good control of our costs over the years so what a lot of people say when they look at us, like at the moment we've got an audit going on into the management structure, is it's pretty lean." [6]
	"We've taken out 15% of our medical bed base over the last year and we will probably ... with this ... we'll be taking out another 10%. Yes. I think that's an opportunity but not just to lose beds: to actually use the money to improve processes." [5]			

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	"All those support services, frailty, social care, physiotherapy, occupational therapy, the acute specialties, imaging, it all needs to be conveniently co-located, so that would be my thing." [7]			
Processes relating to change				
Barriers to change	"The second thing in terms of barriers is, is probably external partners. Now my view is we work very well and I get on extremely well with my colleagues in social care and if I need them to do something and primary care if I need them to do something I'll say let's try this, they are generally very receptive, we don't have a culture with them at all of this is your fault, we can't get these patients out of hospital, do something about it, it's very much, you've got no money, we've got no money." [1]	"It's space at the moment. We could have all the money that we needed and we still wouldn't be able to do it… our ED is too small in terms of floor space and for the number of patients." [1]	"If we could have five acute physicians who could revolutionise the way that acute medicine was run here I think it would be an excellent service, but we struggle to get the continuity and the team building things." [1]	"Time is a big barrier, some specialists are trying to break down that 'medically fit but still in my bed' category to understand it a bit more." … "You have to show that something works, often quite rapidly, and it's quite a dirty pilot in the sense that you're doing it without any extra resource initially, and that bit's hard and there's a limit to how many times people can do that." [3]

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	"If we had better wrap around services in the community we would have better options for our patients, so pre-admission, to avoid admission, if we had more responsive services in the community." [3]	"You'll have certain clinicians and certain nursing staff and certain therapists and certain managers that will go along with everything within reason and say 'let's give it a go, let's try this, that didn't work, let's try something different.' And there will be certain individuals that whatever you suggest won't want to go with it because they've always done things a certain way."… "A downside of having a small organisation with a really loyal workforce to a certain extent, is that people have got the history. So if you've tried something five years ago and it was in a completely different culture in the organisation and a completely different leadership, etc., etc., and for whatever reasons it didn't work, trying to get people to try it again is really hard work because they've got that memory and it's 'we've done that before and it didn't work." [4and5]	"We'd really like an urgent care centre but we can't make that decision in isolation of the commissioners and they don't really want an urgent care centre, so that is a bit of a challenge for us at the moment."… "I think culture is a massive barrier."… "There is a belief that we can't do any of those things because they're really hard, so we're just not going to do them." [2]	"The team itself, having come from a group of smaller teams, is one of the big challenges in getting it together to work as one team." [8]

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
	"A lot of our ability to plan our junior doctor workforce is limited because of our geographic location."… "It was really difficult convincing people that come on-board with the ideas that we've got and in two years' time I'll still be here and it'll still be the pathway, and there was a lot of scepticism of somebody else coming in and wanting us to change things and then why should we because in twelve months' time it'll be somebody else? So that was difficult, particularly amongst the consultant body." [6]		"Biggest challenge I have experienced in my time here has been around that willingness to be open and to share some of their learning, some of their incidents and look at how can we help other people to get better." [3]	

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
Enablers to change	"As Director of Operations, I have not come into conflict here in two years with a single physician, they recognise the value of nursing and operational management in my view which I think is, is fantastic. They recognise the pressures and, and if I'm honest I think we work really, really well together, so I think there's an element of the people."… "The other element... for me is there is support from the exec team, so the exec team here is very accessible… there is not a closed door culture or a silo mentality or an ivory tower in this organisation… we will listen, we will come up with solutions." [1]	"An external, external experience is making a difference." [1]	"Based upon that the new generation of leadership started to look at these problems with fresh pairs of eyes, enabled the trust as a whole to leap forward in these ways." [1]	"Enabling of innovation from the top down."… "Good relationships and size of the hospital that really, that enables the bottom up." [FGS]

Site:	Site A	Site B	Site C	Site D
Consolidated Framework for Implementation Research Domains and Constructs				
	"The fact that I've worked here for such a long time, everybody knows who I am, they know who I am, my experience, that I've worked on the wards, that I've done their job, that I actually do understand what it's like to be in their shoes, and I think it's been about drawing on my own experience to sort of sell that and to sort of gel with the teams around me." [3]	"Champions I think. So if I'm thinking in my head with FOPAS [Frail Older Person's Assessment Service], if you have a lead clinician – if you have a clinician that feels really passionate, a senior clinician."… "Having a lead senior clinician to champion something definitely definitely helps to drive through change who are committed to seeing it through. If we'd had an acute physician who, who was as passionate about ambulatory emergency care as our geriatrician has been about FOPAS [Frail Older Person's Assessment Service], I have no doubt that we would have had a dedicated unit before now." [4and5]	"People within the organisation are really enthusiastic and they really care about the organisation."… "They have fantastic ideas but they don't really know how to turn them into reality which is kind of what my team does, it helps people move their idea into a benefit." … "People are probably the biggest enabler to change and we've got some really amazing people. I think giving them the capability is what we're now working on." [2]	"The big advantage of a small system is every bit of the system has to get on and talk to each other." [3]

Site:	**Site A**	**Site B**	**Site C**	**Site D**
Consolidated Framework for Implementation Research Domains and Constructs				
	"Sometimes, it's helpful for somebody to go in and, for a while, to be the general physician on that ward or on that part of the ward. It helps understand the systems; it also helps promote – particularly – the core ward values that we want to push forward." [5]			"The facilitators of change are ourselves. And, as a group, we're very good at looking at the pathways and the process." [5]
	"We're blessed, certainly in recent years, with a lot of new, younger, dynamic, enthusiastic consultants, and when you've got a critical mass of people who are on the same page in that sense then that helps with progress as well." [7]			"The longevity point is an important one, that a lot of the clinicians have been here for a long time, a lot of the senior managers have been here for a long time, so that leads to trust and understanding and some clarity of what is important." [6]
				"We'd had money off the CCG to fund the transformation programme. So, when I got here, I got about a million quid to fund the QI stuff." [7]

Site:	Site E	Site F	Site G	Site H
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<u>Outer setting</u>				
Patient need	"…we've got a very interesting catchment area in the sense that we have got one of the most deprived areas of England … and we've also got one of the most affluent areas …, so within our catchment area we've got a ten year difference in life expectancy." [4]	"We had patients who we were seeing in the hospital who kept on coming back into hospital, so frequent attenders. They were coming into hospital, we were patching them up, drying them out, trying to get them engaged with community services, they didn't go, they relapsed, they spiralled and they come back in. Community services don't see it as their responsibility." [4]	"I think we are, perhaps, in an area where the population expansion is higher than national and, also, we are surrounded by health partners that are, perhaps, not in this favourable position. So we're seeing more and more out-of-areas. [1]	"It's an unusual thing in that our local population is very self-empowered, goodwill, friendly." [2]
	"There's quite a large elderly population, and social services are under financial pressure as we all are." [5]			"In general though now, most of our services are serving populations just in excess of about 220 to 240,000 and that's as we've become more successful in how we deliver services and particularly probably our elective services, , we do outreach clinics there, come here for services."

Site:	Site E	Site F	Site G	Site H
CFIR:				
				"There's some real challenges around rurality, isolation, social isolation etcetera, as well." [4]
Networking with other organisations	"The regional trauma network…. So let's say somebody's got a massive extradural with a head injury, rather than trying to liaise directly with the neurosurgeons, who might be in theatre, actually we'd go to the NCS [Network Co-ordination Service], which works, that works really well." [1]	"Cardiologists go and do for example diagnostic angiogram list once a week but they will do some cross site working over there, neurology covers the whole of the County, one of our haematologists works across the whole of the County."… "I did some of my training at [another hospital] as did one of my colleagues, so that helps, we know everybody. It's sort of we're the best of friends and the best of enemies because there's that local rivalry as well, who is better." [6]	"We did explore that with gastroenterology and nobody – particularly in my area – wants to network with us: not in a horrible way… We've got nothing to attract them and they don't want to be given the rubbish we've got." [7]	"The trouble is, from our point-of-view, we're all very, very independent trusts: have been, traditionally.." [2]
	"You can say why don't you staff your hospital with people who work across at both sides so it adds a little bit of lustre to their job plan, their job description and everything like that?I must say I feel	"Some do because we own activity…So, sometimes, it's because of who owns the activity and sometimes it's because of theatre or demand. So they do cross-	"…it's postcode." [2]	"The strategy of the organisation has been very clear that first and foremost is clearly to deliver quality services, the second is to work with partners then to deliver sustainable services…Neither of

Site:	Site E	Site F	Site G	Site H
CFIR:				
	a bit negative about that… historically when people were with a teaching hospital and a DGH, when the chips are down will try and negotiate a further way into the teaching hospital than the DGH.” [5]	fertilise quite a bit and that brings back ideas on its own.” [2]		us are big enough to do it on our own, so we, we have shared consultant posts, between the two sites to ensure that we provide those locally.” [4]
		“I won’t get involved, necessarily, day-to-day, but if there’s ... They’ll escalate it to us if they’ve got a particular issue and I can escalate. And we do that networking sort of view, if you like, and say, ‘Well, actually, we can do that for you. Could you do that for us?’ So there’s a lot of that that goes on.” [5]		“We have started, I think much more of a partnership. … I think using clusters of hospitals in that way is a much more sensible way of doing things, so I think those kind of networks help.” [5]
Peer or external pressures	“We’re just currently in turmoil because of the merger. Because we’ve merged and there’s restructuring going on.” [FGS]	“I think what’s being done is being done the right way; it’s being done for the patients. Moving some care close to the community, having specialist centres I think is the right way to move forward. And it’s allowing us to work as a network as a health economy, rather than individual trusts, working in siloes.	“Every hospital thinks its A&E is under threat constantly because you hear rumours. But our A&E is not under threat.” [7]	“From our point-of-view, we’re all very, very independent trusts: have been, traditionally. … And it’s kind of like, ‘We’re all going to survive.’ So it does feel like you’re looking round, eyeing up other people, wondering who’s going to be dead first really. But the long-term survival is really going to be networking

Site:	Site E	Site F	Site G	Site H
CFIR:				
		So it's opened up a lot of new doors and new ideas… It's not just about saving money: it's about being more efficient and, if patients get better care at the end of it, then that's all good for me." [2]		across those sites, really. But, who knows? We're all going to end up on a huge strategic healthcare authority again..." [2]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	“If you take say the chief pharmacist, we’ve got one on each site, one of those will lose their job, so people are currently going through redundancy process, people who are excellent in their role have been made redundant because they’re now surplus so there is a lot of uncertainty and anxiety, but we’re expecting them to work normally. That is just the merger.” [2]	“People here, you know, people don't know what’s going to happen, do they, I mean, X in two years might not be an acute hospital.” [3]		“We're in the midst of a vascular review and a head and neck cancer surgery review and a stroke review and we're all kind of clear about what we'd like to happen but we're also, I think probably in a better place in terms of trust to accept that maybe we won't all get what we want out of it.”… “The difficulty is and we've talked about the geography, if we don't provide it here then you're kind of pulling out one of the cards that says is this hospital sustainable? Can it carry on providing what it needs to provide? ” [4]
	“Problem with us is that we don’t have the very robust provision north of us.” [4]	“We’re trying, where we can, to kind of cross those barriers. So, yes, it’s quite interesting because you’ve got one eye on the ‘What ifs?’ and one eye on ‘We need to do it and get on with this now.’” [5 cman]		“At the moment there are huge pressures in primary care and we’re finding practices now that have suddenly decided they don't want to do insulin initiation, which then knocks pressure onto our services at a time when the CCG is telling us they don’t want us to

Site:	Site E	Site F	Site G	Site H
CFIR:				
				see patients anymore, so it’s all a bit difficult.” [5]
	“The honest answer is we don’t know, Hinchinbrooke is a small hospital, there's been rumours for the last ten years, because I live right by Hinchingbrooke, around Hinchingbrooke ED closing, that was part of the STP, we now know it’s not. So Hinchingbrooke staff have been through a tough time, are they going to lose their hospital, is it going to be closed, this perception that Peterborough have taken them over because when you look at the top team it was the Peterborough chief exec, chief nurse, so I can understand their concerns.” [5]	“That is the biggest worry for me, not the CSR [Corporate Social Responsibility], I’ve been through changes for 32 years, it’s about let’s not lose that culture because that is very important.” [5 nurse]		
	“I think, financially, it’s disastrous. We are taking on £23 million worth of debt. This year, they’ll be, ‘Oh, yes, that’s because they’ve merged.’ Next year, it might be, ‘Oh, yes, that’s because it’s			

Site:	Site E	Site F	Site G	Site H
CFIR:				
	merged.' The year after that, it'll be, 'They are the worst performing financial trust in the country by some significant margin.'" [6]			
Local external landscape	"Where we are, just geographically, it's interesting. So I think we're on the border of several counties." [1]			"I think a big problem, I'm a physio by background, is the services are not there in the community, and then they keep changing and they keep changing their names and no one actually knows what is out there on a day-to-day basis and... how you refer on, even the therapists because it changes so much, a community is so separate, so I think that's a huge problem." [FGS]
	"I don't know who all these people are in STP-land but I'm ignoring everything from them at the moment because we've got a list of STP things, some of it is ridiculous. As an example, they want a £460,000 cost saving on readmission penalties, the fact that we've only got £120,000 in the budget, you can't make	"We're very honest and very transparent and we have a motto in our code of 'No surprises'. So, if we know something, we share it; we don't get to the last minute where something's dangerous or unsafe or there's a safeguarding issue: we open up and we take advice and we	"I think we are, perhaps, in an area where the population expansion is higher than national and, also, we are surrounded by health partners that are, perhaps, not in this favourable position. So we're seeing more and more out-of-areas." [1]	"Those services have been decommissioned, have been dropped, have been amalgamated and that's had a very real effect on us." [2]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	a £460,000 cost saving, so I'm just ignoring it."… "the reason it's all sort of hidden, it's very political, the merger alone caused utter distress to the population …, they don't want to be part of us, they just want to be their own little hospital, even if it's not financially viable." [2]	take support. I think we share that with the CCG as well." [2]		

Site:	Site E	Site F	Site G	Site H
CFIR:				
	“We’re vulnerable and we have to maintain good relationships with them because they could kill us if they wanted to.” [4]	“I think it’s very good, I think we work very well together, I think their frustrations are equally our frustrations, if they can’t get staff, they can’t get staff.” [5]	“The community services in this area are quite poor so what I would actually expect from a well-functioning community service and the CCG is in their winter planning to make sure that they’ve got that information and that they target those homes and have community people going into those homes and saying right guys, so we had a problem last winter, what are we going to do differently.” [3]	“I think it's relatively easy for us to, and we do agree how we want to deliver things and the strategy between us about what's the right thing to do but that then is clouded heavily by the finances because the CCG has an underlying deficit and needs a contract with us which is significantly lower than what it's currently trading at.”… “We had a plan and then the Vanguard came along and everyone switched their plan to what the Vanguard needed and that was disappointing.” [4]
	“There’s quite a large elderly population, and social services are under financial pressure as we all are, and I think whereas before health and social care used to work hand in hand, it was a joint budget, that is now not the case so patients can often fall down the black hole.” [5]		“The thing that maybe would be better is our community links, you know, that’s where we really struggle. We have a big medically fit list with numerous reasons why patients can’t go home. You know, if we could get that better we’d have more flexibility of having beds when we came in.” [6]	“The Deanery has a very powerful role, you know, I think the threat of removing trainees does galvanise organisations to do something, so that’s certainly facilitated some of the change.” [5]

Site:	Site E	Site F	Site G	Site H
CFIR:				
External policy landscape	"When you talk about the nurses' skill set and education stuff, the continuing professional development has literally been cut from the NHS, so I've been told, like this year, I can't put any nurses on any cardiology courses because there's literally no funding to educate nurses anymore, so that will pose an issue in the future, because how can I expect our nurses to look after these patients when they're not educated, you can only do so much on the shop floor."… "It's what's being driven nationally, hence the evolution of the acute medic, you know, which is, if you like, a 24 hour, 72 hour specialist in general acute medicine, and I don't think that speciality would have evolved had we not been driven to become a super specialist or a consultant early." [FGS]	"Because they are cutting funding to primary care staff we are seeing a knock-on effect in what we see in our patients." [FGS]	"The fear factor of the money and what NHSI have said, if we don't hit the controls and the standards we're all doomed, we're all going to hell in a handcart." [2]	"The world is becoming more difficult to negotiate in the NHS for the last three or four years probably, whether how much of that is because the number have increased, how much of it is because everything is getting harder." [FGS]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	"I think there was a lot of pressure which comes down for four hours. I think in fairness that pressure is coming from NHSI and NHS England." [1]	"I think finances might stop us. We've been planning for seven-day services for years and years and years and years and I think we've got very few that are genuine seven-days. So we're talking millions of pounds' worth of investment. And, even if we had it, there's probably very unlikely to be the staff out there. They don't exist. We'd have to close a hospital somewhere." [2]		"The trouble is that, in the last year, you feel there's more of a bunker mentality starting, which is new. And that's filtered down You can only push everything so far before things start to snap and I think that's pretty much where things are." [2]
	"In order to improve the outcomes for people with specialist, not even special complex but certain types of diseases, you centralise it and of course you're going to build the expertise, of course you're going to get the research work out of there but you're not thinking about the poor old general patients in the DGH, who's going to look after them? Because if we've got a shortage of doctors, everyone wants to work where all the fun stuff is." [5]	"In the NHS, what we're not really good at: compared to the CQC, they're really good at celebrating success. We don't celebrate success; we move onto the next crisis. We go from crisis to crisis." [5]		"From a personal perspective, the national focus on four hours always makes things more important. ED has had its share of limelight over the last few years in terms of lots of things not going as it should and it leads to pressures and various headlines and therefore national programmes of 'we must do better' and all of that brings focus and focuses people's minds on it being something that needs our focus here too." [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
				“The STPs, I mean, I do think there’s some rationalisation that could happen there, I do think we run things that perhaps would more sensibly be run in perhaps more of a [hub bespoke] arrangement, but you’ve then got the challenge of rurality I think.” [5]
Inner setting				
Structural characteristics		“We are quite a higgledy-piggledy sort of site. It’s not a great, expansive site and we have extended up. There’s very little space for us to expand out.”… “It’s quite an old building; the fabric of the building does need some attention but it doesn’t detract from the level of care that we give.” [2]	“The only thing which hasn’t changed – or which causes a problem, I think – and I’m sure it was anticipated but no one did anything – was the footprint of the hospital. Because, our footprint still remains the same. Then the hospitals and the government started work in how we can increase the footprint. And, in our hospital, all the consultant offices are being moved to another place: out of the clinical area. Those areas are being converted into the clinicals: clinical sites.” [4]	“From my point-of-view, more space: bigger unit. If I had a sixteen-bedded unit, I could increase throughput by 100% without actually increasing workload.” [2]

Site:	Site E	Site F	Site G	Site H
CFIR:				
		"Here you've got to brush past them, you've got to speak and here if you have to stop to look for something, somebody will stop you and say where are you looking for. That is the culture, and we adopt that culture and it works very well, so I think the building is fine. Modern isn't always best." [4]		"The constraint on the space, there is more you could fit on this site in a really, you know, big as well, the constraint on the space is the cash to do it." [4]
Culture	"I come back into hospital after about 18-19 years being out of it, and I still knew half the people in it, because of where we are and the geography and the area people that work here will stay here, which is good because you've got that constant staffing, but you're not getting new blood in." "New ideas." "I guess there's a risk of being a bit entrenched in the way you do things and not evolving." [FGS]	"It's like a family I think. I've always worked here but when I go and visit, it's just the feeling that you get when you come through the front door, it's hard to explain." [FGS]	"Our culture is our weakness, so that closeness is fantastic but it just needs to open up a little bit more so that we can invite the change that needs to happen to get us where we need to be."… "The biggest obstacle is culture. We've got that famous quote that culture eats strategy for breakfast and that's exactly what happens here, it's hard work, it's going up a hill. It's a small trust so it's like a small island, so people are used to doing the things that they've been doing for years in the way that they've been doing it, do not come and bug me about	"We work nicely as a team: it's a nice place to come into and work. There is good interpersonal relationships and morale among people, even if it's not working well from an organisational point-of-view at the moment, it is on a personal basis. So we work for the team and we work for each other. We've got very nice patients: they're nice people; we like looking after them." [2]

Site:	Site E	Site F	Site G	Site H
CFIR:				
			change when I’m so busy please, I haven’t got time to change.” [3]	

Site:	Site E	Site F	Site G	Site H
CFIR:				
	“The cultural environment is one of fatigue, they’re fed up, they feel disenfranchised.” [4]	“You’ve got people who want to work here who are motivated, believe in, I’ll tell you what, the [name redacted] approach, I think people buy into it and it just feels slightly different to any other place I’ve worked and people really genuinely buy into the [name redacted] approach and it’s not just words on paper, and I think that is what makes the difference.” [1]	“We never really argue about patients and things and people being moved and stuff. And we can always – if there is a dispute – one consultant would talk to the other one and we’d work it out. Maybe that’s an advantage of a smaller hospital. Maybe we do have to work together and we do ... If we talk, we tend to resolve it.” [7]	“The downside of being in a lovely place is that there’s a way of doing things which you probably don’t see if you’ve been here a long time but it was really apparent when I moved here that when you first tend to suggest things there’s a bit of a ‘Well we don’t do that here’. Who are you to say that that will work, we don’t do that here. So there is a bit of resistance to change, there’s the way of doing things and it has pretty much worked so don’t come here with your clever ideas, kind of thing! Some of that was born out the fact that the Trust does generally well, performs generally well and all was relatively rosy in the garden so if it’s not broke don’t fix it.” [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	"You've got a culture where all of the senior staff are approachable, all of the senior staff will muck in, they do the job, they know the job, they are contactable, approachable, willing to listen." [5]	"I think the more you push goodwill, the more pushback you will get and the more goodwill you provide, the more it's expected. So I think it's quite a fragile beast but I think that [name redacted] is built on ... I'm sure someone's mentioned the [name redacted] Approach to you while you've been here today. It's a set of rules – if you like – that we like to live by: it's about respecting each other and things like that. And I think that's been valued for a long time and I think that a lot of our reputation is built on good attitude and good working relationships." [2]		"There's a real commitment from clinical staff here, there is a passion for this place, they care deeply about it." [4]
	"The entire culture of the place, really, is 'Keep the family together; don't have arguments with anybody.' But what that actually translates to is, 'You can't manage anybody if that involves being nasty at any point or irritating anybody at any point.'" [6]	"Because of the institution's reputation and ethos it generally attracts good people, which makes it good to work. I think everyone here wants to work here and wants to provide a good standard of care, and care is about the hospital, so I		

Site:	Site E	Site F	Site G	Site H
CFIR:				
		think therefore the strength is the standard of care is generally high." [3]		
		"You're not watching out for your back here. You don't feel, if you make a decision or do something, you're in fear of what you do and you've got to cover your back. I think people trust people to do what they do and You don't tend to get too much interference in your decision-making." [5]		
Leadership and climate change	"We're just currently in turmoil because of the merger." [FGS]	"So I've just been allowed to get on with it and I don't just do it all myself, like each time I run changes past other people, so I'm not just a lone ranger but we've just been allowed to get on with things and I think as acute medics we're quite dynamic in this department and we're trusted between us to get on with things and deliver patient care, and we can prove what we're doing along the way but we're not micro-managed." [1]	"It's often difficult to find that time to think strategically about changing and to be able to have that confidence to make those big leaps that you need to get to get to the system where you want to be when, at the same time, you feel like you're putting sticking plasters on the holes in the dam all the time. And it does feel like we're doing that at the moment." [1]	"There is a massive encouragement to try and do your best and generally my experience would be most people go that extra mile. Most people in this organisation tend to be really loyal." [FGS]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	"Most departments are very open, they generally come to us, we don't impose, so if they come to us it's because they've got a vision, they know there's an opportunity, so generally you're on an open door." [2]	"We've got great directors and our chief operating officer, our deputy chief operating officer, director of nursing and medical directors are all great innovators in their own areas and encourage it in others. We have a clinical innovate, where people bring ideas and discuss: they table them to a little panel and then we seek out funding and things like that. So it's good. We have a lot of involvement from people." [2]	"Our culture is our weakness, so that closeness is fantastic but it just needs to open up a little bit more so that we can invite the change that needs to happen to get us where we need to be." [3]	"What we're trying to get better at doing is then applying some filtering criteria so that only the right projects drop down our funnel and then drop into the pipeline of scoping, planning, delivery, benefits, realisation, and then they drop out of the end of that pipeline, if you like, and then we make sure, the clinical transformation board then makes sure that the next project that drops through meets our transformation criteria." [1]
	"If everybody wants things to happen then it's quite easy to make them happen." [3]	"People do generally feel engaged and I think, even from the top, the [name redacted] approach, which has been going for years, definitely does filter down from the top, and that's why also I think it's quite well respected." [3]	"We're trying really hard to put ourselves out there as a team, because when I started a couple of years ago it was very siloed and we weren't together, and hopefully, and I think the team would say the same, we do feel we're united and we're ready to take on the next challenges almost, but it's really difficult with some of the things that are being asked of us at the same time." [6]	"Most of it is by discussion and agreement, there are very few draconian 'thou shalt do this' to make things better which is a much better environment to work." [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	“If you want to implement change you need champions within the area. We’re not very good at harnessing the leadership and turning it into something that is more constructive for the organisation.” [4]	“We’ve got lots of skeletons in the cupboards here but I think the point is we try and address them, rather than cover them up. So, actually, our appraisal rates are low at the moment. Rather than say, ‘Actually, what’s wrong with the data?’, ‘Let’s get the appraisals done’, which is what you’d suffer elsewhere. So I guess it’s about delivering, not delivering the numbers to make the situation look different.” [5cman]		“We don't have a change team that get dropped in, what we've done is we've a used development approach, so based on the Virginia Mason lean methodology.” [4]
	“We have a safety culture here, we recognise that things go wrong, mistakes happen, staff do not get penalised, it’s around what happened, what should happen, what can we do to stop it happening again, what was good, what wasn’t so good, and I think it’s involving the frontline staff.” [5]	“I absolutely believe in growing your own, I believe in picking out your stars, working with your stars, investing in them.” [5 nurse]		“As the Clinical Director, one of the things that gives you credibility is actually being a general physician and doing the acute take, I think your colleagues will respect that and are more easily persuaded if you’re clearly doing the same things. I think it’s much more challenging, and you see it... and I think that’s why it’s more difficult for non-clinical managers to persuade colleagues

Site:	Site E	Site F	Site G	Site H
CFIR:				
				that they should change the way they do things when it comes to acute care delivery." [5]
	"I think it's right at the top. I think there's an extraordinarily siloed thinking. So, rather than taking an organisation forward and this person realising that, in order for the organisation to move forward, there may need to be relaxation of that person's particular control grip on a thing which they are accountable for, all they're interested in is what they're accountable for." [6]			
Drivers and imperatives for change	"There is pressure from outside to foster improvements and reduction in budgets." [1]	"Being strapped for cash as we are and have been for the last five years, has given us a very different view of the world. We have had to use innovation to deal with some of the problems we are facing unlike neighbours who have perhaps had in the past greater pools of cash to pull on." [FGS]	"I think it's also fair to say that we are probably a little bit behind the curve, if I'm being generous. The portfolio that I set out to take on this role was on that agenda of changes I think we need to go through. We have made some progress: we have done some good things but, in terms of, 'Do I think the medical model	"So some of those drivers, I explained, are about difficulties that we have in recruiting to certain posts, but there are other drivers too which is to do with how we improve flow, how we make sure that people aren't staying in hospital for longer than they need to and

Site:	**Site E**	**Site F**	**Site G**	**Site H**
CFIR:				
			reflects what is currently the way forward?' No. 'Do I think, organisationally, we've got the understanding of, perhaps, where we need to be?' I think we probably do. I don't think we're quite sure how we get there." [1]	how we make sure that we deliver that great quality care." [1]
	"Do I think holistically about the hospital and about the grannies on the trolleys in ED? Yes I do, and that's what drives me, not because I get an email that says 'You haven't taken as many patients as you should his week', I don't listen to that, but I am aware of the system." [3]	"Most things we now we try to change, we're supported because we're making efficiencies. We're trying to just make ourselves more effective and responsive to services to a population." [2]	"The fear factor of the money and what NHSI have said, if we don't hit the controls and the standards we're all doomed, we're all going to hell in a handcart." [2]	"There aren't the services to discharge people to and that's had a catastrophic effect on us. So it's been quite difficult this year, actually, because what we're trying to do is do things that slow the rate of decline. So the aspiration in improving services isn't aspiration: what we're actually trying to do is slow the rate of decline, which is pretty miserable but it's true." [2]
			"I think the big driver is, Number One, the fact that most of the patients that come here are medical. A&E's medical: it's not a trauma centre. So, if you look at the proportion of patients that come	"From a personal perspective, the national focus on four hours always makes things more important." [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
			here, they are mostly medical patients. So, if medicine is not doing well, A&E's not doing well." [5]	
				"The Deanery has a very powerful role, you know, I think the threat of removing trainees does galvanise organisations to do something, so that's certainly facilitated some of the change." [5]
Organisational incentives and rewards	"They're kind of little bits around the edges which just make people feel valued and appreciated. I think when they start getting pulled away as well, just simple things, like changing the parking and actually reducing the number of parking spaces." [1]	"I think the attraction here is obviously where it is." [5]	"We get a lot of positive feedback from patients and external people that visit our areas, you know, junior doctors have nominated one of my areas as the most supportive ward, my Band 7s are stable and enjoy their roles and their jobs, you know, turnover is not that bad as such, although staffing and recruitment is a big issue. We've won lots of awards for the staff awards, innovation, my frailty nurse has won the Chief Exec Award a couple of weeks ago, my dementia nurse specialist won an award." [6]	"People who do one-off great things in terms of quality of care get recognised, they can receive a Making a Difference Award, some people receive those awards today, or they could become Team of the Month because they did a one-off great thing." [1]

Site:	Site E	Site F	Site G	Site H
CFIR:				
				“We've got better in my seven years of not saying thank you and rewarding people through that kind of positive appreciation but also of telling them it's okay to try.” [4]
Available resources	“We are a very data rich organisation, we can capture absolutely everything.” [4]	“Being strapped for cash as we are and have been for the last five years, has given us a very different view of the world. We have had to use innovation to deal with some of the problems we are facing unlike neighbours who have perhaps had in the past greater pools of cash to pull on.” [FGS]	“But it doesn’t get, necessarily, matched with increased resource in terms of ‘income’, but not matching with actual whole-time equivalents. I think the consultant body feel more pressured in terms of work than they ever have.” [1]	“From my point-of-view, more space: bigger unit. If I had a sixteen-bedded unit, I could increase throughput by 100% without actually increasing workload.” [2]
	You’re worried about the merger? “Well, yes. Absolutely. I think, financially, it’s disastrous. We are taking on £23 million worth of debt. This year, they’ll be, ‘Oh, yes, that’s because they’ve merged.’ Next year, it might be, ‘Oh, yes, that’s because it’s merged.’ The year after that, it’ll be, ‘They are the	“We have finite resources; we have finite space so we’re trying to work more inventively.” [2]	“We are very well supported by our directorate and the trust. And, obviously, with the political interest for our target and the college indicators, we have got a lot of funding and support.” [4]	“We presented an impassioned plea of could we have permission to start working up this as a financial argument about a year and a bit ago and everybody said "yes, that sounds a really good idea, we support what you’re doing, but you’ve kind of got to make it balance from a money perspective". So that’s the

Site:	Site E	Site F	Site G	Site H
CFIR:				
	worst performing financial trust in the country by some significant margin.'" [6]			challenge and we're probably not far off being able to demonstrate that in terms of the greater activity in the ED, but it's not a great period of time when it comes to money. So even if we could show as a service we're doing enough, now is not a good time so we'll have to wait. It is good as it is but it would be even better with seven." [3]
		"A lot of the rest of the staff don't move round that much, which, actually, is quite unusual, whereas, a lot of places are much more transient. I know we've got our turnover rates but, actually, turnover rates don't show the core people that stay." [5]	"We did try to recruit more acute physicians at one point when finances were a bit easier – though it's never easy – but 'stronger' might be a better word." [7]	"There is more you could fit on this site in a really, you know, big as well, the constraint on the space is the cash to do it, so, you know, the financial in terms of capital and access to capital is really significantly inhibiting what we can do on this site." [4]
Processes relating to change				
Barriers to change	"There is pressure from outside to foster improvements and reduction in budgets,	"I don't really think we're a great one for barriers at Poole. I think, when we	"It's often difficult to find that time to think strategically about changing and to be able to have that confidence to make	"Senior staff and space. And, actually, that's it: it's not willingness and it's not a lack of planning and it's not a lack of

Site:	Site E	Site F	Site G	Site H
CFIR:				
	and actually that is leaving very little money to do anything." [1]	make a plan to change, we make it very well."… "I think normal finance establishment and space would be our main barriers." [2]	those big leaps that you need to get to get to the system where you want to be when, at the same time, you feel like you're putting sticking plasters on the holes in the dam all the time. And it does feel like we're doing that at the moment." [1]	strategic support. It's none of those things: it is, literally, reasonably motivated senior clinicians to be involved with it and physical space: the actual, physical space. We're very short. We've got fine with orthopaedics, endoscopy, new MRI suits, ED redevelopment plan. So there's a bun fight for space more than anything here, actually. It's too small." [6]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	"Ops hates Quality, Quality hates Ops and they're knifing each other, left, right and centre. And there's no corporate way forward." [6]	"We've got good services set up, but because we're relatively small and we've got fragmented services, that has sort of hampered some of our development."… "Our main constraint is financial, so you've got to make the case for it on a financial basis." [3]	"They're shattered because they're doing all the work that actually if they had registrars and junior doctors they wouldn't have to do, they haven't got the energy to do anything else." [3]	""Mainly the barriers to change are just about time really if I'm honest. For those of us who have ideas and want to translate it, it's just about that kind of time and support from a management point of view to be able to work things up to a point where you could say this is an idea where it's now a plan, this is when we could do it, this is what it would be like."… "The biggest barrier I think is about capacity in terms of individuals and people. All the other things are no different to anywhere else, it's just energy, money, whether it's the right thing to do and what are the other things that are distracting everyone away from this being the thing we focus on." [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
		"It's been a longer process where people became more accepting of it but the clinicians are being the challenge because, if you're an ED consultant in this Hospital, you came here to work in this Hospital; you're not working as a service; you're working in this Hospital. And that identity, I guess, is a bit of a challenge." [5]	"Other barriers: people don't like change, do they?" [7]	"It's often, it's the fear of change for individuals that are within the service itself and quite often it's also about what they feel works for them sometimes, their personal barriers to it."… "That's one of the biggest barriers right now, is that capacity to change, just simply because of the workforce challenges." [4]
Enablers to change	"If you've got an open door you're pushing on that open door and it makes life very easy." [2]	"We're trusted between us to get on with things and deliver patient care, and we can prove what we're doing along the way but we're not micro-managed." [1]	"The thing that drives change forward is good leadership but good ownership, good followership as well and ownership from the staff. If staff can own the change and actually initiate the change." [3]	"So it's more about the fact of putting suggestions together and, actually, people getting behind that."… "The other thing it's quite small: the other, really important thing about Harrogate is you don't stand on people's toes." [2]

Site:	Site E	Site F	Site G	Site H
CFIR:				
	“Charismatic leadership and explaining the benefits supporting … acknowledging the disbenefits.” [4]	“I think we don’t work from the top down or the bottom up: there’s a great deal of communication; there’s a great deal of transparency and openness and staff have been engaged in things that have happened: the clinical services reviews and things like that. We have quite a good coms team. So being able to have open conversations enables people to bring forward their ideas and they support change.”… “We’ve got two amazing senior sisters in medicine and elderly medicine. They’ve got very good recruitment process on: as soon as someone applies, they grab them by the throat and bring them in for interview, rather than waiting for an advert to close. They’re very proactive.” [2]	“Probably facilitators to change are money. Maybe the biggest one would be a Labour government, wouldn’t it? Let’s be honest. Things change. And the NHS got turned round, didn't it? It was pretty terrible before and it’s pretty struggling now. So that would probably be the biggest facilitator to change, wouldn’t it? Let’s be honest. Facilitators to change are evidence, aren’t they? And the mood and the general wisdom of lots of different units.”… “CCG support, I suppose, helps. If you get them on board, you can get things moving and, if they’re happy to accept what you’re doing with your acute medical unit ... because they could easily be a barrier.” [7]	“We’ve got a new Chief Exec which always brings in a bit of a breath of fresh air. X before was lovely, but he’d been here a long, long time and so there was definitely a way. X has come in with some obviously different observations and ideas and that gives a bit more impetus to trying this and trying that.” [3]

Site:	Site E	Site F	Site G	Site H
CFIR:				
		“We were able to build the MRU and it is a very important point to note that this hospital at the very top levels are open to that as well. I had to get that money but the chief execs and the finance and the directors of operation were all totally supportive.” [5]		“We've got a core of staff who've been here a long time, who, they're deeply passionate about this organisation, who care about it, and go over and above what you'd expect of them to make sure that patients get the best they possibly can and I think that facilitates change because people are then trusting, they're prepared to try it, they're prepared to give it a go.” [4]

Site:	Site I	Site J	Site K
CFIR:			
<u>Outer setting</u>			
Patient need	"Because of the cultures that we do have locally, we do see some wonderful multigenerational caring. And yet we have lots of other issues because of the deprivation. It's a strange mix but very interesting as well." [5]		"Our local population is ageing but it's also increasing, so it's probably the single biggest increase that's been seen I think between censuses in the last two censuses. But also, it's a really ageing population." [Int3 Sman]… "…our catchment…It's difficult to find two more diverse communities in terms of the socioeconomic factors on those areas. So, that disparity. [3]
	"We need to understand what the community needs and whether it is affordable and doable in the economic constraints of the NHS." [5]		"And this assumption that the hospital is sucking up all the money because of our activity, and actually, it's much more around the fact that patients are choosing to come to hospital because they can't access services elsewhere." [5]
Networking with other organisations	"We're obviously not going to be a neurosurgical centre but some which are less obvious like acute stroke now will go to X, and also we would refer to X for ophthalmology, ENT, plastics, so that is mildly detrimental in terms of it's a bit more travelling. It doesn't totally impact on us, once in a blue moon you	"We had this formal memorandum of understanding where we work together around specific pathways." [4]	"I'm also seconded by the Trust to another hospital, which is our local HP tertiary liver centre, where I do clinics and work there." [1]

Site:	Site I	Site J	Site K
CFIR:			
	might have a real emergency and then we generally will have an agreement that say the ENT surgeon on call for X will come here if there is a patient who really is not well enough to travel. I remember that happening once in the time I've been here." [2]		
	"The important word there is collaboration, it's not that we are looking to send services somewhere else, it's working collaboratively and that the end point in all this is to sustain the workforce model because we know it's difficult to recruit and retain highly specialised consultants in a small district general hospital." [4]		"Cardiology, we used to do premier PCI [Percutaneous Coronary Intervention] and we'll still do that in the daytime if that's what needs doing, but nonetheless, that pathway essentially went past us, and that now goes to tertiary." [3]
Peer or external pressures	"It is challenging times in terms of the financial constraints, the staffing problems, particularly in ED, the staffing, it's definitely difficult to do your job where it feels like the expectations, both from our patients and also from regulators is always increasing and yet our number of staff and things like that are not getting any easier." [2]		"I think we're lucky here and we're very protected, and that's partly a consequence of our size and what's happened in the past, there's no neighbouring Trusts for quite a long way so we have to provide a core of services." [1]
	"Also, being aware that we're very close to bigger hospitals and that we don't become that community		"And this assumption that the hospital is sucking up all the money because of our activity, and actually, it's

Site:	Site I	Site J	Site K
CFIR:			
	hospital, as in the true terms, as in we lose everything other than day surgery."[5]		much more around the fact that patients are choosing to come to hospital because they can't access services elsewhere." [5]
Local external landscape	"I think there are clearly financial impacts that you can see in community services as in care homes, social services, that type of thing, and given our geography and given our population I think we are definitely feeling the pinch on that, we have got ever increasing numbers of patients who are medically fit to be discharged from hospital but we cannot get out and then they end up falling, they get infections, it's not a good place to be if you don't need to be here, so I think we definitely feel the financial bite in that sense." [1] "But if the community had more resource it would actually solve a ton of our problems anyway. Because we've evolved our system to try and cope with what's going on. But if you fix that bit for us, because we've evolved our system to cope with what's going on, we'd actually probably be doing all right." [3]	"So, there's some really good working now between the CCGs…and it's just a fantastically forward that you've got a CCG that is talking about the sector, our patch, rather than these small CCGs, so that's good. And local authority is actually having a similar type of working relationships now, so that's good." … "I think the NHS configuration is probably a lot more complicated than it used to be and I think that's probably made relationships a bit more challenging. So, you've got commissioning support units, CCGs are a very changing entity and GPs are equally as confused as sometimes as our clinicians in our acute providers. So, we work and live in a far more complex world now, it really is." [4]	"The hospital for many years, as I'm sure you know, was underfunded, under-resourced and understaffed, and this meant that established services, when the commissioning environment changed, some of the sub-specialist services vanished." [1]

Site:	Site I	Site J	Site K
CFIR:			
	"One of the things that is very frustrating is the geography that we sit in. Not the geography of the country and the topography, but the fact that we sit on the border with three… It's driven me insane. I still don't understand it all completely….If you're elderly with mental health issues and you come to me I give up in despair and sit at the table and rock, because trying to get any older person's mental health care for frail elderly person in crisis is impossible. If you are an alcoholic farmer who has depression in quite an isolated way but has been functioning at quite a high level for a long old time. From next week the new alcohol pathway team that has taken on the tender won't see you." [5]	"I've literally had patents that have been if they literally lived across the road they'd get this service!" [5]	"I've had some really good meetings in the last few weeks where I do feel like people have realised that we're on the right track, that we're sort of proving ourselves a bit as an organisation and actually we should be trusted in some way to be leading that clinical conversation. So that's probably what I mean, but no, you're right, it's hard, money is hard, commissioning is hard, I feel sorry for the commissioners." **Why?** "Why? Because they have been told to focus on money and they seem to be doing it, and of course the money is important, of course it is, but I couldn't live like that, you know, if I were them I'd be telling the centre of the Department of Health 'You're not paying enough', that's what I'd be telling them, I'd be saying 'This is all very well, but I can't not pay the Trust the money required to provide the care'." [2]

Site:	Site I	Site J	Site K
CFIR:			
			“So, there’s a historical problem with our relationships, but also there have been numerous things that perhaps the CCG feel haven’t gone their way, they’ve been given a very hard time, there’s been lots of changeover from NHS England in the last couple of years and so, they’re very, very cautious that they’re going to get stung. In fact, probably their default positions, “I’m not really sure I fully understand what you want to do but I know it’s not going to be any good for me and so I’m resistant.” And so, to be fair, to be fair to them that’s probably a valid position from their perspective, they’ve had a very hard time form NHSE, things that they have signed up to before that actually are the right model for patients.” [3]
			“This organisation’s very clinically led and I think the CCGs are clinically led but perhaps the clinicians don’t quite work it as well. They talk the talk but they don’t do the job, if that makes sense, anymore. So, I think that’s a big challenge for us.” [5]

Site:	Site I	Site J	Site K
CFIR:			
External policy landscape	"So we did an assessment against the future hospitals report that came out and it's controversial because some of the, it does go against type on specialist medicine which all the Royal Colleges are going, we have to super-specialise."… "We can provide all that general medical and acute training and we've been trying to, and we've had a Clinical Director for Health Education trying to work with the deaneries to say look, instead of sending me junior doctors and that doctor training in gastroenterology or respiratory or cardiology, we can provide the general medical training much better than you can because we see more of it and your doctors will see more of it but it's Health Education England that won't change and I get your point that the Royal Colleges want to go one way but it's not got down to the universities yet." [4]	"The STP stuff, we all admit it is a good strategy, we want it to work. I was told that I needed it implemented by September, it's now October and it was never going to be implemented by September. And it's just things like that. And then you get to the point where I go to meetings thinking, "Oh my God I'm going to be told off for not…" And in fairness that's not my organisation, my organisation stands behind me and says, "We've done this and we had to look into this and do this" But I think the NHS as a whole is very… We're trying to do things too fast because we've got a lot of things we need to fix, and I think that's really challenging because I think that does feed into every organisation because you have to have things done yesterday, you always have to have things done yesterday." [5]	"British Society of Gastroenterology, the BSG, and one of the recommendations for a hospital this size, providing our services, that we should have something like 12 to 13 consultant gastroenterologists, and when you look nationally at where gastroenterologists are, nationally it's an under-recruited speciality and it's particularly acute in the south-east." [1] "The national mood and almost some of the thinking in acute medicine was about generalism at the time, so we started thinking 'Well actually we've got an opportunity here, because if we can bring in generalists who truly want to be generalists, and we can build a team of people that are interesting and exciting and actually respected for what they do, then we could solve some of our problems', so we did." [2]
<u>Inner setting</u>			

Site:	Site I	Site J	Site K
CFIR:			
Structural characteristics	“Our ability to receive ambulances is better now, it used to be that that was just done in a corridor so now we have a proper handover area where patients can be handed over with a curtain round and with a bit more privacy and dignity.” [2]	“Our wards were set up, they’re 30 years old now, they’re not set up to look after those people in that sort of closed environment.” [3]	“Necessity is the mother of invention, so some of our moves were related to having an expanded bed base and who would we get to service the expanded bed base. So you can tell we’ve been building things here, and that’s because we needed to and we weren’t afraid to do that, but we had to then think, ‘Okay, what’s the new ward do?’” [2]
	“Yes, physical environment. And we have tended to get shoved from pillar to post, especially when it gets really busy. So, our ambulatory care unit needs to be on ward 1, which is next door to the AMU. We got moved from there to ward 15 when it got really busy, winter, full of beds. And then last winter, when we were upstairs, ambulatory care, you come in after one hellish weekend and you find virtually all your space has gone yet you’re still supposed to do exactly what you were doing before.” [3]		“And the design of the hospital on two floors, with one long corridor, actually you get a lot of business done in that corridor journey.” [5]
Culture	“The other thing that I’m just managing to break with some people is this email conversation, it’s a small hospital; if you can’t walk down the corridor and knock on someone’s door and have a chat with them	“It’s a very interesting organisation in that there continues to be a core group of staff that came to work in the organisation when they were in their earlier working years and stay here for the whole of their	“We talk and we have conversations, and whenever I’m walking down the corridor, you know, everyone I meet is like ‘Oh are you alright? How are you doing?

Site:	Site I	Site J	Site K
CFIR:			
	what is the world coming to, and I think we're getting some progress on that." [1]	career, and that is right from porters, housekeepers, people in finance, you know, across the piece, and I think it makes it a very friendly organisation and we do come together quite well." [3]	What's this?' You know, it feels collegiate, it's a nice word" [2]
	"I don't think there is that anonymity that you might have in a bigger organisation, so I can certainly feel if I walk along the corridor I will see people, other consultants, nurses from the wards when I used to work on the wards, people from the management team, and I think there's a lot more people who just know each other and therefore go that extra mile for each other because they know each other." [2]	"That builds into the culture that I would have no problem going down the corridor and saying to our chief operator "I've got this issue can I talk to you about this?" And she wouldn't think it odd that I was sat there talking to her about it. In another organisation, someone at my level probably wouldn't have ever spoken to their chief operating officer, and I think that that is something lovely about working in this because you all feel that you have a part in it and you are actually heard. And I think then that means people stay and then that means that you build a culture where things can actually change." [5]	"We've had a couple of people in the past who would express views like you did, but it was a small number and I don't think any of them work here anymore, partly that's about culture, you know, we wouldn't tolerate a dismissive attitude to any of our patients." [2]
	"One of its greatest positives is its sense of camaraderie, its flat organisational hierarchy or what it perceives to be. Obviously, there has to be a hierarchy at times. It appears to be flat. And at times, when things are challenged, of course, we draw it up and		"You put people in a room together, of all different grades and they've all got equal place, and in the NHS, which is notoriously hierarchical and falls very much a role culture, actually that's quite a change, that's quite a step forward, where you've got a healthcare assistant or a medical records clerk talking

Site:	Site I	Site J	Site K
CFIR:			
	make it a little bit steeper and harder to go up the hierarchy at times.” [5]		to the consultant on an equal footing, and that’s really important. And that ability to say, “Actually, every one of you has something to offer and every one of you can influence how our patients experience our hospital and our services, and you can all challenge each other,” is really quite new in terms of NHS culture.” [3]
			“Overall, it’s the trust as an organisation – particularly the chief executive – has been hugely supportive of the emergency department and is massively visible and that makes a huge difference. Because, at my previous trust, the chief executive – and I’m very serious about this – nobody knew what he looked like.” [4]
Leadership and climate change	“We’re seeing changes now, but the board are fully aware of that and the struggle for the board has been how they can action it because they are the board, they haven’t had that effective clinical management and clinical leadership in place before I don’t think.” [1]	“Even though we’re in a good place at the moment, it hasn’t always been this good for six months. So, trying to embed that with new staff: and the skill mix is a lot more junior than it ever has been before. But I think, because we’re aware of that, we’re just having to do it in a different way: teach the service improvement stuff.” [2]	“There’s not enough, there’s not enough people. I mean, we’ve tried. All these things, it’s going to happen, it’s getting closer to happening, it’s just incremental change and it’s glacial incremental change.” [1]

Site:	Site I	Site J	Site K
CFIR:			
	"The chief executive and director of operations and all the people, they communicate with me pretty well as a CD about what their objectives are, what they're expecting of us, yes, what they're hoping is going to happen. And I do think they're pretty responsive to some of the things that we want to do as well." [3]	"We have a program management office that, really are focusing some of our cost improvement programs. But it's really ensuring that it's the quality improvement that drives that, as opposed to just looking for crude cost improvement savings." [4]	"a lot of my job is diplomacy and setting the strategy and then working out the interesting ways that we get to where we want to be, but the kind of red lines for me, so a phrase I use all the time is that we need to add value, so whenever we do something new or we bring in more consultants how are we adding value to the patients." [2]
	"I think our executive body now are in a position where they are, it's a pretty stable exec team, it wasn't at a time, it was going through lots of changes, it's pretty stable now led by X and I think that tier below, the clinical leadership at that tier below in the divisions is really important, especially nursing leadership, we were criticised to have some gaps in nurse leadership in particular, and I think we just need someone that could, you know, we do have a good quality improvement cycle but it, there's something else." [4]	"Our resources are thinning, we're not getting any more resources, and actually what we're basically asking people to do is to try things differently on top of already providing the care that they're already doing, and actually that's very challenging when you're getting even more patients with higher acuity coming through the doors." [5]	"But I do worry about Victoria Mason on two levels. Number one: I just wonder if it's the next thing in the NHS and, having been in the NHS as a doctor for thirty years, I've seen a lot of things that are 'the next thing in the NHS'. … And the other thing: I keep coming across these things that say they've reduced turnaround time in eye appointments from sixty-five days to six days. Well that was a year ago: I'd be really interested to see if it's six days now." [4]
			"And also that the hospital's changed beyond recognition, the executive team particularly have supported nearly everything that we've proposed." [5]

Site:	Site I	Site J	Site K
CFIR:			
Drivers and imperatives for change	"So NHSI have recently written to all Chief Executives and said do you know what, we've done some spreadsheet numbers and we've found that the way to run pathology in the country is have 29 hub and spoke systems, so this is your hub and spoke, we want to sign it off by your Trust Board by September, give us a delivery upon by January and have implemented it by June." [4]	"I think it's very important that change is communicated to frontline teams. And I think the change that's being driven by the STP, it's very clear, if you're sitting in a room and you're very close to how the strategic changes are being made, that you understand. But then when you try… Well, that is actually filtered down to basic clinical teams, sometimes it can just seem as change for the sake of change." [4]	"So when he arrived, six years ago now, he set about creating a clinically led hospital that was management enabled, and no one really knew what that meant at the time, but we do now, and it means that the clinicians are really in charge, and then the managers work with us to enable the things to work." [2]
			"So, one of the vehicles that we've got to do that is through Virginia Mason work that we're doing, which X has swallowed a Virginia Mason pill and…." [3]
			"So the government, basically, stipulated that they wanted to have a front-end GP service. So we applied for a grant – Enterprise: I'm not sure what you call it, but money – and we won the best part of a million quid…. So we've used that a) to put two GP rooms on the front of the department. And there's so many functional changes around that: we'd be here all afternoon. But, in terms of geography, that allows GPs to see patients in a more GP-like environment. And

Site:	Site I	Site J	Site K
CFIR:			
			we've also used it to change the way we process patients. We changed the geographical nature of it but, also, the way we process patients in terms of patients coming in by ambulance." [4]
			"There's investment in our departments, so they believe in acute medicine, for example. Sometimes they think, I think, we're the saviours to everything, which is sometimes difficult to counter, especially because my boss is also an acute medic. So, although he's my boss and he works for me, I work for him, so that's an interesting dynamic, and also because we've know each other for such a long time. But we think along the same lines in terms of where our vision for our department is, you know, we want to be the best in the region, if not a bit wider." [5]

Site:	Site I	Site J	Site K
CFIR:			
Organisational incentives and rewards		"From a nursing career progression, We're taking on different skills than we've ever done. And it's that kind of progression. We're taking on different levels of skills now. But you've also got the opportunities to actually complete the courses. The courses are there, which are available." [2]	"And it is quite nice to come into work every day and see a screen that says, 'The CQC rated this hospital good across areas. We saw 93.5% of our patients in four hours.' 'We are very low in Doctor Foster's mortality list' and so on. Actually, that's quite nice. I'm thirty years into my medical career and so I'm a hardened old rhino and, if I can still feel a bit of pride ... There's quite a lot of that going on." [4]
Available resources	"There are clearly financial impacts that you can see in community services as in care homes, social services, that type of thing, and given our geography and given our population I think we are definitely feeling the pinch on that, we have got ever increasing numbers of patients who are medically fit to be discharged from hospital but we cannot get out and then they end up falling, they get infections, it's not a good place to be if you don't need to be here, so I think we definitely feel the financial bite in that sense." [1]	"The resources are limited, each specialty would like to expand and have more consultants, expand the service, but funding is limited so there's always arguments like should it be cardiology or should it be another specialty." [1]	"The hospital for many years, as I'm sure you know, was underfunded, under-resourced and understaffed, and this meant that established services, when the commissioning environment changed, some of the sub-specialist services vanished." [1]

Site:	Site I	Site J	Site K
CFIR:			
	"It is challenging times in terms of the financial constraints, the staffing problems, particularly in ED, the staffing, it's definitely difficult to do your job where it feels like the expectations, both from our patients and also from regulators is always increasing and yet our number of staff and things like that are not getting any easier." [2]	"I would put a hell of a lot of money into actual computer systems that did what we wanted them to do. Because actually a lot of the risk around patients and a lot of what we need to access, it slows people down, it frustrates people, it delays care, it puts care at risk and I actually think that that's something that we have to invest in, but it's not ever really a priority, or it seems a luxury whereas actually think that we've gone the past the point of it being a luxury." [5]	"You have to understand, in this system, there is a huge deficit. It's probably the biggest deficit in any one STP in the country, it's certainly one of those category four STPs, or whatever category they're in. It's the ones that there's a real problem, there's a real financial deficit in the CCGs. So, therefore, you can imagine the CCGs position and the local GPs position is that they're in huge financial deficit, we're going to make a £21 million surplus or at least that's the aim. They think that we're sitting here on golden thrones and that they're scratching about not got any money." [3]
	"But if the community had more resource it would actually solve a ton of our problems anyway. Because we've evolved our system to try and cope with what's going on. But if you fix that bit for us, because we've evolved our system to cope with what's going on, we'd actually probably be doing all right." [3]		"Money. It's a public service. I think the way the NHS finances is bizarre. So I know that this emergency department brings in more money than it spends." [4]
	"But although, as a nurse, you feel like you shouldn't talk about the money, you need to. I think to be the leader of tomorrow, you need to understand that. Surgery's not my bag but I also understand that if we		

Site:	Site I	Site J	Site K
CFIR:			
	don’t get the electives in and we get that revenue in and telehealth doesn’t work because we’ve taken the nurses out of there, then my ED doesn’t run because we won’t be here.” [5]		
<u>Processes relating to change</u>			
Barriers to change	“What is frustrating is that the biggest barrier to changing things in this place is the consultant body, they are very stuck in their ways because things have been fine and it’s just ticked over and if you ignore a problem it will go away, because that’s what’s happened in the past; that is the biggest challenge.”… “So it’s that type of thing, challenging that type of ingrained behaviour, that is my biggest challenge but we are definitely seeing progress in that, but that is the barrier and if we can get through that then it will be okay eventually.” [1]	“It’s very difficult. I think it’s very important that change is communicated to frontline teams… Well, what is actually filtered down to basic clinical teams, sometimes it can just seem as change for the sake of change.”… “There’s so much change happening across the sector as well that demands that clinical engagement, and it is sometimes very challenging to commit very busy clinicians to be part of that change process and to make the best use of their time in a way that meaningfully engages them and that doesn’t have an impact on service delivery.” [4]	“There are a truly astonishing number of sub-committees, of sub-committees, of people who want to stick their oar in, who get in the way.” [1]
	“Mostly environment, cost, maybe an element of enough staff to do as much as you want, certainly in terms of general nursing staff, can be a bit of a barrier	“It’s probably pockets of individuals because I think it seems to be individuals with colleagues who get their colleagues to think the same way. We do have pockets	“Actually, at the moment, it’s really very difficult. Difficult actually because the role of NHSI and NHSE’s not helping that, so it’s designed to have us

Site:	Site I	Site J	Site K
CFIR:			
	to certain things because we just haven't got enough." [3]	of resistance around the trust. But then equally, if you have an individual that says, "Oh, come on guys, let's give this a go, and if it doesn't work…" And if you have that kind of attitude you can turn people around. So, I think it is pockets." [5]	combating with each other, if I'm completely honest." [3]
	"I'm not even going to say finance because it's always going to be there with the NHS, it's sort of a red herring with the money thing, it's always going to be there so that's not really an issue for a barrier for change."… "I think we worry too much as a small organisation about the big takeover, the big hub and spoke and that sometimes does stop, it does stop some change and development." [4]		"And I just feel there's too much bureaucracy creeping in. That's the one thing I would say. I don't have the freedom to operate that I did five years ago. But maybe that's inevitable." [4]
			"It's often, it's the fear of change for individuals that are within the service itself and quite often it's also about what they feel works for them sometimes, their personal barriers to it." [4]
Enablers to change	"… the absolute backing of the exec team and the management team below that. If you have got a good	"There was obviously a big spotlight because we were an integrated care organisation. And there was a desire	

Site:	Site I	Site J	Site K
CFIR:			
	idea and you can coherently explain it to them, primarily that benefits patients, it's very clear whenever you hear any discussion with the exec team, and I'm not just saying this because you're here, it is genuinely patients first, everybody on the exec team thinks that way. Finance is really important and we can't have one without the other, if we run out of money we're doomed but I think that would never be at the expense of the patients' care and experience. They are very supportive." [1]	and a real willingness, particularly around certain clinicians … to do something differently..." [4]	
	"A good management team who are willing to let you get on with it, try new things without saying the first answer being, "No, you can't do it because of x, y, z… " [3]	"I think it is being quite small and I think it's having senior people. We've always had quite a good backing for the key changes, we've always had COO and CO support for certain things. I think having champions …, she's very influential in terms of things." [5]	"There's no coincidence that when you have continuity and you have a management team that has been in position for a long time, then you're able to achieve things that you can if there's this constant churn." [3]
	"We get a great support, absolutely great support, so what, at every rapid improvement we'd had, so we had one for, I think we've had five so far, the Directors and … in particular have led those sessions right from the top." [4]		"I think the single thing that makes it all possible is the trust has been hugely supportive." [4]

Site:	Site I	Site J	Site K
CFIR:			
			“I can’t imagine that I’d have been able to, or my junior doctor would have been able to achieve that in a short period of time at a bigger hospital. So, I think that kind of innovation is nurtured here. And I think size is a lot to do with that, you get lost in a bigger system.” [5]

Representative quotes

	Site A	Site B	Site C	Site D
<u>Medical generalism and specialism</u>				
Concepts of medical generalism	"All of our consultants have the gen med. Yes. We're not very specialist." [FGS]	N/A	N/A	N/A
Patient casemix	"I was on-call yesterday, for example, and, in twelve-and-a-half hours, I didn't have to speak to any specialists. I'm a respiratory trainee and there was nothing that needed my respiratory specialist staff, which I know, from my experience, that wouldn't really happen." [FGS]	"What we are seeing, I think 80% or more on care of elderly around the hospital, even on the acute medical unit, and we are receiving patients with multiple comorbidities and they are being admitted again and again." [FGS]	"The meat and drink of the trolley patients that come in, that demographic is becoming older and older and older." [1]	"We do see overall a younger population happening because it's a transient young population that come and go and we don't really have a large, you know, elderly population." [FGS]
	"Young mobile adults are the most ideal sort of patients but we know that they only make up a small proportion of our acute medical take." [2]	"We have a gastroenterology ward, but the majority of people on that gastro mostly being in our patient specialty, most of the patients on our ward are general medical the same as everyone else." [2]	"We're significantly seeing more in the over seventy brackets. It's under eighteen – which, obviously, we don't have on our wards – eighteen to seventy and over seventy. And we're seeing a lot more in the over seventy category." [5]	"Generally, acuity's gone up and complexity's gone up. And that's gone up in every patient group: not just the elderly." [4]

	Site A	Site B	Site C	Site D
Attitudes of generalists towards work and patients	“I enjoy seeing lots of different medical problems and seeing how you can manage those on an ambulatory basis is quite satisfactory.” [2]	“The training is only maybe for five years, or some specialities six years, it does not train for every aspect, and our training is evolving every day.” [FGS]	“When we went into emergency medicine, all my colleagues went into emergency medicine, and it’s become far more geriatric emergency medicine particularly.” [1]	“I love my general medicine, that's how I learn because when you're a general physician you're on with a cardiology registrar or a gastro registrar and I can't keep up with everything so for me it's CPD being on, on take and I love it because you just don't know what's going to come in, it's really exciting.” [FGS]
	“Some of the elderly care physicians ... some of them still see themselves as rehabilitation specialists and are a little bit hesitant about the on-call. There’s one who would like very much to come off the general medical rota.” [5]	“I’m a general medicine specialist and during my training years I learned and I realised that I loved the acute part of it but the chronic part is not that interesting to me. The whole chronic care of the elderly.” [3]	“I see all different special ... those sorts of patients as an acute physician, whereas, I also have the benefit of going into providing specialist care as a diabetologist and endocrinologist. So I think the variability’s what gives me satisfaction, rather than doing the same thing every day.” [4]	“We are not triage monkeys. I’m a big believer in emergency medicine being incredibly important and a fantastic specialty. I don’t believe us in being Jack-of-All-Trades: I believe in us as Master-of-All-Trades.” [4]
Attitudes of specialists towards work and patients	“Some of the cardiologists don’t have qualifications in general internal medicine so they are not happy looking after people who have non-cardiology problems.” [2]	“From my point of view it is somewhat frustrating in that I have a ward where I have a cohort of patients in whom my skills are not best suited to their needs, and yet there are patients around the	“If there were five acute physicians then all those people who get a little bit grumpy about having to do an on-call would be less upset, because the team would be bigger, they’d feel as if they	“Out of everything else in the NHS, the most stressful time is the take. Oh yes, there’s no question about it, knowing the unknown and knowing the unknown number of doctors you have to face

	Site A	Site B	Site C	Site D
		hospital in whom I could have a significant impact but my time is such that I cannot be useful in that way." [FGS]	were peripheral parts of a bigger thing rather than having to undertake fundamental parts of it." [1]	with, knowing that nobody's going to continue the 24 hour responsibility, I feel for the patients." [1 and 2]
	"Cardiology registrars: you're then breeding this thing. You're breeding this atmosphere amongst your juniors then, of, 'We're too good to be doing that stuff.' 'Well, actually, you're on our general medical rota, therefore, participate in our general medical teaching and participate in a general medical approach to your patients.'" [4]	"Recruitment can be difficult and the people that do come, want to come here, have got quite a good lever to say "I'm a specialist, I don't want to be your on call rota, I don't want to do general medical stuff". Interestingly, they are happy to look after general medical things but not to be the on call rota." [1]	"And I think the issue arises, as I understand it, because those cardiologists are not general trained: not trained in general medicine. And I think they feel that they're not trained so they don't want to take the responsibility of a patient who's not purely cardiology." [4]	"JDs now, they are advertised very much as your speciality and general medicine, and general medicine is what you do here, and there is a generational aspect to it. So if we think about the 15 people on the on-call rota, some of the most senior consultants in our hospital are still on the rota." [3]
Interactions, relationships and balance between specialists and generalists	"The move for Gastro is that they don't do gen meds on-call because they should have their own gastro rota, which is what we're working towards. We're not quite there yet." [FGS]	"The more we take patients like that out of the system the more concentrated the wards are going to be with those elderly, really complex, really frail, so we're then compounding the problem of having generalist or specialist trying to look after this cohort of patients." [FGS]	"If there were five acute physicians then all those people who get a little bit grumpy about having to do an on-call would be less upset, because the team would be bigger, they'd feel as if they were peripheral parts of a bigger thing rather than having to undertake fundamental parts of it." [1]	"I don't think respiratory have a problem, I think they tend to be proactive, they'll come along to ACU, they're keen. Occasionally I end up having to look after respiratory patients on the respiratory ward because they've got too many and they end up looking after general medicine." [FGS]

	Site A	Site B	Site C	Site D
	“The only areas where it has caused slight difficulties is in our cardiology bed base, some of the cardiologists don’t have qualifications in general internal medicine so they are not happy looking after people who have non-cardiology problems.” [2]	“We have a number of people who are, who have done general medicine who are no longer doing general medicine. The difficulty is the more people drop off that rota, the more it falls to everyone else and setting a precedent is a dangerous thing if you don’t have a specific role.” [2]		“Because we don’t have acute physicians here everybody sees themselves as part of the problem, and it would impact on everybody equally if somebody wasn’t pulling their weight.” [3]
Future of medical generalism	“The recognition is that care of the elderly and frailty is the direction that we need to recruit in.” [FGS]	“Thinking about generalist and specialist care in smaller hospitals, you have to understand, and I think it’s not just small but actually all hospitals, we need to work as one service rather than split services with barriers in between.” [FGS]	“There’s several issues, obviously, I would love there to be some way that patients who were in the nursing home, residential home setting, could somehow access care differently, and there’s lots of different visions of how that could happen, but it may involve either modifying current specialities or even developing a new speciality which is very much more outreach.” [1]	“As far as I’m concerned hospitals have to have acute medicine, I can’t see that I would have stayed here if there was no acute medicine, for sure, because that’s what gives you the specialities.” [1and2]
	“It’s trying to say, ‘This is the way medical generalism is going. It’s no longer “We all want to be specialists”: it’s now, ‘We all want to be generalists – with a special interest, of course, so we	“We’ve spoken a lot about the ideal that we’d have generalists here. That’s what we need, to be honest, and we’re looking to – with the integrated care packs type model – we’re looking to move a lot of		“I would *love* a dedicated EM geriatrician role. When they were starting to do that ... I think that’s a wonderful, wonderful concept. I haven’t seen anybody else be able to deliver it

	Site A	Site B	Site C	Site D
	can differentiate ourselves. But it really is reinventing medical generalism in this hospital.” [5]	our specialists who can be - specialists like respiratory, like rheumatology, etc. We need to get these guys out into the community. We probably need more generalists in this hospital.” [1]		yet, but I think that would quite amazing.” [4]
Future of medical specialists	“There are a number of specialties where I might say actually you probably do need a core area that specialises in, in that particular sub-specialty of medicine and there are other areas where perhaps not.” [1]	“If you’re trying to recruit specialists, they want to do their specialist work, they don’t want to be doing any elderly ward rounds, so if you had that model, like you were saying, elderly physicians across the board and then you could actually do your specialism going round, I think that would help recruitment.” [FGS]	N/A	“Specialities have to exist, I mean, I can’t believe that we could be all generalists just doing general medicine.” [1and2]
	“We probably have slightly too many in-patient cardiology beds for the amount of pure cardiology patients coming in. A lot of patients with cardiology problems do also have other multi-morbid problems and sometimes that’s an area of difficulty, obviously other specialties can in reach to support those patients as well.” [2]	“You have to be able to cope with whatever comes through the door really.” [5and6]		

	Site A	Site B	Site C	Site D
	"There's going to be generalists looking after the patients. But, for some of them, you will, from time to time, need specialists to come in and, some of them, it will make sense for their care to transfer entirely to the specialist because it's a well-defined, purely specialist problem. Cardiology is probably the clearest example of that." [5]			
<u>Model of care</u>				
Interesting aspects of model of care	"We don't have specialty takes." [FGS]	"Ambulatory care. It wasn't invested in, or to a very small extent, and it was just left to sort of get on with it, to grow, sort of evolve really. FOPAS was entirely the opposite because it was the view of one person, whom you may or may not have met. And it was invested in. It was resourced completely." [1]	"After years and years of everyone pointing their finger at emergency departments for not hitting the target, there seems to have been a sea change in the perspective and there's appreciation now that that target is a system wide issue, with the main problem now being patient flow." [1]	"Geriatricians are at the interface between hospital and community and I think it is an important recipe for why we have a very effective acute medicine programme here because teams are going and pulling patients out." [FGS]
	"We created a, a floor for medicine that had, erm, the ability to turn patients round in an ambulatory fashion and take, and was open fourteen days, fourteen	"We've revolutionised, trying to revolutionise this sort of primary care, secondary care management referring patients follow up model. And there's	"We have tried to create wards to manage specialties and I think in doing that we've then lost a little bit of that general medical ward." [3]	"What works incredibly well here is that, potentially, the OT or the physio that sees them today might then be one in the community tomorrow." [4]

	Site A	Site B	Site C	Site D
	hours a day, Monday to Friday, erm, which was, which was very, very helpful to flow, particularly out of A&E."… "I'm very much don't reinvent the wheel, do you know what, there's plenty out there that we can learn from and my view is we take the best bits of everything." [1]	quite a lot of interesting and potentially exciting stuff." [2]		
		"It's not probably the best way to work or to move patients. Sometimes I have the feeling that it's just this huge commitment to try to keep up with the four-hour breaching goals that they've got in ED but then just shifting patients or moving patients from one place to another doesn't really actually make any difference for the patients if they are going to be moved up into somewhere in which they won't be well looked after." [3]	"All the GP patients have just come to the front door. I think it works really well because everybody's triaged to the same standard." [5]	"IIT generally accepts them, and most of the GPs, local nurses, community matrons will refer to us, as will the social workers." [8]
Ability of the model to meet patient,	"There's a definite slant where there's a lot consultants in certain specialties, which are not doing general medicine,	"Patients get a really good deal, on the whole…	"We've struggled to find a sensible, decent, sustainable model in the trust for a while, but that's because of not having	"Our solutions locally incorporate strategies around frailty, very elderly, which are mostly around focussing on

	Site A	Site B	Site C	Site D
professional, service needs	compared with our population and our requirements.” [FGS]	because of this relationship we have with other departments and things, we give really quite a holistic service actually, because if we see somebody and they need some physio we’ll go and get it sorted out, we can get it, this scale does make it quite manageable.” [FGS]	people, so if we had five acute physicians in the trust as a starting position, around which to build a team, I think whichever model we use would work really well.” [1]	keeping people at home and preventing admission, rather than using the acute take to manage their needs.” [FGS]
	“I still have the feeling that we can do better for our frail elderly that come in this hospital and I think we can do better in terms of identifying their needs quickly, erm, linking into external services quickly and not allowing them to decompensate whilst they're in an acute hospital environment.” [1]	“It’s not a problem dealing with all the patients coming into the hospital because we can do it. We can manage. We could open more beds and that wouldn’t be a problem, but what do you do with all those patients after the acute problem has been solved? Where do you send them?” [3]	“The challenges are lack of continuity, basically. Because, if a consultant is coming from another trust and providing sessional input, obviously, they’ll deal with the situation at the time but, obviously, sometimes patients need to be followed up, results come back, admin and things. So those have to be picked up later by myself.” [4]	“There is capacity to take general medical patients that aren’t our speciality, but obviously it’s the availability of a bed at any given time that’s the limiting factor, not how many beds are dedicated to gastroenterology, you wouldn’t ring-fence an empty bed in case a gastroenterology patient comes along, we wouldn’t be allowed to.” [1and2]
	“Typically we couldn’t fill the whole short stay unit with pure short stay unit patients which is why we end up getting some of these second best cases, so inevitably on the short stay unit we are managing some of these more complex	“Our clinicians like their specialty and you inevitably end up with a cohort of patients where there isn’t an ideal ward for them to be managed on.” [4and5]		“I think ED attendances for everybody have gone up. I think, for us, have gone up less than elsewhere. And I hope that’s because of an awful lot of things we’re doing around it to support and prevent it.” [4]

	Site A	Site B	Site C	Site D
	multi-morbid patients who stay longer than we'd ideally like on the short stay unit, ideally those patients would be on the frailty unit." [2]			
<u>Smaller hospitals</u>				
Unique characteristics of smaller hospitals	"If you're working at a DGH, then the assumption should be that you are going to do much more general medicine and you've made that life choice in your career to do that." [4]	"In small DGHs you tend to have your, - your community is invested in its hospital. Much of your staff live in the town that the hospital is in." [4and5]	"Coming to a smaller hospital, one of the things that struck me was around that difference in access of specialist healthcare and the things that you had at your fingertips in a university teaching hospital that you don't have in a district general, when you have to send patients elsewhere or ask people to come in." [3]	"One of the unusual things here is perhaps that everybody talks to everybody. … It's too small to have arguments with people." [FGS]
	"The realities of a small DGH: trying to replicate a tertiary hospital in miniature isn't really terribly feasible in terms of numbers, of people in a specialty. So there is always a balancing act." [5]			
Advantages of smaller hospitals	"It's quite friendly and everyone knows each other and you can get things done very quickly for that reason – because you know each other." [FGS]	"Things become manageable and achievable, and it's almost you could see it as a test of change in order to look at it	"There is a lot more of that team spirit, there's a lot more potential for improving those working relationships across areas because people consider the	"There's a real like working together type approach between A&E and Medicine here, whereas in other places it's a try and bounce the referral, try and

	Site A	Site B	Site C	Site D
		at national level, so this is a one-stop for that.” [FGS]	hospital as a real key part of their lives, it’s the hospital that delivers care to their friends and family, so they’ve got an invested interest in wanting to make things better.” [3]	bounce it, like it's more of how do we defend medicine from the A&E referrals.” [FGS]
	“I’ve always known I’d want to be a consultant in a smaller hospital, it’s just so much easier to build the networks and the relationships in the smaller institutions to make things run smoothly than in some of the big tertiary centres.” [2]	“You get to know everyone and everyone gets to know you. You know who you can rely on and who you can’t. And it’s easier. I think probably because it’s a small hospital everyone is friendly and everyone is quite helpful.” [3]	“The major strength is teamwork: because we all know each other, we all pull together for the greater good of the patients.” [5]	“We can achieve a lot because, if we want to make a change, it doesn’t go up six ... and ten meetings before we can actually say, ‘Actually, let’s try this’ or ‘Let’s give this a go.’ We’re not afraid to give things a go and I think that’s really positive. And I think, by having an organisation where there’s not lots and lots of tiers of people in each post, you can make change quite quickly and implement.” [5]
	“I think ‘small is beautiful’ in terms of change and flexibility.” [5]			“One of the pros is that you have the same people making the decisions all the time, so the quality control piece hopefully is slightly tighter but you can do that in a smaller organisation.” [6]

	Site A	Site B	Site C	Site D
Challenges of smaller hospitals	"Because we're a peripheral rural hospital a lot of people, especially if they've got children and family, they want to work nearer the big cities for other reasons, social and schools and things, so it's a bit harder sometimes to attract staff to come and work here at consultant level." [2]	"You sometimes feel threatened by the centre up the road, I would say, in that everyone's vying for business, and if the specialities in the small DGHs aren't treasured and recognised we will lose them." [FGS]	"There's something about within small hospitals not seeing what else is happening, not recognising that change is an essential part of everyday life. It's the same within a small town or village where everybody knows each other." [3]	"We could be perceived as quite vulnerable really. We are only a small hospital with great, big X down the road. And you don't get exposure to the more acute medical conditions or acute surgical conditions. And I think, for us, that sometimes becomes a challenge to recruit staff because, for cardiology, you want to come and work on a cardiology ward but you're going to see no intervention." [5]
	"To understand and to emphasise to my colleagues the realities of a small DGH: trying to replicate a tertiary hospital in miniature isn't really terribly feasible in terms of numbers, of people in a specialty. So there is always a balancing act." [5]			"Downside of it at the moment is around how do you address some of the quality requirements which are fundamentally about scale which you can never achieve on your own, so that is a challenge." [6]
The future of smaller hospitals	"There is no, one model. But it's a general bunch of ... I *think* it's going to be a bunch of models which have some similarities but are different." [5]	"Instead of thinking that small hospitals are going to become extinct, it's about saying how small hospitals deliver services differently in the future." [4and5man]	"There may be a role for hospitals like this in the future to develop a service like that, but I think it's still going to need outreach and in-reach, so GPs who have extended skills, or community	"If you go on high quality clinical staff doing good things and a decent volume of patients you will survive. If you don't have enough patients you've got a

	Site A	Site B	Site C	Site D
			based physicians, not necessarily GPs, who are largely based in the community trying to prevent admission, and consultants in the hospitals who work in the communities to prevent admission." [1]	problem, if you haven't got good clinical staff you've got a problem." [6]
			"I personally strongly believe that unless we make changes then the hospitals in their current form are not going to be sustainable in the future, either clinically or financially." [2]	"Partly, the narrative is wrong. A lot of the narrative is just about saving money. So there was a very heavy, clear narrative at NHS England – brackets – (London) – NHS London before that – essentially said, 'If you vaporise one small hospital in each sector, the books balance. But the patients have to not go anywhere else." [7]

	Site E	Site F	Site G	Site H
Medical generalism and specialism				
Concepts of medical generalism	"It's what's being driven nationally, hence the evolution of the acute medic, you know, which is, if you like, a 24 hour, 72 hour specialist in general acute	"I suppose elderly care physicians are our most generalist service." [FGS]	"You sometimes see the culture that a speciality interest is still, actually, what the person is interested in. And, in specialties that may not have expanded	"Whilst I think for patients they're better being under the specialist if it's black and white, I think the fact that I'm also a

	Site E	Site F	Site G	Site H
	medicine, and I don't think that speciality would have evolved had we not been driven to become a super specialist or a consultant early." [FGS]		as rapidly as others, that people have taken on an acute medical role with their interest because it was a way of getting a substantive post." [1]	bit of a generalist as well is good for the patient." [FGS]
	"I always maintain that doing general medicine, I learnt my trade in district generals, in the middle of the night as an SHO for years and years, you know, and I always maintain that it's a brilliant hunting ground for general medicine as a DGH like this." [3]	"I think the good points of having generalist care is that everybody has a good oversight to everything that is going on and therefore you have that continuity of care. I think the downside is that when you then have to refer to a specialist you can build in sometimes one to two days of delay for that specialist input." [5]	"For a hospital like this to continue to thrive it has to be dealing with the general everyday medicine, which is just basically people being general physicians, whether they're geriatricians or rheumatologist or whatever. The true speciality stuff, if you look at the standards, you won't be able to sustainably run the speciality services in a place of this size or this health economy, so you have to be clever enough to realise that you need a cadre of generalists who can deal with 90% of what's going on, and then that magical 10% that needs that true specialist needs to be shunted quickly to where they need to go." [2]	"My tagline is that your role as a general physician is to make everyone else do their job, because it literally feels like you're going down to the playground and dragging people to come home early to do scopes, to offer opinions, to get their arse in gear and actually do the job that they applied to do." [2]

	Site E	Site F	Site G	Site H
Patient casemix	"From the specialist wards point of view we get patients up who have comorbidities, so they've not just got one thing wrong with them, they've got a lot of different things that need sorting out, and particularly from a discharge point of view, the social side of things, it can be very complex." [FGS]	"Going back to the elderly population, we have the highest rates vascular acutes in the country." [FGS]	"Many physicians feel 'I don't really enjoy', if that's the right phrase, 'dealing with frail older people on my on-calls'." [2]	"Nobody comes in with pneumonia: they come in with PCB and HIV and lymphoma. Nobody comes in with salmonella: they come in with Burkett's lymphoma and they're duodenal. It's just the diagnostic yield and all that is massive. And, mainly – this is one of the interesting things and, again, entirely front door, non-evidence based – when I started, acute work was ... I worked in X so it was booze and cardiology." [2]
	"We're the smoking capital … so all the adverse things, teenage pregnancies, smoking, all that type of thing is here and that knocks on to the health demand being here." [4]	"We felt a growing elderly population impact on us in a number of ways. At the front door and, in our discharge services, we struggle to find placements and, sometimes, the discharge is difficult. So it's impacted and we've tried to be proactive and respond to it but it's going to be a continuing pressure." [2]	"I think it would be impossible to get them to take responsibility for everyone because, actually, maybe about 60% of all our patients are geriatric: it's a very elderly, frailty population. It's impossible. If they had a kind of acute frailty unit, or ward, where some of the patients can go, that would help." [5]	"It's probably about a 50:50 split actually between those frail elderly and the complex co-morbid patients who aren't necessarily elderly." [5]

	Site E	Site F	Site G	Site H
Attitudes of generalists towards work and patients	"The fact that I do do general medicine, I mean, I learn something new every day, or I might remind myself of something I'd forgotten every day, it's just brilliant training and brilliant to keep your mind ticking over. Yes, I can't be the font of knowledge about every new thing that comes on in every speciality, but I can access that knowledge, from which I learn and retain. You know, the exposure that you get, I just think it's great, purely from a medicine purist point of view, is great, you know, I just never stop learning, and I think, having that holistic approach to patients that you only get from the experience of doing that every day, means that you can see patients as a whole and you're treating them as a whole, and that's what they want." [FGS]	N/A	"Care of the elderly feel that they're way overburdened with the inpatient population." [2]	"My tagline is that your role as a general physician is to make everyone else do their job, because it literally feels like you're going down to the playground and dragging people to come home early to do scopes, to offer opinions, to get their arse in gear and actually do the job that they applied to do." [2]

	Site E	Site F	Site G	Site H
	"The acute physicians are slightly naughty in that, what they want to do is eight till four, every day and nothing else. And so that wasn't on because it's ludicrous." [6]		"It can be a bit disheartening when you're doing a consultant ward round and the patient just says, 'Well, I only want to see the cardiologist' and 'Are you the cardiologist because I was promised I'd see a cardiologist?' And you're thinking, 'Well, the cardiologists don't like doing on-call.' You say, 'They're not here: they're far too busy and you've got me.'" [7]	"I enjoyed general medicine, I was very keen to maintain a practice in both general medicine and my speciality, and I felt... having worked in smaller hospitals I actually think I enjoy working in a smaller hospital." [5]
Attitudes of specialists towards work and patients	"I don't think it's that people don't want to become acute medics, general medics or medics with an interest in whatever, I think it's because they don't know and they're not confident to say 'Well alright, I'll take that on', you know, and because they see the pressure of the general medicine rota and say 'Well no, I'm not going to do that', and then, as quick as you like, say 'Well right, I'm going to do this super specialist training and I only want to know about this thing'." [FGS]	"We don't often outlie to other areas. When we do, we're seen as a bit of a burden and that comes across in the attitudes of some of my colleagues in operational meetings and so on. And we find that quite difficult to stomach because they're a great population and, of course, we're all going to get older at some point." [2]	"In terms of work/life balance, I'm finding being on two rotas – to be honest – is difficult, of course. And, perhaps, unlike most physicians, I have to attend the site when I'm called on-call and I don't sleep because I won't sleep if I'm called in at night and I'll do procedures and things. So that's probably more of a challenge. But I'm sure other people find it equally as challenging."… "I trained as a junior doctor and I did all sorts of general medicine and I did lots of care of the elderly medicine and I did specialist care of the elderly medicine, a	"There is something different about a DGH, isn't there, which is why we're all working here because we like the DGH, because we are inherently a little bit more generalist, probably." [FGS]

	Site E	Site F	Site G	Site H
			lot of it. So I'm probably fine and it's fine that the people I see ... I was probably lucky, maybe, to do that and then end up working in a hospital where elderly medicine is managed by general physicians on-call. So maybe that ... I'm comfortable with that." [7]	
	"If you take cardiology and respiratory medicine, we're 25 miles or whatever it is from one of the world's leading centres so they understand what it is to be a super-specialist and yet they have chosen to be here so they understand that that's something different that they're doing." [4]	"I think if we weren't set up as we were here and I was now still doing an old fashioned general medicine, where you were doing everything, I probably would be looking elsewhere." [3]		"The way of offsetting their concerns about it is to say 'You're just doing it one day a week and the rest of the time you're doing speciality', so it's perhaps to make the speciality bit more attractive, but I think it is a problem." [5]
Interactions, relationships and balance between specialists and generalists	"The specialists are very pulled in many different directions, the ward cover, clinical cover and then the front facing review of patients as well, I can't speak for them but the impression I get is they feel they're stretched in many different ways, and the privatisation, you know, they're being asked to discharge patients	"Lately the physicians are certainly feeling the strain between the in-patient and out-patient conflict and to be honest, in winter it's one message and then in summer it is probably a slightly different message. So it is a resource challenge isn't it and that's going to generate at times some tensions." [FGS]	"AMU consultants are likely to be more assured in ... It's not taking risks, but calculating whether something is a risk or not. I think the other side of that is, then, you actually free up your speciality consultants to do the other bones that the hospital needs in terms of managing speciality work." [1]	"We have consultants designated to certain wards, so if there aren't enough beds for elderly care patients they would be put onto one of the other medical wards. So, as a respiratory physician, of course I have a lot of patients under me who are in with a respiratory problem and a lot of them are elderly, but we also

	Site E	Site F	Site G	Site H
	off the ward yet they're being asked to review patients who are coming in as well, and to work their team so they've got the resource to cover everything." [FGS]			have a lot of other elderly people in with other problems that are under me because they're on my ward." [FGS]
	"I don't think they don't want to help, it's not some kind of bad vibe, it's just that they're thin on the ground, so we use a lot of the specialist nurses." [3]	"All the cardiologists, so as a group, we would not do general medicine if we could, is the honest answer, and it's not because any of us necessarily don't enjoy it, but we would rather do our specialist work." [3]	"I think every group feels they have the short straw. But I can only speak for the acute physicians." [5]	"Everyone who works here is, basically, a generalist. And, although they have specialist outpatient activities, they are all reasonable generalists. That's diminishing and people are trying to get out of generalism, which is a problem." [2]
Future of medical generalism	"It's one thing that's quite interesting to note about the resurgence of the generalist. Again speaking about my own specialty, which I know is a very small specialty, because of the reasons I've explained about centralisation of services in haematology, lots of our DGH colleagues are not fully established. So that means you might have two people doing on-call, so they are doing a one in two and so as a	"The only thing I think that needs to be thought about when you look at generalist models versus specialist models is actually what that means for people that are doing the jobs. From an ED point of view you are talking about models where you are bringing all the specialties into the emergency department and asking them to come and manage their patients so what is the role of the ED physician in that?	"I think, the more we have acute specialists who are truly acute specialists, appropriately skilled and appropriately enthused, I think the better that will become – *I think*." [1]	"If you've got teams that can be flexible in a smaller place and have a bit more of a scattergun approach then the specialist model works relatively well, but the number of people who are going to have blurred lines are going to become more and we all have to change with that a little bit, don't we." [FGS]

	Site E	Site F	Site G	Site H
	generalist we can help out – telephone advice – we can help out with all of that.” [4]	Actually is it an attractive role and will you get recruitment to ED because most of the type of people who join ED tend to enjoy resuscitation, tend to enjoy the sharper end of things and if you take that away from them then essentially they become a person who manages lots of other specialities and manages flow through a department but doesn’t actually get that clinically involved with patients and I think that’s not an attractive role for somebody who wants to be involved. I don't know how the generalists feel in terms of the acute physicians and what their specialist interest is versus bringing specialists in to take that away from them, I don't know how that lies with them.” [FGS]		
	“You have a finite number of people who can learn the services that you can refer to, learn the capabilities of those services and who, therefore, become expert in managing the first twenty-four/forty-eight hours or so. They will clearly need to call in people for things	“I think what we’re missing is the staff that want to work in geriatric specialties because it’s not, I guess, as sexy as something more dynamic or demanding. It’s not ED or cardiology.” [2]	“For a hospital like this to continue to thrive it has to be dealing with the general everyday medicine, which is just basically people being general physicians, whether they’re geriatricians or rheumatologist or whatever.” [2]	“The only other thing is how do we work harder at frailty, it is going to become more and more of an issue so how can we take some of the good practice that goes on in units clearly set up as frailty units, how can we do that

	Site E	Site F	Site G	Site H
	which they require advice and help on but, what I have seen, when you have the generalists who are in their specialties, is an enormous risk aversion to discharge.” [6]			here where we have some really good elderly care consultants.” [3]
Future of medical specialists	N/A	“I think we provide very good general services, and I think downstream our specialist services are very good, but I just don’t think we’re big enough or with enough people in each speciality to provide the early specialist services we would like.” [3]	“The true speciality stuff, if you look at the standards, you won’t be able to sustainably run the speciality services in a place of this size or this health economy.” [2]	“If we were recruiting now we might not recruit to a general medicine gastroenterology physician, whereas I think all the other specialities, definitely we want someone who can do both, and to some extent, I think when it comes to recruiting, when we’re interviewing, it is as crucial to us that they can deliver on the general medicine side as they can deliver speciality.” [5]
Model of care				
Interesting aspects of model of care	“We were running at over 95% for seven months, best part of a year, about two years ago, and everything was going swimmingly. It was quite interesting that at the same time the medical admissions model changed, was the same time that actually the target kind of disappeared. It	“We’ve built our services on the needs of the population so I think it’s probably more historical than any great plan.” [2]	“I can’t see us, as an organisation of this size, we will be able to achieve that full, acute medical model. So I think we’re going to have to look at some form of hybrid.” [1]	“I think we can afford to run a speciality model because we’re a DGH and therefore that cross fertilisation is much easier.” [FGH]

	Site E	Site F	Site G	Site H
	was also about the same time that the numbers really started ramping up as well, so to what extent each of those factors played I don't know. I mean, certainly if you talk to the CIO, actually the same people who are working in ED now are the same ones who were here providing 95% two years ago. What's changed? It wasn't ED." [1]			
	"We've grown the department a lot really because it was ticking over but it wasn't really focused on ambulatory emergency care, which it is now, and we do have other stuff but actually we'll probably lose more and more of the routine stuff, and the focus purely is on ambulatory emergency care and admission avoidance and acute and semi-acute medicine and the interesting interface that ambulatory care offers in that way." [3]	"I think we're different here because 85/90% of our activity is non-elective. That's a real shift from any other hospital I've been at." [5]	"We're in the process now of reviewing the configuration of what we call the emergency pathway which would be ED, ambulatory care and AMU, and how patients flip through those areas." [3]	"So there is a bit of resistance to change, there's a way of doing things and it has pretty much worked so don't come here with your clever ideas, kind of thing!" [3]
Ability of the model to meet patient,	"A lot of patients who would have come in before are not coming in now, they're being able to be kept out, so the patients	"Everybody gets on and everybody knows everybody and things just happen. For example in ambulatory care	"We don't have as many registrars as we should have and that's why the consultants are working so hard, so that	"The challenge with that I guess is what you're researching in many ways, is that, going back to what you were

	Site E	Site F	Site G	Site H
professional, service needs	who are coming up to the wards are very sick, but they also have complex social needs as well, so they tend to stay longer. Yes, so I think they would say they find it harder." [FGS]	the other day I had a patient who came in I think with a headache, she saw a nursing auxiliary who welcomed her, did her bloods and did her obs, then saw one of my nurse practitioners who started clerking her, saw her, did some basics, I came in and reviewed her and it was a very quick history and she needed an MRI brain, from what the GP had told me it was very obvious that's what she needed, so phoned up MRI, send her straight down. So within ten minutes she'd seen a nursing auxiliary, she'd seen a nurse practitioner, she'd had a consultant review and had an MRI which you can't pay for and that is an example of what happens in this hospital and I haven't seen that in others where I've worked, and it just works because everybody works together." [1]	links to your question about the clinical engagement, they're shattered because they're doing all the work that actually if they had registrars and junior doctors they wouldn't have to do, they haven't got the energy to do anything else." [3]	saying earlier, you don't have patients now who have just got one single problem, single presented complaint, but manifested and linked to lots of other co-morbidities, but we've always felt I think that that speciality model, getting patients predominantly managed by a medical team and a wide supported team who are trained experts in those areas, it's just becoming a bit more defuse, isn't it." [FGS]
	"We've had meetings with GPs and I meet with the CCG once a month and we send back this message that we are not general medical outpatients, this is the focus, and this is what they want,	"Thinking about decondition and things on some of our wards: we're not as responsive to patients as I guess we should be and that might be down to a lack of therapy staff in some areas; it	"I think it's very reflective of our local GP service, talking to the patients. And I think it's very reflective of, also, people's expectations now: that they	"You get to the stage where additional effort isn't going to change outcome. So it doesn't matter how hard you work; it doesn't matter if you put another twenty hours of work – it's still going to fall flat

	Site E	Site F	Site G	Site H
	clearly, they pay the bill, this is what they want, they want us to be admission avoidance, they don't want us doing the GPs work." [3]	might be down to levels of nursing. It's not necessarily an intentional fault but it's just something that comes with other issues that we have." [2]	come, wanting an immediate answer." [7]	on its arse. And, because of that, people relax a little bit. It's ironic and it's not very positive but, in a way, you think, 'Well, I've done the best I can." [2]
<u>Smaller hospitals</u>				
Unique characteristics of smaller hospitals	N/A	"There's only a certain amount of establishment we could expand to without the whole place imploding. And I think, at the same time, you would lose all that knowledge. You don't walk round the corridor without saying, 'Hello' to someone." [2]	N/A	"There's a significant role for DGHs that's different to teaching hospitals when it comes to that concept of teaching and the high-end teaching stuff because I have worked in teaching hospitals where the accommodation for teaching was far superior to what the poor patients had to have and sometimes I think there's a distraction in big centres where they forget maybe what the core role is, which is about patient care and DGHs rarely forget that because that is their focus and that's what they're here to provide." [4]
Advantages of smaller hospitals	"You can just have a conversation with a person as opposed to sending an email to	"Because the structure is quite easy to access, you can kind of get decisions quite quickly. So I can go and knock on	"If you're ambitious in one way and want to make progress with management, you can actually make that	"One of the things about smaller hospitals, one of the strengths we have is space to do things." [FGS]

	Site E	Site F	Site G	Site H
	an address, and I think that does make it easier to try and get stuff done.” [1]	the chief of operation’s door – or even Debbie’s actually, depending on what it is – and go, ‘Actually, what do you want to do? We’ve got that or that.’ [5]	progress quicker in a smaller institution that you can in a bigger institution.” [1]	
	“In a DGH I can visit every single ward in this trust and I can get to meet every single person. I work in the ED clinically so when they’re really busy they phone me up, can you come down and help, so I take the suit jacket off and help and then once a month I do a clinical shift with them in a nurse’s uniform. So you can get around and you can meet people and you get to know, so your stakeholder engagement.” [2]	“On the very positive side for a small district general hospital it means you have a multi-skilled workforce who can look at many of the issues.” [5nurse]	“If there is a dispute – one consultant would talk to the other one and we’d work it out. Maybe that’s an advantage of a smaller hospital. Maybe we do have to work together and we do ... If we talk, we tend to resolve it.” [7]	“The strength, I suppose, in one aspect, is control over large elements of your working environment on a day-to-day basis. And ‘big fish, small pond’ isn’t it, really? You get to enact change directly. And, if it cocks up, it’s on your head but, if it’s successful, you can say, ‘Oh, that was me; that’s great. Thank you very much.’ And it allows you to man-manage to an extent, particularly doing generalism.” [2]
	“It’s the breadth of practice in a District General Hospital.… It’s easier to make a difference.” [4]			“One of the advantages of doing it in a smaller hospital is you’ve got everything, you pretty quickly know everybody and everything’s there.” [5]
Challenges of smaller hospitals	“All the good interesting stuff has gone to the teaching hospital so that means that, okay that’s fine, you can say I’ll do	“Our weaknesses are, sometimes, our staffing; finance is a weakness; estate is a weakness; ability to respond to	“In a small hospital, it’s very difficult to get buy-in to taking your	“We’ve got less options for where you can put people, terrible language but you know what I mean. So when we’ve tried

	Site E	Site F	Site G	Site H
	some work here and some work there but actually many people don't like that, we're seeing that with the merger of two Trusts. People want to work in one site, of course they want to work in one site. So in order to improve the outcomes for people with specialist, not even special complex but certain types of diseases, you centralise it and of course you're going to build the expertise, of course you're going to get the research work out of there but you're not thinking about the poor old general patients in the DGH, who's going to look after them? Because if we've got a shortage of doctors, everyone wants to work where all the fun stuff is." [4]	massive changes would be a weakness again because of staffing and finance. It's all interlinked through those three headings." [2]	gastroenterologists out of the acute medical rota to do the GI bleed rota." [1]	to re-jig our wards in the past it's very difficult to generate whole areas for one group of patients because your number of wards is relatively limited." [FGS]
	"I'm very jealous of big hospitals – especially those with academic departments – because of the sheer numbers of staff that you can get in at flexible rates to fill your gaps." [6]	"Being a smaller place, in terms of if you want to do new things you're more constrained, you're more vulnerable if there's gaps or people are off, and therefore that puts more pressure on you, so you have less time to maybe do the development stuff you want to." [3]	"It's a small trust so it's like a small island, so people are used to doing the things that they've been doing for years in the way that they've been doing it." [3]	"The downside is very much about your resilience in the teams and your ability perhaps to cover all the bases in terms of specialists versus generalists." [3]

	Site E	Site F	Site G	Site H
The future of smaller hospitals	"There needs to be respect for them." [4]	"With the way things seem to be going with the workforce and things, I do wonder whether small hospitals in this sort of form really can continue to be sustainable and survive.… "The problem is most people now want to do their specialist work, and therefore I think probably the model of the smaller hospital, with more and more places now amalgamating, is probably the way it is going to go." [3]	"For a hospital like this to continue to thrive it has to be dealing with the general everyday medicine, which is just basically people being general physicians, whether they're geriatricians or rheumatologist or whatever. The true speciality stuff, if you look at the standards, you won't be able to sustainably run the speciality services in a place of this size or this health economy, so you have to be clever enough to realise that you need a cadre of generalists who can deal with 90% of what's going on, and then that magical 10% that needs that true specialist needs to be shunted quickly to where they need to go." [2]	"It does feel like you're looking round, eyeing up other people, wondering who's going to be dead first really. But the long-term survival is really going to be networking across those sites, really." [2]

	Site E	Site F	Site G	Site H
		“I think what would be the best thing to make this hospital flourish in the future is to be seen as an exceptional place for care in its own right, so it may be the major call centre rather than the trauma which we have been, but it still needs the investment, and it also needs the ability to continue to be the master of its own destiny.” [5]	“‘How can they survive?’ Obviously, they need to have a link with the major hospital.” [4]	“We need the narrative at national level to stop saying that we're too small, because actually if you look at the continent we're quite big.” [4]

	Site I	Site J	Site K
Medical generalism and specialism			
Concepts of medical generalism	"People have always said that medicine for the elderly was the last bastion of general medicine because you have to cover everything, so yes it probably does work better for our older patients, but I guess now we have acute physicians and they probably mop up a lot of the stuff for everyone else, so between them and medicine for the elderly I think that probably does cover all the general medicine stuff really." [2]	"Sometimes you make a decision that it's right overall for the patient but from a cardiac perspective you might like to do something else but you choose not to do it because you don't feel it's the right overall direction of travel for that patient. So I think that's to be encouraged otherwise everybody just says what they want to do and the patient still hasn't got a plan." [1]	"We will take into account the clinical condition the patient has, but we'll also look at the likely length of stay of the patient, and also because a speciality respiratory consultant is good at being a specialty respiratory consultant, a specialist AMU consultant is good at being a short stay consultant. So actually, if we think that the patient will benefit from that level of review and that level of discharge orientated thinking maybe, so maybe we would think 'Well let's use the GIM'."… "Well an over 75 year old or someone with frailty, of course the whole point of a geriatrician is you're a generalist for that population, but that's what a geriatrician is. So I don't necessarily think that they are a generalist, they're geriatricians." [2]
	"I like the very generalist model at the front door with less ologists, but those that they're downstream doing what they're really good at. That makes way more sense to me than an ologist where you used to have just on-call and if it happened to be their day on-call and somebody came in with a gastro problem, that patient got superb care, if it was a gastroenterologist." [3]		"I won't quite be satisfied until I've only got cardiologists managing inpatient beds, respiratory clinicians managing inpatient beds, gastro managing the gastro unit, but the rest, acute medics with in-reach of specialities. So, having a diabetologist or an endocrinologist managing a ward, disaster, well, in the extreme but nonetheless." [3]

	Site I	Site J	Site K
Patient casemix	"Most of us are very reasonable people and we just accept that as a respiratory physician, if the only base ward bed is on my ward then I may take an elderly patient with complex geriatric type problems and I've just got to suck that up and deal with it because it's a DGH, I can't be looking after just people with specialist respiratory stuff and I think most people get that." [1]	"Our cardiac ward has the third or second highest average age of patients so I'm basically a geriatrician. Our average is higher than some of the care of the elderly, we have three care of the elderly wards but the second or third highest and oldest population group. So here we run our service as not discriminatory based on age, if they have a cardiac problem they can be 100 years old and we'll have them on our ward, and obviously we'll have to deal with some of the other non-cardiac issues because of their age or co-morbidities." [1]	"The major pressure that we see here is exactly the same as everyone sees in the whole of the UK, which is the sick elderly who are infirm with multiple problems and complicated social circumstances." [1]
	"People are living longer. We do a great job within primary and secondary care to support the longevity of their life with medications we have and all the other things go on operations. So, it means that we do have a much older generation who are with us much longer. And also, their needs change and adapt. And because of that, we're starting the see dementia, Alzheimer, cognitive issues far, far more in our everyday work that I ever remember, even 20 years ago. And with that comes all the issues around the legalities of their care." [5]	"One of the biggest areas for medicine is elderly care and people who are... you know, most of our wards are people who are over 80 or even 90 and need the care of a geriatrician, those sorts of services, and rehabilitation." [3]	"When we wrote the geriatric strategy about five years ago, when we audited it, it was about 65% of the on-call, no 62% of the take were over 75." [5]
Attitudes of generalists	"And I actually, once I get going, like the long days as well." [3]	N/A	"The thing I'd enjoyed most in my training was being on-call and looking after people in A&E, you

	Site I	Site J	Site K
towards work and patients			know, when they were unwell, so acute medicine was right up my street.” [2]
			“One of the things I’m trying really hard not to do is tell other people to do their jobs. Because, one of the joys of being in emergency medicine is the cardiologists think they can manage all the chest pain better than you; the orthopaedics surgeons think they can manage all the broken bones better than you; the general surgeons think they can manage the abdominal pain better than you: what they all fail to realise is that, in actual fact, we serve them up – for want of a better phrase – and don’t put this in the pejorative – we serve them up the meat.” [4]
Attitudes of specialists towards work and patients	“We all accept that that is the case, that if we wanted to be super-specialists in our own field of specialism we would have been looking for jobs in teaching hospitals. Maybe there are one or two people who are here because they couldn’t get jobs in teaching hospitals, but that’s slightly different. I’m here for the work life balance.” [1]	“The perfect example, it happens sometimes, we got a call saying there’s a 105 year old demented patient who has come in with a heart attack and is completely dependent, would you like to do an angiogram, and I was like, I can do an angiogram but is that in the best interest of the patient and you’ve seen the patient and you can decide that and let me know. And often they will actually come back and decided it’s conservative therapy, but sometimes I have to go and make that	“Although we don’t contribute to the general medical take we will still look after general medical patients if they’re transferred to our ward, and we will also look after general medical outliers on the lower GI surgery ward upstairs, which might be no one, it might be in the middle of winter half a dozen.” [1]

	Site I	Site J	Site K
		decision myself because some people don’t want to make it.” [1]	
		“So we were talking about whether the staff liked moving around, and no, they don’t like it. I think if you’re going to work on a ward and you particularly like a speciality, that’s the reason why you apply for a ward and work on a ward, and also there’s just something about safety and being comfortable about being on your ward because you know where everything is and how it works, and then, you know, you looked after those patients yesterday, so there something about continuity, and also they might not necessarily have the skills for that area. I mean, a lot of them are generalists, more the junior nurses, but if you were to move a senior nurse to run the shift you would need to know some of the more specialist skills. So it is difficult, I really do understand it’s difficult, but somebody’s better than nobody, unfortunately.” [3]	“Geriatricians are not there to do things people don’t want to do, they’re there to be geriatricians and to do the things that they enjoy doing, and that’s a much more positive way of looking at it.” [2]
Interactions, relationships and balance between	“Gastro are quite keen to come off and I’m quite keen to get them off. It’s difficult, every group of clinicians that you talk to are the busiest group of clinicians in the	“I think when you provide a general cardiology service you need to have a breadth of knowledge I suppose, I guess you don’t necessarily need to have a depth of the knowledge but you need to access to the	“Although we don’t contribute to the general medical take we will still look after general medical patients if they’re transferred to our ward, and we will also look after general medical outliers on the lower GI

	Site I	Site J	Site K
specialists and generalists	world, the challenge is getting people to see the bigger picture." [1]	super specialised specialists, so the pathways must exist for that." … "Cover can be a problem so we can't all be away at the same time, in a larger department perhaps it's easier to choose the time that you want to be away because there are more people around to cover. So the department is a bit more cohesive, you need to really get on and give and take more, so cover is one issue." [1]	surgery ward upstairs, which might be no one, it might be in the middle of winter half a dozen." [1]
	"It's gradually shifted from that to us employing more acute physicians, us delivering all the daytime bit, extending it until much later in the evening, us not being on the general on-call rota but still doing some weekend sessions. So, it's gradually evolved, depending on what consultants we've had really." [3]	"I think the acute medicine has always been, A. considered very progressed, some very, very innovative clinicians, most of the care of the elderly consultants have been recruited to be part of acute medicine and COOP, the same with respiratory, cardiology. Maybe it's because we were a small hospital. We have some clinicians who, basically, if they had their way, would have whole wards that would be just specialist wards, but we are a very small hospital in terms of our bed base." [4]	"So I believe the sweet spot is you need some fixed commitments that give you structure to your life and make you feel less mad, and they allow you to not get stressed about what you're doing and not forget about it, and then there's some other things, because you're sharing, that are rota'd." [2]
			"Then we have the chairs bit, as you come in to AMU, and that was just getting overcrowded. As much as I see why targets are useful, the problem with the patients that ended up in that area is they

	Site I	Site J	Site K
			weren't subject to any targets, so it felt like they were the lost tribe. So, you'd have a patient coming in who needed admission, who'd wait eight, nine hours for a bed because they're not four-hour target. So, no one was interested in them. So, we did some work around patient experience, we put it on the risk register." [5]
Future of medical generalism	"I think increasingly we're going to see that an increase in the kind of generalist who do have specific training in acute medicine but also have a specialty interest as well. I think that's the way forward in terms of our recruitment." [1]	"I think we need to be really focusing on what our key business is. I think we could reduce the amount of specialities that we have, I think keep the core things, like respiratory and heart failure and the elderly physicians of course, but then we've got very small units, they're very vulnerable, the neurology, rheumatology, very small, you know, as soon as somebody, a couple of physicians or a couple of nurses, go on maternity leave it sort of completely collapses, whereas if they were part of a bigger unit then they would do better I think, and then we could really concentrate on the things that we do well, which I think is the elderly, complex elderly population." [3]	"A lot of general medics, and I heard, as I think you know, the registrar of the Royal College say 'There's no such thing as generalists' the other day, which made me very upset because I've got generalists and they'd be upset if the Royal College were saying that about them." [2]
		"One of the people that has just left, he did half acute medicine and half geriatrics but we've decided to go out for fully acute medicine, mainly because his response was, "I liked it but I'm a bit crazy, I don't	"When I started we had lots of different speciality clinicians and they managed the take and we put in the acute medical model, we have acute medicine managing the acute medical model and I'm now

	Site I	Site J	Site K
		know if anybody else would like that job!" I think at the moment we're open to most things because we're so desperate to get people in!" [5]	expanding that more and more and more and that's no accident. What I'd really like is all of the inpatient medical beds, with a couple of exceptions, respiratory, cardiology, gastro, being managed by acute medics with a specialist in reach." [3]
Future of medical specialists	"And then you've got either specialists within the hospital or elsewhere who can either give advice by coming and seeing the patient or over the phone or the patient can go to them, and most of the time I think it works well but I don't know." [2]	"It's an adjustment of the overall training I suspect because so much of cardiology unless you're a super specialist at a tertiary centre with the patients are very filtered by the time they get to you. I have interface with GIM basically, so I can give a cardiology opinion that's grounded in the dual realities for that patient because of my training." [1]	"I want them to be outpatient based and reaching in if those patients with, say, rheumatology problems they can reach in and provide a specialist input. But actually, those patients are managed by acute medics." [3]
<u>Model of care</u>			
Interesting aspects of model of care	"We have a good relationship with our emergency department. It's a bit of quid pro quo really because essentially, we give them open access. You don't need to call me and say, "I'm referring you this patient, or the registrar and say you're referring this patient. They just add the patient to our list of patients to come in, they're coming in." [3]	"When I joined this hospital, for instance, it was very apparent that the really good work had been done around acute medicine in terms of very innovative thinking around acute medicine, ambulatory care, the whole rota. So, I think that's probably been a big attraction and particularly some of our training grades have gone through that, have obviously, a lot of them	"My opinion about if you try to go down that route and over-complicate it sometimes it's hard to recruit because people actually are interested in general medicine, but interested in the front door of the hospital, they feel useful. So what we've done to make that work is our geriatricians have their own

	Site I	Site J	Site K
		have come back and applied for our consultant posts, so I think it's always been an attractive offer." [4]	take for the over 75s, so they're doing that proportion of the work." [2]
	"I'm really surprised that over the past five or six years we've invested, you know, 14 million pounds in services that are being talked about being centralised, it's a big thing for a small hospital to invest seven million pounds in a new Emergency Department and six million pounds in a new Acute Unit when these are the very things that just down the road are being changed." [4]	"Our ambulatory care is probably a big factor to why our conversion rate is so static. But also, I think it probably goes back to the fact that our community services are part of our organisation, it's easier to get some of the patients out. The barriers you have are when it's not the same organisation!" [5]	"My own belief and was for medicine and indeed, that always in my head I've had this view that actually I don't really want generalist, I want acute medics to run the whole of the hospital in terms of medical beds." [3]
Ability of the model to meet patient, professional, service needs	"We have a number of challenges in terms of our bed base which I don't think is necessarily quite right and challenges in terms of having outlying patients who are under medicine but outlying into beds on surgical wards." [1]	"We don't actually currently do the community clinics and the reason for that is because of the number of cardiologists here, it's difficult enough trying to take leave at the time you want to take leave if people are off site, it makes covering the acute cardiology a bit harder, so we haven't got that set up but essentially we have enough consultant cardiologists here." [1]	"I think that we've got quite a nice set up at the moment, I think we've got a good set up, and I think we've got a very good quality service, I think we've got a consultant delivered service, I think the patients are really, really well served by it. It's taken time to get there, it's been a lot of effort from all of us, but I wouldn't want to make any changes to what we're doing for our inpatients." [1]
	"I think it's like any patient that you move to maybe slightly the wrong ward again, isn't it, is that they're not going to get as good a deal. So, any patient that you end up outlying that you think probably shouldn't have out-lied, or any patient that goes under a speciality that you	"So yes, do we have the right configuration? No, if I was starting, get a blank sheet again, no, probably not." [3]	"I wouldn't be satisfied with the model unless I could make myself clear it's the right thing for patients and actually safe and the right thing to do and adds value, and I do believe that, but we had to engineer that." [2]

	Site I	Site J	Site K
	think, well they probably shouldn't have, then they're not going to get as good care." [3]		
<u>Smaller hospitals</u>			
Unique characteristics of smaller hospitals	"I think that especially small rural hospitals do offer something different to the community and that's probably the thing, that we've got staff that live and work within the community that it is service and they will go that extra mile to deliver the right care for the patient because they know that their families, their friends are going to be admitted to this very hospital at some stage and that's probably not the same for a bigger teaching hospital that's in an inner city where it's a different feel, it feels more a process." [4]	"In many ways the concept of an integrated care organisation is almost a combination of primary and secondary care, which is not applicable to tertiary and the larger general hospitals. It only works with the smaller, more community-route based units." [4]	N/A
Advantages of smaller hospitals	"The strength is the fact that you can communicate with everybody, you can have conversations, if you want to do something it's relatively easy to do it and do it effectively." [1]	"Communication between the specialties is very easy here, because it's small we all know each other and I think sometimes you have made a priority mixture of the pathways set up so that the trainees when they rotate, at least there's a pathway that they just need to slot into. So I think that works very well." [1]	"I think that what we do in the smaller hospital, in the district hospital, is we see patients where they are and we see the problems where they are, and that gives us a very different insight into illness to when you work in a larger institution seeing a tertiary referral group and done both. I think the benefit, I think the benefits for the local population is that you get local care for local people." [1]

	Site I	Site J	Site K
	"I don't think there is that anonymity that you might have in a bigger organisation, so I can certainly feel if I walk along the corridor I will see people, other consultants, nurses from the wards when I used to work on the wards, people from the management team, and I think there's a lot more people who just know each other and therefore go that extra mile for each other because they know each other." [2]	"From chief nurse to medical director, you're on first-name terms so you know who to go to. So, working in a smaller organisation, you always know who does what and who's more influential for different elements." [2]	"It's that familiarity and people know you. So, progress and change is much easier in a smaller hospital than a bigger hospital where you are a small cog in a giant wheel. Here I think there's that opportunity to contribute and feel valued for that contribution." [5]
	"We have the right be independent thoughtful clinicians. We can prescribe and suggest and support our medical colleagues and be equal to them and their peers and enjoy that freedom. And it's very difficult to do that that often within a big institution." [5]		
Challenges of smaller hospitals	"We're spending a fortune on locums, we are very often having to have consultants act down to fill those registrar shifts which is prohibitively expensive and now we're having to explain ourselves to NHSI who are saying why are you overspent and it's because of the deanery. Those types of things are out of our control yet we are held accountable to them and that is very difficult for us as a small organisation." [1]	"There are disadvantages, so cover can be a problem so we can't all be away at the same time, in a larger department perhaps it's easier to choose the time that you want to be away because there are more people around to cover. So the department is a bit more cohesive, you need to really get on and give and take more, so cover is one issue." [1]	"I suppose also that you can't have every service that you would like to have on-site. We don't have renal here. I know it's a longer-term aspiration, we'd like renal. But those kinds of, if you do get a pa… Or oncology, it is still sometimes difficult to get the right management for those patients early on." [5]

	Site I	Site J	Site K
	"Weaknesses, I don't know. I think because it's a small hospital and we will pretty much take anybody then sometimes that can bite you when it's a bit busy. So, I'm not sure if that is a weakness, it perhaps is. When we're totally overrun for space and I'm slightly struggling over why a patient came to us, when if perhaps they'd have just spoken to somebody it might have saved an admission may be, or perhaps gone to a slightly more appropriate team." [3]	"The negative sides of it I guess is that, being a small organisation, I think it makes it financially much more challenging, because you've got to have one of everything and then if that one person then goes off sick or they go then you're left with nothing, whereas the economies of scale that you would have in a larger organisation." [3]	
The future of smaller hospitals	"I would say we need investment but it's not as simple as that, you can't just keep throwing money at the NHS and think things are going to get better, what we need as an organisation is for a sea change in our consultants' opinions particularly, we need to start thinking outside the box and doing things differently which we are doing in many areas." [1]	"For my organisation to flourish in the future, much more of what we're doing around really looking at much more integration with primary care, with local authority and then to flourish so that the surgery that we do retain on this site, because people do want their routine surgery, that we actually progress our collaborative model with our bigger hospitals." [4]	"I think the challenges for the organisation here are going to be the same as the challenges for all NHS Trusts in the country, it's how we provide care with dwindling resources. You know this, but everything that's in the newspapers about winter pressures is true, we've got our..." [1]

	Site I	Site J	Site K
	“I'm hoping, will show that small hospitals have a real key role to play in acute medicine and if you mess with the dynamic or where patients go from an ambulance you may save on some costs but you end up, the unintended consequences may be for example that your ambulance costs will escalate so far that it cancels all the savings made by the Trust for example.” [4]	“I would like there to be more partnership working, and we’ve tried it before but there is something, going back to linking in with more integrated care into social care. I think that’s massive.” [5]	“Those small specialisms are constantly under threat in the DGH and so that’s difficult. Although there’s all this we want stuff closer to home, actually you’ve got to really look at the long-term viability of those services. And anywhere you’ve got one consultant playing at something, then that’s probably not viable. But actually, that really changes the culture and tone and feel of the organisation if you can still have a bit of that and make it viable. Because you want some doctors that are pushing the boundaries and are a bit more radical.” [3]

Sample interview quotes coded by Medical Generalism, Model of Care and Smaller Hospitals

	Site A	Site B	Site C	Site D
Workforce				
Consultants	"We've vacancies at the moment in respiratory, we will have a vacancy in diabetes, we have a vacancy in care of the elderly. If I said what, what would be my first choice, I would be recruiting acute physicians." [1]	"If you went round and you had a really good relationship and interaction with primary care, so you felt that once you'd done all your bit you'll get people out quickly, they won't come back in, they'll be supported, you've got good relationships, then actually that would make it a more attractive place to work because you could then also think about developing your own sub-speciality whilst you're here as well." [FGS]	"You may have noticed already that there isn't a body of acute physicians in this trust, and that is probably one of the single biggest problems in this hospitals. Most of the acute physicians are locum? They're either locum, all the people are good, but there's just not much ownership, you see." [1]	"Yes, 'Are we hoping to expand?' The business case is 'shortly about to go in' – in inverted commas. But, whether there's A: money and B: consultants out there might be a different question. But I won't have the wrong man for the job." [4]
	"This organisation, before I came, had difficulty recruiting but had people who had been here for a long time. What seems to have started the ball rolling was tensions around 'Who's on the general medical rota and who's on the ...?' So the gastroenterologists and the cardiologists were in significant dispute about this with the medical director." …	"Most of the consultants are actually recruited on a business case based on their speciality." [2]	"Acute medicine is probably one of our areas of biggest challenge in the workforce from a medical perspective, so recruiting enough consultants is probably our single biggest issue." [2]	"There's a strong view, that when we're appointing physicians by and large they go on the rota, that is their job, so hopefully anybody coming in will understand what they're coming into and then you deal with some of the issue up front by being very clear about what you're appointing to." [6]

	Site A	Site B	Site C	Site D
	“We’re left with a single, very stressed, respiratory physician who can’t see a way out of this.” [5]			
	“We are finding when we're looking for new consultants in some of the specialties, so respiratory and cardiology is that new young dynamic want to make a name for themselves consultants want access to that tertiary centre, so it's a, we're marketing it really as best of both worlds, come and live in the green fields whilst two days a week having access to a tertiary centre, and that seems to be working.” [6]	“We don’t have any consultants on our current model who are purely general medical physicians. We’ve got the acute care physicians who look after EAU. So the whole lot as they come through the door but all of our other consultants are physicians with an interest in.” getting them approved from an organisation point of view on the whole isn’t the difficult bit. It’s actually finding something in the job advert to trigger somebody’s interest particularly.” [4 and 5]	“There are two adverts out at the moment, which are 50% diabetes and endocrine and 50% AMU and we’ve got a candidate. I think the interviews will be in the next week sometime. I think that’s the way forward: is to leave it open and see what people are interested in and what sorts of candidates are around.” [4]	
Junior doctors	“The mindset of the junior doctor is massively different to what it was when X and I were junior ... We were here to do the job and then that ... But, now, they are very much ... with everything that happened last year ... very much more aware of their hours, much more	“They come here thinking ‘Oh god, what do they do?’, actually the fact that they get hands-on at everything... They get better training being in a small hospital.” [FGS]	“We have a pool of Trust grades who, the feedback that they give us is really positive, they really enjoy working here, they would recommend the work here.” [3]	“On a more junior level it sort of really limited some of what we were doing, so, because by the time you've got a consultant coming in at, you know, every single day and making just about all the major decisions then on the more junior level you're just a bit like okay,

	Site A	Site B	Site C	Site D
	aware of their days off, much more aware of their training and they see themselves very much as ‘I am a trainee, therefore you must train me.’ [FGS]			I'll just follow your plan then and then there isn't that much scope for us to be independent.” [FGS]
	“We’re having to support our lack of junior doctors, we’re having a big cohort of advanced nurse specialists, so that is going quite well.” [2]	“What does a surgical F1 do? They take blood cultures for people with fevers and they write up analgesia which is basically medicine. You don’t need surgical doctors. They’re not surgeons. They don’t go to theatre. You could give them an educational supervisor who’s a surgeon. You could rota them to go to theatre once a week and it would be more than they do now. And they could help us. And so when we get busy, instead of going to the mess, everybody shares.” [2]	“Junior doctors-wise, I think there is a group of consultants which have been identified as able to provide educational supervision and that’s done by the post-grad centre. On AMU itself, we’ve got regional gaps in registrar training. So, for the couple of years I’ve been here, there’ve only been two registrars allocated to the rotation.” [4]	“We’ve been very lucky with our middle grade cover so far and let’s hope that continues, because it’s always difficult, isn’t it, you know, the rota gaps are at the level below consultants, aren’t they, rather than at the consultant level, that’s the problem.” [3] “you need someone to say, ‘Juniors: well, actually, the patients that you’ll be seeing will be amazing and this is the skill set you’ll get. And we advocate that, not only will you learn a huge amount in every medicine ...’ And, as I say, massive ‘say’ ‘... we will teach you in medicine. We’ll teach you in surgery. We’ll teach you in gynaecology; we’ll teach you in psychiatry; we’ll teach you in injuries.’ That’s a massive skill set for anybody going in.” [4]

	Site A	Site B	Site C	Site D
	"I think there is a kind of 'Pulling the junior doctors up': making sure that they're all working and pulling them up if they're not working. I think there is slightly less of that here than there is at other places, which is a barrier to change and a barrier to getting them to 'toe the line'." [4]			
	"We look at our numbers that the doctors see, whilst everyone thinks 'Oh they're only FY2s, they don't do much', they see a lot of patients, so if you've got a third of the number of juniors then that makes it all the more harder." [7]			
Nursing	"The role of the advanced practitioners have come in and taken over some of the responsibility of the junior doctors. Because, I see it all the time: actually, now, a lot of jobs are beneath junior doctors because the nurse will do it. Yes, and I think that's a problem. It is a problem." [FGS]	"On the wards the nurses, I wouldn't say the satisfaction is very good. We've had quite a problem retaining our staff, we've had a lot of people leave and we're recruiting from abroad, but they're starting to leave as well and go to the bigger hospitals." [FGS]	"We've just, basically, looked at the whole establishment and changed it to suit our needs because the Band Five staff are just not there." [5]	"We do work within the national guidance but I think, the more registered nurses you have on the ward, you do see a better quality of care. And that's not to dismiss the role of the healthcare assistant but they are trained to do their work. I think patients feel more reassured when they can see the nurse. If there's a nurse in a bay, it makes a big

	Site A	Site B	Site C	Site D
				difference to how the care is delivered and organised." [5]
	"We developed that role in addition to the advanced practitioners, so our Band 4 on the acute medical unit actually is rosta'd instead of a Band 5 and takes responsibility of eight patients, and although she can't give out the medications she's a real asset to the team." [3]	"Our overseas recruitment drives are really successful from what I can gather. So our most recent ones were Italy and Spain, I think. And we've retained our staff quite well once they come over." [4 and 5]		
	"What we're finding with ANPs, which has been our initial approach was that we're just robbing Peter to pay Paul and we're taking our best, most skilled, most experienced nurses from the wards and turning them into ANPs which leaves the wards struggling." [6]	"We've had a lot of people that have come to retirement age gone and what we're really missing is that middle tier of staff nurse who's experienced and skilled. And so we've got either very senior nurses or we've got really really junior." [5 and 6]		
New roles and workforce strategy	"We have dabbled a bit with physician associates to fill that gap. The University has sent some trainees and they may be coming through in the next few years but I suspect they're going to need a	"There's a broad strategy but yes it's very much that way. I presented to the Board on our medical workforce strategy. We have a considerable	"We're offering them that sort of flexibility without just being flogged all the time, plus, if they're more junior, we'd offer them rotations around the different specialties in the hospital. So	"ED, we've just brought in a new role of an Advanced Nurse Practitioner, so, and I know they've introduced them, I think X have them at the moment but that'll be nurse practitioner with prescribing and

	Site A	Site B	Site C	Site D
	period of learning to get up to the level that advanced nurse practitioners are at because all our advanced nurse practitioners have been senior nurses before.” [2]	problem here if you look at the next 15 years around our retirements.” [2]	I’ve been able to secure promises from different people in the trust, like the IT lead would happily take someone if they wanted to do medical IT and management would take someone and quality and governance would take someone and audit, so whatever anyone wants to do, and if someone comes with their own project, we would happily support that as well.” [1]	they'll see patients as a junior doctor would I think in ED and then refer them from there.” [FGS]

	Site A	Site B	Site C	Site D
	"We've had secondment opportunities into other specialities, such as respiratory and we're just going to start two of the girls job sharing into a gastro post, we've released those staff to gain those skills and work alongside those specialists so that they can have a more rounded view of medicine and their capabilities, and that's something that we really want to progress." … "we've put in more bids for respiratory, I think it's care of the elderly, we've put bids in to try and obviously progress this. I think there is a real commitment in the trust to sort of progress this model." [3]	"We have to attract people by making sure the accommodation is nice and that we help them to get their visas sorted out so helping people to come into the country." [2]	"We had an agreement at executive team level probably nearly 12 months ago to where there was an opportunity to potentially over recruit in some specialties because we couldn't recruit to another specialty, we would do that, and use the consultant workforce as flexibly as we could to cover all of the areas. And I think that has made quite a big difference in our ability to recruit as well." … "Some of the roles that you will have seen in ED are reflective across the organisation as to what we're trying to do. So we've got nursing associates, we've got specialist nurses, we are one of the pilot sites for physician associates." [2]	"We're doing an associate nurse programme, yes. We've got two people doing that at the moment and they've only just started recently. So that's still new. But, yes, the return to practice nurses: we're on about our fifth or sixth one." [5]

	Site A	Site B	Site C	Site D
	“We can to some extent, influence how well we do in terms of getting junior doctors but there's a large extent to which we can't, so therefore putting something different in place. ANPwise we've got a real desire to develop that workforce and not, I guess ANPs is probably the wrong terminology because we're looking at advanced practitioners that aren't necessarily from a nursing background.” [6]	“We’re doing a lot of training with ENPs and we trained up four extra ENPs but we didn’t really have jobs for them. And we didn’t want to lose them to sort of ‘CCG land’. So we’ve – we made the decision, and the Trust made the decision to actually double up our ENPs so that does support – you’re absolutely right, that supports flow through the emergency department.” [5 and 6]	“We’ve just put a business case together to increase the funding for the Trust grades for both the junior level and the more senior level to help support that and then we’ve done a lot of investment in nurse practitioner, nurse consultants.” [3]	Do you have a clear strategy about that or is it on a kind of business case by business case basis? “At the moment it’s on the latter basis. The big issue for us around medicine going forward is the seven day working agenda and what does that then mean for the acute model.” [6]
			“We have our own practice-based educator in ED. So they come with a planned programme of works for them to work through, which I think has been the saving grace of keeping our staff here.” [5]	
Other	“Some of us would prefer to work at a DGH where we’re offered things or we can sit in our rooms and know faces. But, actually, spending an hour-and-half in the car – two hours in the car – in the	“Because everyone’s desperate. It’s got to that really rather underhand to poach people approach.” [2]	“It’s such a draining experience being an on-call medical registrar or junior, I can’t see that that always offers a huge incentive or enthusiasm for people to do into the speciality, and that has to be	“I think you’ve got to want to come here. I think most people ... We rely quite heavily – if nothing else – on word of mouth and that works.” [4]

	Site A	Site B	Site C	Site D
	morning every day to come to work ... “ [FGS]		something that can only be addressed with root and branch reform.” [1]	
	“The ability to recruit to those posts and the funding for that is a whole other issue but no, I wouldn't say that at this moment in time if we could wave a magic wand and put the ideal model in place, we haven't got it.” [6]	“I think we do have to be quite inventive about how we use workforce and not be so rigid about whose job, it’s whose job. I think as long as we’re communicating properly and the patients are getting assessed appropriately at the right time, that to me is the most important thing.” [5 and 6]	“We’ve had, also, with all the changes with agency staff, a lot of agency staff who have come to us and said, ‘We would really like to work at your organisation.’” [5]	“If you’re a high flying academic you’re not going to come and work here, if you’re doing some kind of cutting edge interventional type work you’re probably not going to come and work here, so therefore the people that come and work here tend to be people who are far more focused on their NHS practice, so generally speaking they’re not as consumed by private work, they’re not as consumed by academic research, they’re not necessarily as concerned about advancing their own individual agendas, and now I’m being completely unfair on other organisations but by the nature of the case mix here and by the nature of the hospital on the spectrum of consultants you will attract a certain grouping, and I think that grouping lends itself to running a very good local hospital.” [6]

	Site E	Site F	Site G	Site H
<u>Workforce</u>				
Consultants	"To push everybody off and then have to attract people from all over the place to see every patient at the front door, who's risk will then be very, very much higher because they don't know the processes around them, they don't know the hospital, the systems, the cross border differences." [FGS]	"It is now more of a struggle to fill consultant posts than it was before. You know, some of that might be the local geographic uncertainty, but certainly before it was never a problem because people always wanted to come and work here." [3]	"I came here very strategically in my final year. I also knew two of the guys that worked here and I felt, 'I'm going to fit with them anyway.' So, yes, I came here for my final year with the intention of convincing them that they couldn't afford *not* to give me a consultant job. And here I am! So, yes, locality was really important to me at that point." [1]	"It has had a strategy in that the need for increased generalism and acute coverage has been recognised and has been pushed forward in each job plan that's come up. But it's been sacrificed out of necessity: we have been unable to recruit anybody to any specialism within the hospital. We've had a great deal of difficulty. We need two cardiologists; we need a respiratory doctor; we need another endocrinologist; we need two general physicians or acute physicians. We cannot recruit to those specialisms at all." [2]
	"Medical recruitment is one of the big initiatives now that we've merged because financial sustainability will depend on medical recruitment. If we were fully established we wouldn't have a deficit, we'd be a profit making hospital." [4]	"ED doctors again ... Who wants to be an ED doctor at the moment? The press and all that sort of ... Who wants to go and become an ED doctor?" [5]	"I just don't think you'll get a cadre of physicians who are known vocational geriatricians to just ever get interested in a lot of frail or elderly medicine, even though they work with it all the time in their training." [2]	"One of the reasons we think we need another consultant is to take some of that supervision, mentoring caseload and that's the non-clinical side of it and then the clinical side of it is just being enough of us around to support the more junior workforce on the shop floor. ACPs are great and will be fantastic but

	Site E	Site F	Site G	Site H
				while they're getting to fantastic there is quite an additional amount of support needed." [3]
				"We're looking at probably something similar in elderly, so could we have someone who does geriatrician but actually does a day a week in Cat as an acute physician as well? But I think we've reached a tipping point in the last 12 months where we're probably all in agreement, we actually need one other full-time acute physician." [4]
Junior doctors	"We don't get a lot of support from the Deanery for training juniors and whatever, so we need to expand our appeal to the people outside of traditional training routes." [FGS]	"As a trainee everyone wants to come here because it is the place where everyone is nice, it's a nice environment." [FGS]	"A lot of them are driven by I think some of the support from their junior doctors, so their day work with consultants has diminished because they're now manning where they need to be, the front line jobs, and the business of having your coterie of juniors who you just had to kind of say 'Here's your long list to do and you are readily available', but EWTRs and the new contract, again, I don't know what you're hearing and I'm	"The problem doesn't come with me and the acute medical coverage: it comes at the expense of everybody else. So there is an organisational strategy that the juniors are sacrificed up to acute medicine when required. The juniors get a bit fed up with that towards the end of their rotation. So, not the fixed ones that work every day but the ones that are coming in: there is quite a bit of burnout. So, what we find is we will start with

	Site E	Site F	Site G	Site H
			just making a speculation about what the guardians and what the system is going to say about the introduction of the new contract, but I'm going to predict that as we go into this particular winter we're going to have a lot of disenchantment." [2]	three empty slots and, by the end of the period, we will end up with six empty slots because people are just going off to training or for travelling for a bit. So it's more about the strain on them. So, actually, it far more affects ward cover."… they're moved around a lot. There are a lot of spaces and it's not a big hospital so they're encouraged to be very flexible but, after a while, their flexibility hurts them a little bit. So, by the end of it, they come round to give you feedback, in the end, it tends to be quite negative. When you read the feedback, it's reasonable feedback. We don't *like* it – the deanery slap us around quite a lot – but it's reasonable feedback." [2]
	"I'd like to work with the juniors more and have more of them here, just because I think there's great learning opportunities really and we see a lot of medicine." [3]	"We never had an issue retaining medical staff; we get great feedback from the deanery about placements here; they get great exposure to a variety of complex issues on the wards – the long-	"For the medical staff one of the serious challenges that we have is that our medical rota, our junior doctors, we're probably the poorest in the country in terms of our junior doctor fill rate, and that means that our consultants and our	"The trainees see the general medicine as the drudgery that they have to do, that it's all for service delivery and that actually it interferes with their speciality training." [5]

	Site E	Site F	Site G	Site H
		stay and the short-term assessment units." [2]	registrars are constantly having to act down." [3]	
	"The junior doctors are the most cheesed off but they are the ones that are working the fewest hours. **I actually think that is part of the problem.** Yes, so do I, the demise of the firm structure and the personal support and teams and stuff like that and the mess and all that sort of stuff that we used to have, well certainly when I was training." [4]	"The thing about nurses, if you upskill them they're less transient, you know, potentially they will stay, whereas the junior doctors move and you never know what you're getting, so actually we are increasingly trying to get more of our services provided by nurses if we can because we know we've got a bit more consistency with them." [3]	"I think we all feel that we'd like more junior doctors, especially on certain days. Rotas probably the biggest challenge isn't it? You'll get days when you've got not a lot but enough and you'll have days when there's none or those nobody and then they ring in sick because they look and think, 'I don't want to come today because it's ...' [7]	
Nursing	"We don't have that progression, we've lost that, so like you were saying earlier, there's how long you've been a nurse before you become a Band 6 is so much shorter than it was when we had the grading, so there's not the same skill sets there that there was." [FGS]	"Consultants have been very supportive of nursing roles as well, they often support them and we use nurses where we can't recruit." [6]	"Nursing retention in certain areas, they've had some successes with that and that's been a big positive, and you may pick up an ambivalence but some of the models of nurse leadership in specialities has been very, very good." [2]	"But there is that problem: we've lost one of our ward nurses who became an ACP. She's a great ACP but she's no longer a nurse." [2]

	Site E	Site F	Site G	Site H
	"The nursing recruitment strategy for nursing is more developed and they've got a very good overseas recruitment strategy, they've got a psychologist who tends to the nurses and psychoanalyses them all the time and we're using our previous foreign recruits in our new recruitment, so yes, that's a well-developed process and I would say that medicine lags behind that because we haven't really had a consistent and unified approach." [4]	"We've got two amazing senior sisters in medicine and elderly medicine. They've got very good recruitment process on: as soon as someone applies, they grab them by the throat and bring them in for interview, rather than waiting for an advert to close. They're very proactive." [2]	"In terms of nursing we've got 100 plus vacancies across the trust so we're looking at different models for addressing that, we're going overseas, we're looking at physician's associates and we're even thinking about India now, so we're doing that rolling advertisement for nurses thinking about strategies for retaining people to stop them going." [3]	"The other thing that we're keen to do is to make sure that people are working at the top of their licence, that's how we describe it, so if you're a Band 5 nurse, for example, are we confident that the activities that you're doing today are the things that really can only be done by a Band 5 nurse and not by the Healthcare Assistant or some kind of assistant nurse role." [1]
	"We've got SafeCare in terms of ensuring that nursing to patient acuity is balanced. That would be nice if we didn't have 50% vacancy fill rates in some of our Band Fives of course. So it's all right having SafeCare: you need this but then the ability to provide it when you have no staff is a different kettle of fish." [6]	"The patients are iller and they require trained nurses, so my thrust has always been to improve the trained nurse ratio and we have managed to do that on our acute medical wards, we also multi-skill our nurses so that we make sure they are fit for purpose in terms of we invest in their training, their education, we work very closely with the consultants and the consultants teach as well and work with the nursing staff, and we have an integrated service." [5]	"We do encourage, I certainly do, moving from different wards and getting lots of different experiences, because a Band 5 only being in one area for a year or two, becoming a Band 6 is a no-no in my head. I mean, I've been nursing 37 years, you need to have experience of other styles, leadership, learn things from other people, other areas, so I encourage people to go to other wards to get that if they can." [6]	

	Site E	Site F	Site G	Site H
New roles and workforce strategy	"A nurse consultant role, who is very much a decision maker, and that's kind of a new role which has been piloted and been successful." [FGS]	"The workforce isn't that big here. As a medical workforce, I don't think ... I think the challenge we've got is the other workloads still exist and that's where ... The bit that we don't seem to be able to crack is job plans are what things are based around: it's not just 'drop and go and do'. And that's where we really struggle because we're meant ... We really need to do that but, actually, they're already committed to doing *X*, *Y* and *Z*, which is in their job plan." [5]	"I don't think we have a workforce strategy – or a well-considered one – at the moment and I think we're in desperate need of one." [1]	"I actually think X is really forward thinking. When I worked in London I tried to make them train me up to be an advanced practitioner because it was the future but they said no, you can do your prescribing and that's it and now they want advanced practitioners because they have realised that actually this was the way forward and what I am doing here they think is great. So actually for a smaller hospital to put in that programme and give us the support that we've had, I don't know anywhere else that does it in quite the same way." [FGS]
	"In the past we have certainly made noises along the lines of, you know, there's a lot in the advert going 'Somebody with a paediatric interest would be very welcome, although any other interest we'd also be interested in'." [1]	"There is a lot of flexibility that we have to give. The other thing if we're speaking in purely selfish terms, we have a very small workforce so we have to try and work that force the best we can, if you are working three days with four days off it's highly likely you'll do an additional shift if we are short, where	"My view is that the depth of discussion over the medical workforce in terms of specialty projections has not been as mature as it could be." [2]	"Within the workforce and organisational development workstream there is a project on clinical workforce strategy, and that is looking at what should our clinical workforce look like in all our clinical areas, across the organisation, in the coming three to five years, and it's asking difficult questions about, in challenging times, when we

	Site E	Site F	Site G	Site H
		you won't if you're working five days." [5 nurse]		know that it can be difficult to recruit enough clinicians in certain specialities, it can be difficult to recruit enough qualified nurses for our inpatient areas, we're asking ourselves questions about have we got the right job roles and do we need to actually change the way that we think about those job roles and how we deploy our workforce." [1]
	"We don't tend to have very junior doctors on here, mainly because we have not had the staff to support them, not because we don't want them, but it tends to be really busy on here, we don't want to replicate things unnecessarily, we recognise there are great training opportunities here but we don't want that traditional model of junior, middle grade, we just haven't got time for that really, so at the minute the AMPs have replaced FY1s, FY2s in terms of that sort of initial assessment of patients." [3]		"Financially, and patient safety-wise and the services we provide – the quality – is far better that we have a little bit more expensive doctor but a doctor who is there, which we can govern, we can train; they can improve so they work with us." [4]	"One of the reasons we think we need another consultant is to take some of that supervision, mentoring caseload and that's the non-clinical side of it and then the clinical side of it is just being enough of us around to support the more junior workforce on the shop floor. ACPs are great and will be fantastic but while they're getting to fantastic there is quite an additional amount of support needed." [3]

	Site E	Site F	Site G	Site H
Other	"I come back into hospital after about 18-19 years being out of it, and I still knew half the people in it, so you don't get that, because of where we are and the geography and the area people that work here will stay here, which is good because you've got that constant staffing." [FGS]	"If you split a hospital in half, obviously, you're going to lose staff, you're going to change culture; it'll be a whole new staffing structure." [2]	"Look at the specialities that are chosen top and those that are not, you often find that those that need the specialists the most are the least applied to for physicians of the future." [2]	"If you said to me 'Am I looking forward to doing this for the next 15 years until I retire?' I can't even begin to think about that because I just feel ill. So just the future, looking at the NHS, there's a lack of nurses, there's a lack of doctors." [FGS]
	"People in the organisation seem to get away with behaving badly, not doing their job effectively and we just allow that, we don't do anything about poor behaviour, and the process to remove anybody is so difficult." [2]	"That is the biggest challenge, trying to maintain morale and innovation and people being satisfied when everything's always getting busier, with less people and more demands, and always under pressure to save more money this time." [3]	"Interventional radiology is probably the biggest challenge for smaller DGHs in terms of my experience and the one thing that I would pick. Because all the interventional radiologists want to work at a nice, big university hospital." [7]	"One of the other challenges you have is with an increasingly female consultant workforce, you know, we would have gaps for maternity." [5]

	Site I	Site J	Site K
Workforce			
Consultants	"We need more geriatricians here, we have money in budget for more geriatricians and I cannot for love nor money recruit blooming geriatricians." [1]	"With medicine, I think the brand around respiratory, some of our long-term additions, we do attract people, care of the elderly's got a good reputation, never any problems there." [4]	"There has been a huge amount of consultant appointments and the consultants who have been appointed are younger. It's interesting when you work here actually, and a lot of the older consultants left in various ways, so when you look at the consultant body there are very few grey haired senior consultants here because they were all cheesed off." [1]
	"Recruitment, that is our biggest challenge as an organisation both in terms of maintaining services and patient safety, but also in terms of finances, we are spending a fortune on locum doctors. There is a number of things that we're putting in place to deal with that and to help that and we're trying to be innovative in looking at the workforce in terms of does this job need to be done by a doctor, can we employ a different level of person, physio, nurse, whatever. So there is quite a lot of innovation and that is a really good thing here and again that's been really easy to do, but if we get given gaps it's harder for us to soak up those gaps." [1]	"We actually do have a massive consultant shortage at the moment. They're all dropping like flies. They're all doing lovely things like getting pregnant and getting their dream jobs but they're all leaving me at the same time." [5]	"You've got to want to see patients, you've got to want to contribute, you've got to put patients first, I'll never worry if consultants are putting patients first, you know, and the system gets second place for a bit, but the patient does come first, my job is to make that all work. So values and behaviours of consultants are important." [2]

	Site I	Site J	Site K
	“Well, it’s not really a preference, it’s about who we could get, when.” [3]		“It is cheaper for me to employ my colleagues as locums for six hours on a Saturday and Sunday than employ a consultant. Because, to employ them for six hours on Saturday and Sunday, probably costs the trust sixty thousand pounds a year: to employ a consultant costs that *and* you’ve got to pay for their holidays *and* you’ve got to pay for their study leave *and* you’ve got to pay for their pension contribution. So it’s a cost. I’ve got my budget, some of which I’m spending on locums but it’s less than I’d be spending on a consultant.” [4]
Junior doctors	“I think when you get lots of mixed specialties on a ward it doesn’t work, you can’t get the right nursing staffing skill mix, it’s difficult for the nursing staff in terms of numbers of ward rounds and what they’ve got to think about, it’s difficult to have enough junior doctors allocated and you’re forever having consultants saying that they don’t have a junior doctor for the ward round, and it’s like well that’s because there’s five of you and you all turn up at once and you’ve got three juniors, we don’t have a tree that we can pull juniors off.” [1]	“Communication between the specialties is very easy here, because it’s small we all know each other and I think sometimes you have made a priority mixture of the pathways set up so that the trainees when they rotate, at least there’s a pathway that they just need to slot into. So I think that works very well.” [1]	“I always say to our juniors, when they start, ‘If you can find me a better junior doctor rota’ ... because they’re all out of medical school for two years and on Facebook and so on means they’re much more closely knit with their friends than they were. ‘If you can find me a better rota, I’ll implement it.’ So, again, we try and look after them: we try and support them and so on and so forth. But, actually, if you take a step back, that’s a really crap way of doing things.” [4]

	Site I	Site J	Site K
	“We have tried to get a second by using the tactic that well, “You’ve got two and you’re about the same size as us. So, why can’t we have two?” type line. Yes, there just aren’t enough in total in the pool and so we keep getting knocked back. The thing is, if we have one, because we do turn up to all the meetings, help out all the interviews etcetera, it’s very rare for us to get a gap in acute medicine. We’ve consistently had a registrar for absolutely ages now and we don’t get given one of the gaps because we’ve only got one person anyway, and we do help out. Whereas, if we had two, what might actually happen is that sometimes we might only get one and we’ll have made a plan for there being two. And so, at the minute it actually works out for us, because we just have one all the time.” [3]	“There’s something about the friendly atmosphere. It comes back from a lot of the trainees that go, “It’s just friendly here,” and it is.” [5]	“And so many of our core medical trainees come back to us as registrars, despite having had a baptism of fire, if you like. I think that’s because of the environment you’re working in. If you’ve got consultants on the shop floor and that supportive environment, you don’t mind working hard, as long as you’ve got someone telling you when to stop and supporting you.” [5]

	Site I	Site J	Site K
Nursing	"I think the pay gap is the single most influential thing as to why nurses in particular are now leaving to go and work for agencies and coming back in actual fact to do the exact same job they've left." [4]	"At the moment, any nurse in London can go and get whatever job they want. They've got an option of jobs that they can go for where, previously, you'd have ten people applying for one job. At the moment, if you get two applicants on your shortlist for the same job, that's kind of a level of ... It is just really difficult because there's too many jobs out there and people have got too many choices and you, literally, go and choose which job you want now, rather than being selected because you've actually got the skills for that job." … "The issues with the bank is a lot of the bank nurses are actually nurses who have already got a full-time job within the trust. So they're nurses who are taking on additional bank hours. So that becomes quite restricted on who's available because they're already doing thirty-seven-and-a-half hours per week already. And, for legal reasons, you can't go higher than fifty-four. The problems with the agencies that we find is, over the last six months, we've had difficult with the agencies actually filling the shifts. And then, when they have filled them, people are just not turning up, cancelling them at the last minute and then they're not telephoning you so you can do a back-up plan. But I'm sure that's not just here: I think it's everywhere really." [2]	N/A

	Site I	Site J	Site K
	"The ability to come in and cruise, as it were, in a certain way. "I come in, do my job, I go home again. I enjoy an interaction with other human beings, I like to be part of the care providers," isn't enough anymore unfortunately for us as employers and senior nurses. We need you to be embedded more and take that bit of responsibility. And actually, be an active part of a patient's management. And I think that's quite scary for a lot of people. And especially maybe the slightly older workforce that hasn't needed to work necessarily at that level, or wanted to before." [5	"The registered nurse, yes, whereas the registered nurses at the moment are more doing this assistant practitioner role in order to get to this point where they're directing, and of course they've all got to learn, but what we then get is a very transient population of nurses that are up... well they either go up and go into the management roles or they go 'Actually I want to go and specialise and I'm going to do it somewhere else'. So we have quite a transient population across London." [3]	
		"Again, as part of how to address the shortage that everybody's experiencing. Also, appealing to some of our nurses who have taken early retirement, because a lot of nurses retire when they're 50, 55, to actually come back to work with us on bank. And every year over winter, which always proves that, this is the second year that we'll be doing it, we offer a bank bonus, work five shifts and you get 350 if you're a nurse, and if you're a registrar you get 500, something like that. So, really trying." [4]	

New roles and workforce strategy	"Looking at combination posts, so we're going to go out for an acute physician with an interest in geriatrics to see if that might get somebody. We've got somebody who is coming in at the moment who is coming off the training scheme, currently a registrar who we are desperately trying to attract because she is an acute physician but with an interest in stroke, we are crying out for a stroke physician and I can't get one so that would be perfect because that would help us in two areas. So that I think increasingly we're going to see that an increase in the kind of generalist who do have specific training in acute medicine but also have a specialty interest as well. I think that's the way forward in terms of our recruitment." [1]	"The skill mix on the nursing staff, potentially, five years ago, we'd have had more Band Five nurses that are trained and skilled. But, because of the recruitment issues throughout the whole of London and here as well, we have had to tweak our skill mix. So, potentially, we were working with five nurses on a long day with one healthcare and we're now doing a model with four nursing staff and two healthcare. But that's really been around the recruitment problems we've had: we've just had to come up with a different model of care – staffing model – so we can still deliver that same safe care." [2]	"So, I looked at the skills gaps that we needed and PAs fit the bill. So, I knew that from PAs I'd known or spoken to our students that they didn't like working isolated, and the biggest reason that PAs are leaving general practice is that feeling of isolation. So, we pushed for a team. So, we put PAs into all the areas where we'd had potentially negative GMC feedback, so where the workload was particularly high. So, we did have at that point, PAs in acute medicine, elderly care, cardiology and respiratory, and then we've just built on it from then."… "What we've started to do now in acute medicine, as well as PAs, is we've got our advanced nurse practitioners who are home-grown, our senior nurses who have gone through that course. And they work just as the PAs do alongside the juniors, they all do the same roles, they have a varied job. So, on AMU, the juniors, the PAs, not so much the AMPs, but they'll do two weeks of doing ward rounds and then two weeks of doing on-call so they get that varied experience."… "I'm a great champion of other roles, probably with my background as well. Like I say, the patients don't really care who they see. As long as they see the right person it doesn't matter what your title is." [5]

	Site I	Site J	Site K
	“We’re gradually training up some of our own nurses to become ANPs, so it might be that it’s a bit of a mixture of the two, but it certainly was in the business case for the new unit that there would need to be an expansion of the number of advanced care practitioners. So a bit of both, a bit of working with who we’ve already got and a bit of recruitment of additional ANPs.” [2]	“I think there is something about reviewing the skill mix on a regular basis, depending on how things go, and because it’s changing quite rapidly over the last few years we’re constantly reviewing skill mix, and the staffing ratios as well and the dependency, so every six months we do a staffing review to make sure we’ve got the right establishments on the wards.” [3]	
	“So we did an assessment against the future hospitals report that came out and it's controversial because some of the, it does go against type on specialist medicine which all the Royal Colleges are going, we have to super-specialise.” [4]	“Everyone’s trying to be innovative but there is that London problem because people can’t afford to work, to live there… Part of our SEC strategy, which is what we’ve announced, we haven’t officially announced who it is but we’re working in partnership hopefully with the strategic partnership around our estates is actually to build new accommodation for nurses on-site here.” [4]	
Other	“At the moment it can sometimes feel like we’re staffed for an average day and if you’re having a bad day it can be a difficult day.” [2] “For members of staff, if you’re increasing their skill-set, for them that would equate to increasing their work. But not only that, more staff would talk to you	“Agency are not delivering. And it’s safety. And, what people feel like sometimes – especially even with the bank shifts – ‘Oh, it’s a bank shift, I’ll cancel it’ but not ultimately realising they still have the big safety aspect of it. ‘Ultimately, you said you were going to work so you need to honour your commitment, not “I’m too tired	“It’s about people who will kind of work for the Trust, work as a team, and that’s the key thing for me. So I don't want people who are going to come, certainly we don't want people who are going to be angry and difficult and mean and not look after people properly, we don’t want those people.” [2]

	Site I	Site J	Site K
	about, “I feel more responsible. I, therefore, feel more accountable.” [5]	now; I’m going to cancel it.”’ – which they are; they’re getting burnt out. It’s just really hard to juggle.” [2]	
		“When I joined this hospital, for instance, it was very apparent that the really good work had been done around acute medicine in terms of very innovative thinking around acute medicine, ambulatory care, the whole rota. So, I think that’s probably been a big attraction and particularly some of our training grades have gone through that, have obviously, a lot of them have come back and applied for our consultant posts, so I think it’s always been an attractive offer.” [4]	“So, it’s been really interesting how we’ve developed a workforce of consultants that each have different interests.” [5]

Sample Interview Quotes coded by Workforce