FACTORs AFFECTING THE MANAGEMENT OF HOSPITALITY IN
HOSPITALS

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This research is submitted in partial fulfilment of the requirements for the award of Master of Philosophy.
For Robert and those who love him.

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ABSTRACT

This study was an exploration of the concept of hospitality within a hospital setting. A working definition was arrived at which formed the basis for the field work. A pilot study, involving a small number of in-patients considered two themes, first whether the concept appeared to have a place in hospitals including, whether factors suggested as central to hospitality, were considered by the in-patients to be at least necessary, if not important. Also the study sought any additional hospitality factors which the in-patients might suggest, and served to test the study tools prior to the more extensive study. The second theme was anxiety, it being considered that where patients were anxious they would not feel 'at home' and if the hospital experience could be improved a reduction in anxiety might be expected. After the pilot study this secondary theme was no longer pursued. The main study, involving approximately four hundred in-patients, focused on hospitality factors and required in-patients to rank the hospitality factors in the order of their importance and also to award the importance of each factor with some magnitude, additional hospitality factors were also sought.

With computer assistance the results were analysed, indicating that the concept did appear to have a place in hospitals. Hospitality factors could be identified and considerable agreement was found, by a varied sample, regarding their relative importance. Not surprisingly, considering the setting, the aspect of 'friendly medical staff' was regarded as of major importance, of the other factors none were regarded as unnecessary and no additional factors were highlighted. The question of the magnitude of the importance of the hospitality factors generally supported the priorities identified but the alternative approach raised implications regarding how the
study tool might be applied as a management tool. The study also indicates several areas for further research.
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CHAPTER 1

Introduction

1.1 Introduction

This introductory chapter sets out an overview of the research activity in a study undertaken between September 1985 and June 1988. The design of the study is detailed and the method of conducting the research is outlined, including detail, both of the setting up of the field work, and an explanation of the structure of the thesis.

1.2 Background

The original idea for this study was crystallized by the seminal article "Hospitality in Hospitals", presented by Cassee and Reuland et al at a conference in the Hague and subsequently published in 1983, (Cassee and Reuland 1983). They suggested that the concept of hospitality had a place in hospitals and that the subject was not yet clearly understood because basic research had not been carried out. With the researcher's experience of private health care, (particularly whilst working for Grandmet Services for Hospitals Ltd., as a Catering and Domestic Services Manager), it was felt that hospitality was indeed very significant to the care and well-being of patients. However, the responsibility for managing such hospitality was often diffused and not clearly recognised as a responsibility of the staff. Also, with the increasing emphasis, within the National Health Service, on privatisation, competitive tendering and performance a general recognition of hospitality and its significance was considered important. This is because although the subject presents some difficulties in practice, the aim is that human aspects of health care are not relegated to a
less important role than that held by the financial aspects.

The study was carried out with the support and supervision of the Department of Management Studies for the Tourism and Hotel Industries at Surrey University. Funding throughout the first two of the three years part-time study was provided by Hampshire County Council and in the final year the project was self-funded.

1.3 Reasons for the Study

The aims of the study can be listed as:

a) To review the concept and definitions of hospitality, in order to arrive at a working definition as a basis for the field work.

b) To determine what patients see as the important aspects of hospitality within the hospital setting.

Before these aims are realised discussion must of necessity remain inconclusive in terms of how applicable particular management techniques may be, within the context of improving the hospital experience of patients.

From these aims the following objectives emerged:

a) To review material relevant to the topic.

b) To develop a questionnaire to use as the study tool in a small pilot study, and to carry out that study in as general a setting as possible.

c) To develop a questionnaire to use as the study tool of a larger main study which would be carried out in several hospitals.

d) To analyse the findings in order to;
i) determine whether the factors which had been selected for inclusion in the questionnaire were generally considered to be relevant,

ii) assess whether particular importance is placed on any specific factor or factors that were identified.

iii) bring out additional aspects which the patients considered relevant,

1.4 Literature Survey.

1.4i Literature Survey Length.

At the beginning of the project it was envisaged that the literature survey would take place during the first year of the project, with the other two years allocated to field work, analysis and writing-up. However, in the event the literature survey has been on-going throughout the study. This became necessary due to the unforeseen ramifications of the study, requiring information from not only sources relating to clearly important subjects such as: catering, hospitals, nursing, management and marketing, but also from many diverse subjects, for example: politics, computing, history and psychology. The changing conditions, (not least politically), with which hospitals have been faced over the duration of the project have also required that the literature survey be extended.

1.4ii Literature Survey Techniques.

At the outset of the literature review and on-line computer search was made at Surrey University. This involved obtaining access to all the published material relating to particular topics, which had been incorporated in the system since it was established (during the 1970's). The material, either in book form, journal form or in the form of pamphlets, is classified according to subject and access is made by the use of key words
relating to the subject of interest. Following the search process a print-out of the selected references is produced. The key words used for this particular study were, 'hospitals', 'hospitality' and 'hospital catering'. This exercise was repeated at the end of 1987 to collect references which had been included since the first search.

The Hotel Catering and Institutional Management Association (H.C.I.M.A.) library bibliographies and lists of journals were very useful in providing reference material throughout the project.

The King Edward's Fund library, although mainly concerned with medicine also provided some useful material. Also, due to the importance of the Cassee and Reuland (1983) article, (referred to at the beginning of this chapter), correspondence was entered into, between Cassee and Reuland and the researcher, which highlighted further useful reference material for the study of hospitality. Additionally various other libraries were visited during the study.

1.5 Design and Conduct of the Study

1.5(i) Introduction

Alongside the initial literature search the planning stage of the study was carried out in the first year. At the outset it was envisaged that the time of the study would be divided up as follows;

Year 1 Planning, literature search and preparation of the pilot study.

Year 2 Field work.

Year 3 Write-up.

As mentioned earlier the conduct of the work did not follow this plan, due in part, to the extended literature
search but also because the time involved in the process of encouraging hospitals to participate, requesting, (and subsequently obtaining), official permission to conduct the field work, was underestimated. The effect of these delays was to put back the start of the main study by several months.

In the remainder of this section the design and conduct of the study sections will be described.

1.5(ii) Pilot Study

During the initial stage of the study visits were made to Bolingbroke Hospital, London, the Royal Surrey County Hospital, Guildford and Queen Alexandra's Hospital, Portsmouth. Discussions also took place between the researcher and various members of the management staff of Grandmet Services for Hospitals Ltd. (later to be incorporated with the industrial catering section of the Grand Metropolitan catering services as Compass Catering Ltd.), including area management staff and national training personnel. Many meetings and seminars with supervisors at the University of Surrey, colleagues at Highbury College of Technology and at Portsmouth Polytechnic took place. From this background the nature of the pilot study was formulated.

It was decided to approach a local general hospital, as the site of the pilot study. The Support Services Manager at the time, and the Acute Services Manager, were interested in the study and meetings were organised between the researcher and several of the hospital management staff. The Unit General Manager was approached for permission to conduct the study. The study was discussed informally with the hospital ethical committee and it was approved as not requiring the committee's official scrutiny, (this was specifically due to the
nature of the questions, that is, the exclusion of any personal or medical questions).

It was considered that due to the small number of respondents who were to be approached in the pilot study, it would be unnecessary to use computer analysis. On completion of the pilot study the researcher once again met with a group of the hospital management to discuss the findings, one of the results of this meeting was the inclusion of an additional hospitality factor, that of 'clear sign-posting', in the main study questionnaire. This factor was identified by the management group as one which was frequently mentioned by hospital users. The management group considered that the factor was of importance and they felt that it would have been mentioned by patients if the pilot study sample had been larger. A further additional factor was also included at this stage, that being 'adequate provision for visitors and visiting'. This factor was included due to the high proportion of respondents to the pilot study who commented that during their hospitalisation they missed their family above everything else. It was considered that, particularly within other hospitals, (where attitudes towards visiting might be different to the open visiting policy of Saint Mary's Hospital) the provisions for visitors would be an important influence on how 'at home' the patients felt during their hospital stay. Also the population to be approached in the larger study was more closely defined, being adults with reasonable reading and writing abilities, sufficient for them to complete the questionnaire unaided, (this excluded certain groups, for example, the blind, some geriatric patients and some psychiatric patients).

1.5(iii) Main Study

Following the discussion of the pilot study findings the main study was planned. Permission to carry out the new
study at Saint Mary's hospital was granted. In order to increase the number of respondents in the main study and to enable comparisons between different hospitals to be made, three further hospitals were approached in geographically different areas. The Assistant Unit General Manager of the Royal Surrey County Hospital, Guildford was interested in the study and, following meetings and discussions with the researcher the necessary permissions were granted. Again an ethical committee was shown the questionnaire and was satisfied that it was suitable for use within the hospital. The District Manager of Maternity Services, in Staffordshire, was also interested in the study and following discussions the appropriate permission was granted to conduct the study at the Stafford District General Hospital. Another hospital which was approached also expressed interest in the study but was unable to participate. This was due to the severe staff shortages they were currently suffering. It was felt by the management that the hospital's involvement with the study would not provide enough information of benefit to the specific hospital, to warrant the requirement of staff time. Additionally the administration expressed interest in the findings of the study, expressing a feeling that the study were sufficiently large to provide them with useful information which might be applied to their particular hospital without its' direct involvement.

The completion of the main study questionnaire went ahead once the necessary permissions were granted, this was over an eight month period, from July 1987 to February 1988. From the outset it was intended that the number of respondents to the main study would be sufficiently large to necessitate computer analysis, however the analysis was not to be statistically complex and several computer programmes were examined. Following
consultations with staff of the University's Computing department it was decide to use the "Minitab" programme. The main study questionnaire was designed with consideration of the selected method of analysis such that the transfer of data from the questionnaires to the computer might be as simple and accurate as possible. Once the questionnaires were collected back the researcher read through each questionnaire translating the responses into the pre-determined numerical code and collated the codes on the computer unit coding sheets. The information on the coding sheets was then entered into the Surrey University computer by technicians within the computing department. The data was entered in the ASCII computer language, this required translation into a binary coding language before it was accessible to the "Minitab" programme. Also, due to relocation it became necessary to use the Joint Academic Network (JANET), linking up to the Surrey University computer from the University of East Anglia. In this the staff of both university computer units, were most helpful.

After completion of the analysis conclusions were drawn and additional research areas were indicated.

1.6 Structure of Thesis

The emphasis of the study is on the applicability of the concept of hospitality to hospitals. The researcher's background and training are within the catering industry, with particular experience in private welfare catering and in catering education. As such the focus of the study is firstly on the concept of hospitality and secondly on the environment of the hospital. This emphasis leads to what might be regarded as the slightly unconventional structure of the thesis. Instead of commencing with a historical underpinning and background to the environment in which
the study is to take place, this study commences by discussing the theory and concept of hospitality and its applicability to the present-day hospital. In chapter three familiarisation with the environment is approached by looking at the hospital as it has developed, highlighting the important influence society has on the nature of the hospital.

The fifth chapter describes other studies which have looked into aspects of the subject under consideration. Chapter six covers in detail the work carried out in the pilot study and discusses the findings which led to the proposals for the design of the main study. The main study is dealt with in chapter seven, including the detail of the analysis of the data. For both chapters six and seven several appendixes have been necessary in order that a complete set of results is available to the reader. The final chapter discusses the findings of the main study and outlines areas where further research is indicated.
CHAPTER 2 Towards a Definition of Hospitality

2.1 Introduction

The concept of 'hospitality' has wide application and is used by different groups and in different ways. The word refers to a broad range of factors which are similar or have a common thread. However, to draw up a definition which accurately reflects all recognised uses of the term whilst remaining unambiguous represents the core of a debate which is bound to continue. However, a working definition is required in order that further research in the field can be conducted. This chapter outlines the study that has been carried out in formulating that working definition by looking at common, general and specific ways in which the term is used and focusing on their relevance to a hospital setting.

2.2 Defining Hospitality

Before discussing the definition of hospitality it is worthwhile considering why the definition is of importance. It is suggested that those involved with the 'hospitality industries', are the group which most require a clear appreciation of 'hospitality'. This understanding being fundamental to the objective application of 'hospitality management'. The fundamental importance of a recognised definition is that it provides a yardstick against which to measure standards. This in turn gives consumer expectation a realistic basis and highlights objectives for the providers. The recognition of a standard also brings consistency to education and efficiency to research effort.

Dictionary definitions have been used:
"...hospitality [is] the act of behaving in a warm and friendly manner or entertaining with generous kindness. It originates from the Latin noun hospice—a place of entertainment or of shelter. It can be defined in another way as generous and cordial reception of guests offering pleasant and sustaining environment. The guest is made to feel at home and naturally comfortable. Hospitality throughout history has centred around security, physical comfort, psychological comfort, all centreing around offerings, gratis or commercial, to others by a host." (Webster Dictionary in Christian in Nailon (1982))

The Shorter Oxford English Dictionary defines hospitality as:

"The act or practice of being hospitable; the reception and entertainment of guests or strangers with liberality and goodwill." (Onions 1972)

These definitions are essentially very broad, covering a field which is so diverse that more precise definitions are required. Attempts have been made to draw up a typology of hospitality, (as discussed below). The term 'hospitality' is used in both domestic and non-domestic contexts. The domestic context usually occurs when a stranger or non-family group member visits the home and is pleased with the preparations/considerations made for them. This was the hospitality described by American writer Washington Irving (1783 - 1859):

"There is an emanation from the heart in genuine hospitality which cannot be described, but is immediately felt, and puts the stranger at once at his ease." (Irving in Beeton 1906)

Burgess (1982), divides hospitality into public hospitality and private hospitality:

"The private act of extending hospitality can be considered as the gift of friendship, shelter and physical replenishment to a guest by a host." (Burgess 1982)

Other authors (Nailon 1981, and Reuland et al 1985) use the term 'professional hospitality' and Nailon (1982) discusses 'commercial hospitality'. However for the purpose of this discussion the division into domestic and
non-domestic hospitality will be used in the belief that this might be somewhat clearer when considering the context of the hospital setting. (Although it is recognised that there remains potential for some confusion when considering long stay patients/residents.) The term 'institutional hospitality', (Reuland et al 1985), has been used to describe the 'hotel services' of institutions. However this is considered less useful, in this context, than the domestic/non-domestic classification, because of the inherent difficulty of defining an institution and because of the negative connotations attached to the word 'institutional'.

This 'domestic' context has the advantage that it is both frequently used and familiar. Standards of domestic hospitality vary, usually with the regard the host feels towards the guest. The different standards were especially noticeable in large households, as that of the sixteenth century described by Harrison (1972):

"In a large household open house was kept for a variety of lesser people, as well as for formal entertaining of relatives and friends. There was, of course, no public transport service, so if a workman or a delivery man came to the house he came on foot or on horseback, and it was reasonable for him to expect to be given refreshment or, sometimes, a night's lodging...

...By the middle of the century the lord and his family no longer dined in the hall with members of the household, but apart in a smaller room called a 'winter parlour' or 'dining parlour'. Important visitors were entertained in the 'dining chamber'."

However non-domestic hospitality is a topic of greater significance to those engaged in, and participating with, the hospitality industries. The formulation of the definition has been developed more especially with reference to the Hotel and Catering industry where one can distinguish three groups concerned with non-domestic hospitality, (although these exist separately, they are not mutually exclusive). The groups are;
a) receivers of the industry's output, (for example: the guests, the clients, the consumers),

b) providers of the service, those involved in planning, producing and carrying out the activity of the hospitality industry,

c) academics involved in education and research to provide the hospitality industry with skilled entrants/recruits and to structure and carry out study to facilitate the effectiveness and efficiency of both the industry itself and the process of education for the industry.

The term 'hospitality industries' itself unites a large and diverse group, including commercial, profit-making, non-profit-making, welfare and state establishments. Within this group the term 'hospitality' is used frequently and often without any offer of a qualifying definition. Indeed, as if to underscore the importance of the term the journal of the Hotel, Catering and Institutional Management Association had its name changed to *Hospitality*, and the *International Journal of Hospitality Management*, has now become established.

Literature has many examples of implied definitions, for example, Fuller 1986, discusses his developing collection of hospitality books, in this the central theme relates to food:

"Hotel and catering courses began to develop during the 1950's. The history of our vocation, hospitality, links subjects such as tourism, food and health, dietetics and nutrition, and wine and social, temperance and gastronomic ones, and these were some of the new areas into which lecturers and students extended their reading." (Fuller 1986)

This growing awareness of the concept of hospitality during the 1950's is also evident from the inclusion of a description of non-domestic hospitality in Bachman's (1951) *Professional Knowledge*:

"...pleasant relations between head and staff infuse hotel and restaurant with a friendly spirit and the
staff do their task with a feeling of inner satisfaction; thus creating a pleasant atmosphere in which the guest feels at home." (Ruch & Tuor in Bachman in Lockwood & Jones 1984)

Another example of an implicit definition, Taylor (1985), suggests that along with the standard hotel service it is the 'small things', particularly staff behaviour characterised by thoughtfulness, which make the difference between basic hospitality and good hospitality. Several authors have offered explicit definitions, (Nailon 1981, Burgess 1982, Cassee & Reuland 1983, Reuland et al 1985,) which all attempt to encompass every aspect of the implied definitions of the concept presented with a variety of elaborations. For example, a comparatively simple definition:

"Hospitality throughout history has been centred around security, physical comfort and psychological comfort [provided] to others by a host." (Christian in Nailon 1982)

This basic definition is elaborated upon by other authors:

"...hospitality [is]...concerned with the provision of physiological and psychological comfort and security within defined levels of service..." (Nailon 1981)

The incorporation of a notion of service is important in that it links the hospitality industry with the service industries in general, and this is the subject of an on-going debate which in turn has a bearing on aspects of hospitality. Further discussion of the service aspect will appear in the next section of this chapter. But here, we will continue to look at other definitions which have been put forward.

Burgess (1982), views the 'conceptual package' of hospitality, in diagrammatic form, see Figure 2.1.
Figure 2.1 Hospitality Elements as a Conceptual Package

After Burgess (1982)
Figure 2.1 shows that Burgess sees the concept of hospitality as five points, (Service, Beverage, Accommodation, Entertainment and Food), within a sphere of psychological and physiological comfort and security, which is itself contained by a sphere of hospitable social interaction. A full description of this concept is presented by Burgess, who explains:

"The outer, primary interacting element is that of the social relationship fostered by the warm, friendly, welcoming courteous, open, generous behaviour of the host, creating the hospitable social environment. This promotes the positive feeling of security and comfort created by physical structure, design, decor and location of facility. Finally the provision of accommodation facilities to sleep, eat, relax and wash, together with the supply of food, beverage, service and entertainment." (Burgess 1982)

This conceptualisation is useful in that it highlights the fact that the hospitality experience is essentially interactive. This sharply differentiates the hospitality industry from most other industries, where the providers are removed from the receivers at the time of consumption. This removal is usually both geographical and in time, whereas hospitality providers are, in some form, with the receiver at the time of consumption. This has several implications including:

a) the consumer's impression of the provider is built-up partly from some social relationship/interaction

b) all the representatives of the hospitality industry who are to come into contact with the consumers will, to some extent, be seen as ambassadors of the establishment, which must influence staff recruitment, selection, training, assessment, etc.,

c) the hospitality experience occurs at a specific time with the attendant problems of perishability. This
perishability is meant in the broadest sense, to include for example:
- promptness of meal service,
- availability of accommodation provision,
- presence of polite and attentive staff,
- the maintenance of satisfactory standards of cleanliness at all times.
- all 'after-sales service' is immediate at the point of consumption, in fact synchronic with consumption.

These implications suggest that the individual involved in the delivery of each hospitality offering has a crucial influence on the success of that offering. Consequently specific training and education is necessary, at all levels of the providing organisation in order that the unique aspects of the hospitality industry are fully appreciated.

From the definitions then, it can be seen that there are fundamental key factors which make up hospitality. That is essentially; physical comfort, security and psychological comfort with some underlying acknowledgement of a payment.

Cassee and Reuland in their paper, "Hospitality in Hospitals", state:

"...hospitality is a harmonious mixture of food, beverage and/or shelter, a physical environment and the behaviour and attitude of people. This produces a feeling of being at home, an "at-ease feeling" in people who do not belong to the group of people who 'produce' hospitality but stay under their roof." (Cassee & Reuland 1983)

This definition stresses that the hospitality factors are blended together and that the feeling created in the consumer is of great importance. The authors stressed that this definition was intended to be useful when considering any hospitality situation, their own
particular focus being hospital based. This contrasts with other authors. For example: Kane (1986) and Haywood (1983), who show implicit bias towards commercial enterprises and Middleton (1983) who, whilst acknowledging that 'tourism industry' and 'hospitality industry' are not identical, uses the terms interchangeably. Since proposing their definition Reuland et al (1985) have extended this model to approach a more quantitative presentation. For this they present a venn diagram, see Figure 2.2.
Figure 2.2  A Model of Hospitality

Key
Pr = Provider  Tr = Transfer  Re = Receiver
P = Product  B = Behaviour  E = Environment
N = Needs  O = Objectives

After Reuland et al (1985)
As shown in Figure 2.2 Reuland et al, present the concept of hospitality as three circles, the first one represents the hospitality provider, the second one represents the hospitality transfer situation and the third represents a receiver of the hospitality. The outer two intersect two sides of the transfer circle. In the intersection between the provider and transfer circles are the three elements of the Cassee and Reuland (1983) definition, product, environment and behaviour. Whilst in the intersection between the transfer and receiver circles are the needs and objectives of the receiver. The receiver's needs are given as those which have to be satisfied including examples of physiological needs such as hunger/thirst and social needs such as security. Regarding the receivers objectives Reuland et al (1985) state:

"Objectives of the guest to enter a hospitality situation are more rational and can for instance be:
* to celebrate a promotion/birthday;
* to facilitate negotiations with a business friend;..."

This model is completed by an arrow drawn from the receiver to the provider, which is labelled 'money'. The authors regard this as a step in a continuing process to achieve a quantitative model as they state:

"The model of hospitality is a static one. It only explains the elements that can be discerned in the hospitality offer and consumption, but not the comparative weights of all these elements. Furthermore the model shows us that hospitality is created in the contact between Provider and Receiver, but it does not explain the actions and reactions of both parties. The model can therefore only be used to acquire a general concept of hospitality and is therefore a good starting point for further discussions about the subject." (Reuland et al 1985)

One important difference between the first definition proposed by Cassee and Reuland, and the revised model, presented by Reuland et al, is the inclusion of the financial element, this aspect was not discussed in detail.
by the authors. However, it does seem to alter the way in which the model can be applied to some sectors of the industry, for example, the state-run welfare sector. Nailon (1981) also stresses that the hospitality industry is a business. The importance of the financial component in many types of non-domestic hospitality, for example: hotels, motels, restaurants and wine bars is clear. That is the client/customer has an expectation of value for money and to a large extent assesses the standard of the product in the light of its' cost. The position becomes much less clear when the consumer does not pay, in a direct sense, for the product, as is the case for most patients in National Health Hospitals. In this instance the patient is very unlikely to be aware of the cost of the product, the implications of which are discussed in section 3 of this chapter.

2.3 Aspects of the Concept of Hospitality

Within the literature there is some consensus regarding the important aspects of hospitality. These are seen as security, physiological comfort and psychological comfort. These aspects are represented in a much quoted model in a classical study of motivation conducted by Maslow. Specifically this study related to the reasons why people work, and in his theory Maslow presents a hierarchy of human needs. This hierarchy can be diagrammatically represented as a pyramid with five levels; self-fulfilment, or self-actualisation, self-esteem, Social needs (acceptance) Safety needs Physiological needs (hunger and thirst)

He considers that once needs at the lowest level of the hierarchy have been satisfied a worker seeks to fulfil the
next level of needs in the pyramid. The theory is not entirely well-received;

"The main supporting evidence for this theory comes from the lowest needs in the hierarchy - when people are very hungry, thirsty, cold or afraid they are not much concerned about higher needs,..." (Argyle 1976)

However, Venison (1983) has applied Maslow's theory to the needs of hotel guests, he suggests that hotel guests seek to satisfy the same needs in the same sequence. Venison sees that the hotel can provide for the needs at the lower levels of the hierarchy but suggests that higher levels of need are increasingly difficult to meet. It is suggested that the satisfaction of these needs may be approached by offering opulent surroundings and the highest level of personal service in an elitist 'club-type' section of some hotels but it is generally considered that these needs would not normally be met by the hospitality usually offered in most hotels.

The definitions of hospitality given in the previous section of this chapter suggest that hospitality is concerned with the satisfaction of the needs of the guest. In particular the inclusion of the word 'comfort' gives notion of satisfying a level of need, which does not necessarily include the level of self-actualisation. This level of need appears to be difficult to satisfy with non-domestic hospitality and efforts to satisfy this level may be inappropriate. The pursuit of self-actualisation may be basic to an individual's motivation to exist and may indeed be linked to religious/philosophical attitudes of the individual, and therefore generally, be beyond the scope of the hospitality industry. It is considered that the hospital setting has several characteristics, particularly regarding the dependency created by illness, (discussed in Chapter 4.1 and in Chapter 6.4), which take the satisfaction of a patient's need for self-
actualisation beyond the scope of possibility. Indeed the majority of patients will, during their hospital stay, experience some degree of discomfort and pain. Their desires will at this point will be considerably more fundamental than self-actualisation. Also, from the providers point of view this would undoubtedly be a prohibiting, expensive standard to work to.

However, apart from these factors, some aspects raised in the review of the explicit definitions warrant further discussion. One such aspect is that of quality and service. It is considered that most current definitions incorporate some aspect of quality, either explicitly (Nailon 1981), or implicitly (Christian in Nailon 1982) using again, the word 'comfort'. This is not a specific standard and gives flexibility across a range of service qualities. Both 'quality' and 'service' are difficult to define:

"Quality... you know what it is, yet you don't know what it is. But that is self-contradictory. But some things are better than others, that is they have more quality. But then you try to say what quality is, apart from things that have it, it all goes poof!... What the hell is quality?" (Pirsig in Nailon 1981)

Quality will consequently be defined only in the vaguest terms or must be taken as inherently relative. The service concept is also important and should be easier to define. Service industries (of which hospitality industries comprise only a part), are an identifiable and very important sector in the economy. An understanding of the characteristics of service industries is important in that the participants, (and in particular the management), in the service industries require particular skills and expertise in order to carry out their business, Levitt (1972) discards the distinction suggesting that all industry is a service industry, however others, (for example; Cowell (1977), Bruce (1987), Hales & Nightingale
(1986) Sasser (1978) and Cunningham & Roberts (1974), do see the service industries as distinctly different from manufacturing industry. The nature of the product can be taken as a method of classifying industries, see Figure 2.3.
Figure 2.3  Products as bundles of Goods and Services

<table>
<thead>
<tr>
<th>Goods</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

- Self-service groceries
- Automobile
- Installed carpeting
- Fast food restaurant meal
- Restaurant meal
- Auto maintenance
- Hospital care
- Haircut
- Consulting services
- Motel services

After Sasser et al (1978)
Nevett (1985), criticises the above model (Figure 2.3), with some justification in the following terms:

"This seems to me to present packages in a curious and distorted form. It is difficult to accept self-service groceries, although associated heavily with goods, as anything but a service industry."

Nevertheless, Figure 2.3 shows that Sasser et al (1978) consider goods and services as distinctly different and the blend of these two as making up an offering which can be described as either purely goods or a blend of both, some part goods and some part services.

In his thorough discussion of the topic Nightingale concludes that service does indeed exist and states:

"...a characteristic by which both products and services can be distinguished may be on the degree of difference in consumers' perception of the use of a particular product or service. Further that the combination of characteristics of an offering may include some, where because of the common needs of many users, be uniform and others which are expected to meet the possibly unique requirements of individuals. This suggests that services may be influenced by what at first sight appear to be the conflicting characteristics of heterogeneity and uniformity." (Nightingale 1983)

He goes on to consider how this might be responded to, and states:

"A way of responding to this may be by providing sufficient choice of uniform services. Another would be to have some basic uniform services and to offer additionally the facility to provide a variety of extras." (Nightingale 1983)

If this idea were to be applied to a hospital setting then the second suggestion seems most useful, in that to provide many choices of uniform services (for example; ward domestic service, personalised admissions procedure etc.), would be prohibitively expensive. However if there is a basic standard of, for example; in the case of meal service even the most uniform system must have the flexibility to provide for special diets and consequently..."
looks like an ideal application of Nightingale's second suggestion.

A second aspect of the concept of hospitality, the significance of which does not appear to be generally agreed upon is that of money or payment. In order to arrive at a model of hospitality which can be applied equally well to commercial and welfare situations the issue of payment has to be addressed. As mentioned in the previous section of this chapter, Cassee and Reuland (1983) do not discuss this element, yet in the revised model Reuland et al explicitly include 'money' as a link from the receiver to the provider, (see Figure 2.2).

It seems reasonable to expect that any non-domestic hospitality must, either directly or indirectly, be paid for. This fact is recognised by some definitions of hospitality, for example:

"...hospitality is the people business of providing security, physical and psychological comfort for reward" (Berger in Lockwood & Jones 1984)

It is the researchers' opinion that the method of payment exerts a strong influence on the hospitality experience. This is due to the effect the method of payment has on the attitudes of both the providers and the receivers of the service. Direct methods of payment create an awareness of an exchange taking place which puts the onus onto the provider to supply what the receiver considers to be value-for-money. The receiver has a perception of the opportunity cost of the service for which he/she is paying, and requires the provider to meet certain expectations. Should these expectations not be met the receiver may wish to complain. Direct methods of payment may also ensure that the more of a service that is required, the greater the charge, (thus with private health care insurance, schemes become important). Indirect methods of payment distance the provision of the service
from the payment, both in time and by making the payment more impersonal, this 'removes the price tag', and may alter the perceived exchange from being a two-way process to a one-way process with the provider perceived to be a benefactor. This may be particularly true where the amount of payment is not related to the quantity of the service consumed. It would seem that, indirect payment has the tendency to alter customer expectation, which affects the customers' propensity to complain. However, if a receiver is dissatisfied it is easier to opt for an alternative provider, (should such an alternative exist), when there is a direct method of payment.

Reviewing the hospitality concept and, with particular regard to different hospitality definitions, the following characteristics of hospitality can be identified conceptually;

a) hospitality is conferred on some guest, (who is away from their usual home), by some host, (who may or may not be in their usual home),

b) the transmission of hospitality is interactive, (involving some coming together of a provider and a receiver),

c) hospitality comprises a blend of both tangible and intangible factors,

d) the host provides for the guest's security, the guest's psychological comfort and the guest's physiological comfort.

2.4 Patients in a Hospitality Context

Before proceeding to a chapter which discusses the hospital as a site for hospitality this section will discuss the patient. It is suggested that patients should be the first to be considered when undertaking studies of
hospitals and that it is important to consider the patient, initially, out of the hospital setting, in order to focus on the individuality of hospital patients. Anyone can become a patient, the group is not homogeneous and in many ways is a reflection of the society. The treatment given to patients to a large extent, reflects an attitude held by the society in general, to the sick. This has traditionally been the case, see Chapter 4.

2.4i Constructive Criticism

It is generally accepted that criticism and complaints provide a form of feedback which, if constructive and if correctly handled, can prompt an improvement in provision. Several authors (for example; Elvy (1981) and Bruce (1987)), have highlighted the fact that complaints correctly dealt with can actually generate a greater level of customer satisfaction than if there had been no cause for complaint. Thus, by looking at why patients criticise hospitals, it may be possible to suggest alterations which could be made to increase patient satisfaction or at least to reduce complaints. Cohen (1964) criticised many aspects of life as a hospital patient in the 1960's, having stayed, as a dissatisfied patient, in a London Hospital during 1963. Her work will be considered more fully in Chapter 3). A frequent complaint of patients is that they feel depersonalised by hospitalisation. Many authors have highlighted this problem, including, Kennedy (1983), Iliffe (1983), Garner (1979), Martin (1984), Robb (1967), Franklin (1974) and also Millard (1984), (whose work in geriatric medicine is discussed more fully in chapter 6. This depersonalisation is felt as a sense of loss which includes:

a) Loss of self-determination, this occurs when the individual fits in with the hospital routine, (which not
unexpectedly runs for the convenience of the system) such that they no longer have responsibility for many of the small every-day decisions of normal life, such as, for example; timing of meals or deciding when to go to bed. There are hospitals which are taking measures to reduce this tendency by allowing the long-stay patients to make more decisions for themselves, see chapter 6. This loss can become so marked that people who have been institutionalised for long periods may have to spend a considerable time undergoing rehabilitation treatment before they can return to the community.

b) Loss of independence which comes with the dependency of illness (see chapter 4 and Chapter 3). This is particularly felt when the patient is required to remain in bed, waiting perhaps for the doctor's round, when they have been admitted for tests but do not in fact feel ill and might like to leave the ward for a change of scene. Measures to counter this include the setting-up of day-rooms and the provision of easy-chairs alongside the beds.

c) Loss of privacy, this occurs to some degree with all patients, however the degree of importance attached to privacy seems to be dependent, to some extent, on cultural background, (for example; westerners tend to seek privacy, with the use of curtaining, screening etc., whereas those from eastern cultures do not see a need for this level of modesty and feel lonely or isolated by these barriers). Linked with the problem of privacy is that of territory, again cultural background affects the space requirement needed in any particular situation in order to feel comfortable. This space requirement is also affected by personality, e.g. some people like to touch the person to whom they are talking whereas others tend to be 'stand-offish'. In hospital the patients are living in close proximity with an unfamiliar group and may need to make
special allowances of territory. This may leave them with a sense of anxiety or conversely, the gregarious may enjoy the increased socialisation. Day rooms will alleviate this problem to some extent but other solutions, such as the establishment of restaurants, cafes, or kiosk areas with tables and chairs alongside, where ambulant patients might take their visitors, allow patients more freedom than the traditional ward.

d) Loss of individuality can take many forms including, 'pyjamaramisation' where patients are routinely put to bed or kept in bed, or at the very least in nightwear. Patients may prefer, outside hospital, to wear jewellery or make-up but in hospital change their behaviour because they feel insecure or inhibited. Personal possessions have to be kept to a minimum because of the space limits and the sense of risk which further confines expression of individuality, (this is described more fully in chapter 6). Also this imposed 'uniform' for patients tends to make the patients feel that they should conform to a role of being ill and dependent. Another important way in which individuality is threatened is by naming. One aspect of this problem is the disease-centred medical profession, for example:

"Miss A becomes an X-ray projected on a screen, Baby B becomes a bad case of meningitis, Mr C becomes the pain in the neck at four o'clock." (Kennedy 1983)

Here the patient becomes simply a number, a disease or a case. Another problem of naming is whether patients are referred to respectfully, i.e. as Mrs Smith, rather than on first name terms or as 'Dear', 'Granny' etc. by the staff of the hospital. Inappropriate naming can occur between patients with the use of unfamiliar abbreviations and over familiarity. Such difficulties lead to a sense of lost status.
2.4 ii The Holistic Approach to Health Care

The extent to which the patient's individuality is acknowledged depends on the attitude of the health service workers. Many people involved in health care, (for example; Bloom (1965), Baly (1980), Bell (1961), Bird (1973), Gordon et al (1984), Howard (1975), Iliffe (1983) and Kennedy (1983) describe the benefits of a holistic approach. It is recognised that where patients are made to feel individual and important, and where medical staff assess the 'whole patient', including an evaluation of emotional, domestic and social contexts, the recovery time is shorter, and it is suggested that the patient feels more satisfied with the treatment received. The holistic approach being used by staff in some areas of medicine recognises the difficulty of dividing medical and non-medical aspects of a patient, seeking instead, to treat the individual rather than the condition in isolation. Some practitioners also advocate the positive involvement of the patient in the healing process.

"Recovery is more likely when we mobilize the whole person in the direction of health.

It is this concept that the whole person be mobilized, that creates - even demands - a role for the patient in overcoming cancer and other diseases. The limits of the patient's responsibility extends far beyond getting himself to a physician who will "fix him up"." (Simonton et al 1980)

The 'whole person' approach to the treatment of disease is becoming more widely practised. Where holistic approaches are being used the hospitalisation is seen to revolve around the healing process, which has implications for many non-medical aspects as well as medical aspects. Nutrition is considered to be a highly important aspect of holistic care. Patient satisfaction becomes a goal of medical importance.
2.4 iii Hospitalisation

When faced with the prospect of hospitalisation reactions vary. In a study of patient reaction to surgery Janis (1971) noted three patterns of emotional responses before surgery each of which indicated a predictable reaction after surgery, Janis described the patterns and their outcomes as:

"1. Low level of concern and considerable optimism
   2. Some concern and little emotional disturbance
   3. High anxiety and emotional outbursts

After the operation;
   type 1. displayed anger, resentment and complained of pain, neglect and discomfort.
   type 2. showed the best post-operative morale and were co-operative with staff.
   type 3. continued with high anxiety and emotional outbursts after the event." (Janis in Burns 1980)

These reactions are, to some extent, related to the patient's personality, however some researchers, (for example; Moran (1963) and Wolffe et al (1964) in Burns 1980), claim that pre-hospitalisation information can reduce the negative responses to some extent. Leary (1983), describes some reasons for anxiety which will affect people going into hospital. Of particular importance are social anxiety caused by contact with strangers and role novelty anxiety. Leary states:

"Role-novelty is another common source of self-presentational uncertainty that triggers social anxiety. Social behaviour is often guided by the roles people occupy." (Leary 1983)

He goes on to state:

"Role novelty occurs when people find themselves in roles they have not previously occupied." (Leary 1983)

Thus, it is reasonable to expect that patients will suffer some anxiety, particularly at admission. This anxiety will make them feel less 'at home' therefore they may
benefit from attention to reduce anxiety. In this regard non-medical aspects can be seen to make an important contribution. The topic of anxiety is considered further in chapter 6.

2.4 iv Implications for Managing Hospitality

Providing hospitality to patients involves providing for their security, physiological comfort and psychological comfort. The standard to which these can be met will depend on many factors, including:

a) whether the hospital is privately funded or is part of the National Health Service,

b) the building and environment in which the hospital is sited,

c) the skill of the unit management and staff,

Patient anxiety is an aspect which will need particular consideration to increase patient satisfaction.

2.5 The Working Definition

Although the definitions discussed present the totality of the hospitality concept they all, to varying degrees, have a complexity which inhibits their usefulness when designing a research tool such as a questionnaire. The aim of formulating a working definition is to retain the essence of the concept in a simple form which is generally easy to relate to for as large a group of the population as possible. In this formulation the objectives were:

a) appropriateness to hospital setting,

b) appropriateness to inclusion in study tools,

c) clarity, (not being verbose or obscure),

d) practical, (something which patients can relate to).
The working definition suggested is that the individual patient should feel as 'at home' as possible during their hospital stay. The phrase 'at home' is intended to indicate a standard of security, physiological comfort, and psychological comfort which the patient knows and is satisfied with. This phrase does not make allowance for those who have unhappy, unsatisfactory home lives, however it is suggested that even such patients would be aware of the concept of 'feeling at home' and are likely to take the phrase in the spirit in which it is intended. The inclusion of the phrase 'as possible' in the definition allows for the judgement of the patient to compare their expectations of hospital hospitality with their experience of that hospitality.

The working definition is intended for use in its specific setting as in other settings, for example, in the case of the hospitality of a five star hotel clients are often seeking a higher standard of comfort than that which they are used to at home.

The intention of the working definition is that it should convey the essence of the hospitality concept within the hospital, without resorting to lengthy explanation. Necessarily this presents a simplification but with consideration of the background presented earlier in this chapter, it is suggested that the definition's simplicity represents a strength with regard to practical research. This definition has the advantage of reflecting the relative nature of the concept and being expressed succinctly and clearly in sufficiently familiar language for inclusion in the questionnaire of a pilot study.
CHAPTER 3 The Concept of Hospitality in Hospitals

3.1 Introduction

Having, in the previous chapter, discussed definitions of hospitality and arrived at a working definition which is seen as conveying the essence of hospitality to be applied in a hospital setting, this chapter focuses on the detail of the hospitality offered within hospitals. The significance of illness and patient expectation is discussed as an important contextual background and a systems approach serves as a basis for classifying the important aspects of hospitality. The outcome of this discussion provides a framework for study tools.

3.21 Illness and Disease

As with the defining of 'hospitality', discussed in chapter 2, defining 'illness' is not straight-forward or clear and depends to a large extent whose opinion is sought. The concept of illness has been discussed by many authors, (for example; Iliffe (1983), Garner (1979), Baly (1980) and Kennedy (1983) see chapter 4). One difficulty with the status of illness is that the boundary between health and illness is somewhat artificial because it depends on the judgement of a doctor working within the confines of known medicine and with the forces of society and convention. The doctor has a key role in determining which patients are admitted to hospital and the patient is dependent upon this decision. If a doctor states that a patient is in need of hospitalisation the superior medical knowledge of the doctor tends to be respected. For many patients hospital admission is either emergency or imperative. Usually, by the time the prospective patient
becomes aware of the need to go into hospital the medical circumstances determine the hospitalisation, in such a way that admission is seen as an unavoidable requirement of medical treatment rather than a subject for the exercise of choice. Thus, prospective patients will adopt and/or be encouraged to adopt, as positive an attitude as possible to their hospital stay. The illness can be seen to be the reason for the patient foregoing their home-life, an aspect about which there is very little choice for the patient. Indeed, with consideration of the lengthy waiting-lists for some treatments many patients may enter hospital with some sense of relief. These factors, including the distressing aspects of illness, may tend to increase the tolerance with which the patient views the hospital stay and reduce the objective criticism which patient's are prepared to make.

3.2.11 Maternity Cases and Hospitalisation
An interesting sub-group, not normally considered to be ill in any accepted sense is formed by maternity cases. Due to the nature of the condition prospective maternity patients can establish a clear idea about their hospital stay and may well have fewer anxieties regarding the medical aspects than patients with other conditions. This suggests that their views should be particularly well-considered and may highlight current deficiencies in the hospital service. Pregnant women often seek to know other women's experiences (or women tend to provide pregnant women with their experiences), particularly when specific local hospital care is considered. Anecdotal evidence is increasingly being included in publications, (for example Oakley (1979) and Kitzinger (1986)) and organisations, such as the National Childbirth Trust, encourage the
writing of 'birth-reports'. In all these sources, criticism of hospitals can be found.

As stated in chapter 1, this study is confined to the non-medical aspects of hospitals, however the line between the two areas is not always clear. The difficulty of separating out medical and non-medical aspects was particularly noticed when evaluating patient's hospital experiences. An example of this difficulty arose when assessing the anecdotal evidence, (reported in the National Childbirth Trust Magazine, Winter 1987), of one mother who considered that the hospital made her labour more difficult and prolonged by insisting that she move from one room, (the labour ward) to another, (the delivery room), at a crucial stage of the delivery and seemingly without any other reason than that of 'hospital routine'. Whether this complaint is medical or not remains uncertain. Whenever complaints are made the assessment must include some consideration of the reliability of the complainant and, where patients are involved, some allowance, for a medical condition may be considered necessary. However when a similar complaint is made by a large number of people, it has to be granted more credence. Oakley has conducted research into maternity care, both during 1979 and 1986 and she states;

"The three most common complaints about hospital treatment are:
(1) feeling depersonalised, like items on a conveyor belt or assembly line
(2) not being able to ask questions or not having questions answered satisfactorily
(3) seeing too many doctors." (Oakley 1986)

Kitzinger (1987) in comparing a large number of 'birth-reports' found that the hospital births were consistently described as more negative than were the home births, (even when labours were difficult and when still-births occurred). Other research, (for example: Junor & Monaco
(1984), Claxton (1986), Kitzinger (1979), Eliot (1987), Stewart (1987), and Gaskin (1987)), supports these findings, and suggests that midwifery care in a home setting can, in most instances, be both safe and more personalised than present hospital settings, giving a more satisfactory experience to both the parents involved and, some claim, (for example Odent (1984), and Leboyer (1977)) for the new baby too. Dr Wagner (1987), a practising doctor who considers that maternity care is too professionalised and too medicalised, states;

"Much of the discussion about home birth creates heat and not light, the emotional side cannot be denied." (Wagner In Hardy (1987))

Many researchers, (for example: Kitzinger (1986), Savage (1986), Inch (1982) and Stanway & Stanway (1984)), argue that a health care system should provide a clear choice such that those parents wishing, or needing, to be in hospital can have a satisfactory hospital stay and those whose health permits and who prefer to stay at home may do so in the sure knowledge that an adequate 'flying squad' is available. The case for choice seems strong but the discussion has prompted hospitals to look at the care they provide and several changes have been made to improve services (although the facilities and services available depend on the locality and are not uniform nationally). Such changes include;

a) 6 hour discharge for suitable cases
b) 'G.P.' units near the site of the consulting unit,
c) within both 'G. P.' and consultant units, alterations to give a more domestic environment, (eg. attractive curtains, wallpaper and pictures in small, often single rooms)
d) policy changes permitting the patient to bring personal belongings (e.g. tape-recorders, potted plants, bean bags, etc.)

e) in some areas the suggestions of Odent (1984) have been implemented, (these were formulated to be used in France where only 1% of births are at home and were home birth is illegal. The suggestions are to make women feel at home and include the use of subdued lighting, attractive soft furnishings, alternative seating and a considerable amount of flexibility in 'hospital routine').

Incorporating the theme of an environment which makes patients feel 'at home' whilst at the same time offering the security and reassurance of modern high technology back-up is the philosophy behind the work of Gordon, an exponent of the Active Birth Movement, who has redesigned part of the London Hospital's maternity wing, in a very practical example of providing for customer demand within the constraints of the National Health Service.

However, as discussed in chapter 4, the difficulties currently being experienced within the National Health Service, particularly regarding funding have tended to prevent initiatives of this nature. Access to General Practitioner units is restricted. Recently some General Practitioner units and a succession of small maternity hospitals have been closed in line with attempts by Health Authorities, to keep down the amount of their over-spend on tight budgets.

All efforts to resist the tendency for hospital experiences to be depersonalising, (as discussed in chapter 2), can be seen as improving the hospitality, (security, physiological and psychological comfort) which the hospital offers. It is the researcher's opinion that a depersonalised service is capable of meeting only the most basic aspects of a patient's non-medical needs within
hospital but that the more personalised the service the more effective it will be in satisfying the patient's psychological needs. This can be presented diagrammatically, Figure 3.1, and is illustrated with reference to Maslow's ideas which were examined in chapter 2.
Figure 3.1

How Service Meets Needs

NEEDS HIERARCHY

PERSONALISED

DEPERSONALISED

SECURITY

PHYSIOLOGICAL

PSYCHOLOGICAL

(Heppell)
3.3 A Systems view of Hospitality in Hospitals

3.3i Reasons for selecting a systems approach

Having established that hospitality exists in hospital settings, it is reasonable to suggest that the techniques of hospitality management might be applicable, with the attendant expectation of improvements in efficiency and control. However, this assertion depends upon a clear understanding of what it is that we propose to control this being, as Wood (1983) points out, the implication of management. In an attempt to reach this understanding, it is considered useful to adopt a systems approach. Several researchers highlight the advantage of such an approach, (for example; Emery (1973), Bertalanffy (1950), Ackoff (1960), Checkland (1972) and Schoderbek et al (1985)). One good reason for this approach has been summed up by Brierley (1987) as follows:

"A system is a tool for dealing with reality. Because human cognitive capacities are limited, real world phenomena are first reduced to models, and these models are used to develop systems to deal with the real world phenomena." (Brierley 1987)

Secondly, the real world problem of hospitality in hospitals has to be regarded as multidisciplinary, as it involves the co-operation of a mixed group of different specialists and, as Hoos (1981) has observed, the nature of multidisciplinary problems is such that meaningful analysis is facilitated by a systems approach.

3.3ii Application of the systems approach

Initially, when considering any system, it is necessary to consider the environment in which the system exists and to determine the boundaries of that system, for this a 'black-box' approach is useful. This shows the system in the context of it's surroundings but does not show the detail inside the system. For clarity a semi-black box is
used in Figure 3.2 to illustrate the system of hospitality in hospital.
Figure 3.2  Hospitality in Hospitals

HOSPITAL SETTING - Environmental Influences e.g.
climate, politics, medical practices

NEWLY ADMITTED PATIENT

Physiological comfort
Psychological comfort
Security

PATIENT FEELING AS 'AT HOME' AS POSSIBLE

FEEDBACK

(Heppell)
Figure 3.2 shows the environment in which the concept of hospitality is seen, with the newly admitted patients being the input and patients feeling more or less 'at home' as the output. The degree of this feeling being the criterion by which the success of the system may be measured. A concept of feedback is essential to any system, this highlights a difficulty hospitals face in monitoring their success. As discussed in chapter 2, feedback, (for example, in the form of, complaints) influences a responsive system but when feedback is not collected and/or not responded to there is a risk of 'loss of direction' leaving the system divorced from reality and liable to decline into chaos. Feedback, then, is vital for the survival of the system. In the researcher's view this feedback is in many cases too haphazard considering the importance of hospitality in hospitals. Presently, feedback tends to have no obvious focus so that the feedback which is collected is diverse. This could lead to persistent problems being overlooked. To emphasise the importance of this problem it is useful to compare the feedback process in a hotel with that of a hospital. Again taking the example of a complaint, perhaps that of a cold meal, the first member of staff to discuss the problem with is the waiter, then if the guest is not satisfied with the way the complaint is dealt with, there is a hierarchy of other staff members with whom the complaint can be discussed, for example, the restaurant manager, the food and beverage service manager, deputy/assistant manager etc. Contrast this with the same complaint by an in-patient. Often the staff member involved in the food service is a nurse, who has unloaded the meal from a trolley delivered by a porter. The patient knows that the nurse's primary role is not food service and may consequently not wish to complain to him/her. At the time of the complaint the porter is unlikely to be still on the ward. Then there is the vexed
question of who it is that has not done their job properly allowing the meal to arrive cold. In fact, Which? Magazine sets out a recommended complaints procedure;

"Start by talking to the ward sister or senior nurse on duty. Your local CHC [Community Health Council] may be able to help you informally. You may decide to write to the hospital or district administrator of your health authority; health authorities are required to investigate and reply to formal complaints. If you are still not satisfied and your complaint is about standards of service and not clinical judgement, you can then approach the Health Service Ombudsman." (Which? Magazine February 87)

However it is suggested that generally patients will only find this process unfamiliar and daunting. In a hospital generally, there is a less direct method of food service than in hotels so there tends to be more room for human error. That is to say, although all hotels do not operate identical food service systems, generally the hotel chef prepares the food which is then taken by an individual member of the waiting staff directly to the guest. Delays will tend to be the responsibility of only those two members of staff and were there any complaints, such as the wrong meal being presented, should not be difficult to resolve. Whereas, with the hospital food service system, (and again not all hospital food service systems are identical) generally, once a chef has prepared food within a hospital kitchen the food is plated by kitchen staff according to the patient's meal request form, the meals are then loaded into trolleys, from here porting staff will deliver the trolleys to the wards, once at the ward the meal will be distributed either by the porting staff or by catering staff or by nursing staff. Delays which occur may be more difficult to pin-point and errors, such as the wrong meal being presented may be difficult to resolve quickly.

Other aspects such as the friendliness or otherwise of the staff or the noise in the next ward present the patient
with the same problem of being unable, conveniently, to notify a responsible staff member whose role is concerned with that aspect. It is suggested that this leads to many complaints not being picked up and resolved, which causes patient dissatisfaction and may contribute to the patient's feeling of helplessness and depersonalisation. Responsiveness to complaints makes patients feel that their status is still respected and that their non-medical needs are still considered important even though they are in hospital. Also, where a structured framework for complaints is presented, constructive ideas would certainly be forthcoming as only the patient can give a patient's eye-view. Feedback does not only take the form of complaint. Feedback also includes praise which is highly important in respect of staff motivation and job satisfaction.

3.4 Determination of Components of Hospital Hospitality

Once the boundaries of a system have been drawn, the detail of the system can be investigated. A clear specification of the contents of a system is necessary in order that the interdependent nature of the components is appreciated. For this a glass box approach can be used, however as Figure 31 has already presented a semi-black box it may be clearer to present the components of hospital hospitality as a list, Figure 33. This list is seen as presenting a 'rich picture', of the type described by Antill and Wood-Harper (1985), of hospitality in hospitals. The concept of a 'rich picture' is that a system can be more clearly perceived with a clear presentation of all the aspects considered to be involved or contributory to the system being studied. This picture is a technique for summarising the components into format which assists with clear and full analysis of the system.
The listing of hospitality factors was considered as a necessary starting point in order that a study tool might be devised, following the study the list could be reassessed to determine whether any of the components were shown by the study to have been irrelevant and to add any extra components which were discovered during the study. The listing was also considered important to highlight to participants those more obvious factors to save time and to focus attention on any factors that participants felt were important but which had been omitted.

The listing was arrived at initially by the researcher's consideration of the question. Having drawn the ideas thus generated into loose groupings which might be considered discussions were undertaken particularly with colleagues and members of the management staff of the St. Mary's Hospital, Portsmouth. Following these discussions alterations were made to the listing, to give a tentative list of the factors which were, at the outset seen as significant to hospital hospitality. This list is presented in Figure 3.3 and was used as a basis for preparation of the study tool for the pilot study.
Figure 3.3 The Suggested Components of Hospital Hospitality prior to Pilot Study

1. RECEPTION - pre-hospitalisation information, smooth admissions procedure, no lengthy waiting, clear sign-posting, information about the daily routine (meal times, activity schedules).

2. ENVIRONMENT - attractive surroundings, comfortable temperature, peace and quiet, adequate light - both day and artificial, curtains and screens, ward size to suit patient's preference.


4. MEALS - plain cooking, menu choice offering a variety, efficient meal order system, options for special diets, including vegetarians, religious groups and ethnic groups.

5. STAFF - sensitivity to patients, awareness of the impact their work has on the patients, considerate, efficient, relaxed and having time to treat the patients as individuals, cheerful.

6. ENTERTAINMENT - adequate recreational facilities (T.V., radio, etc.), access to books and papers, access to a small shop, availability of telephones, provision for visiting.

7. PRIVACY - availability of screens, quiet areas within the hospital, availability of counsellors, small wards, private rooms.
The factors identified in Figure 3.3 have been loosely grouped together under headings which appear to cover the totality of the items within the grouping, this enabled the groups to serve as a foundation for discussion in the research. However, it should be emphasised that these groupings and factors are tentative and are all open to be discarded and/or added to in the light of the field work. The ordering of the factors is without any judgement regarding their relative importance, and each will be examined in turn:

a) Reception.

The 'first impressions' of a hospital stay occur during the prehospitalisation period and during the reception, at a time when it might be expected that the patient is comparatively anxious. Efficient admission is important as the anxious time for the patient is only prolonged by having to wait to be dealt with but the human contact aspect is also considered very important, as it is with hotel reception;

"...the most important greeting has to be the receptionist's genuine smile of welcome..." (Legate 1986)

Patients, newly admitted to hospital need to absorb a variety of information to make their stay more comprehensible, for example;

"Clearly the colours and styles of uniforms indicated status. I knew sisters wore dark blue, but who were the people in white, green and grey?" (Mellows 1985)

Information about routine comes from several sources including: the reception staff, the admissions literature, posters and notices and, not least, other patients.

b) Environment.

The environment greatly influences a patient's impression of the hospital and many researchers claim, among them
Good (1965) and Lindheim (1972), that the environment is an important factor in both the speed of patient recovery and patient satisfaction whilst in hospital. Certainly all short-stay and most long-stay patients have no influence over their environment so if they happen to dislike the decor etc., they have to tolerate it whilst they are in hospital:

"...one ingredient of the patient-role is the acceptance of the hospital environment as given, and this is one major difference between the home and the hospital..." (Sommer and Dewar 1963 in Freidson 1963)

c) Furnishing and Fittings.
As with the environment the patient has little say regarding the furniture and fittings. However, the patient is likely to spend a large proportion of his/her time lying in their hospital bed and sitting in the day-room chairs, should the patient find either uncomfortable their hospital stay will be a less pleasant experience than it would otherwise be. The quality of this factor is considered to be very important especially as patients are largely focused on how their body feels.

d) Meals.
Hospital catering may be considered as producing for a captive market, however the patient, who is away from his/her usual activities often awaits the meal as a highlight in an otherwise boring and often uncomfortable day. The patient will build up expectations and disappointment may well be considerable if the meal does not live up to them. This aspect is quite unlike the medical domain, because here food and drink represent an area in which each individual is an expert on the
patient's preferences and complaints are likely to be voiced, although perhaps not in a useful manner. Beside its nutritional importance, food is an important factor in group cohesion, there is a 'halo-affect' with meal satisfaction. Which is described by several authors, including Murcott (1983) and Lowenberg et al (1979) who state:

"Food is used to promote friendliness and social warmth or, as it has been called the ritual of hospitality... and relationship with friends." (Lowenberg et al 1979)

Cunningham points out that hospital food is often very different from that which patients would normally choose to eat, but that complaints more often take the form of grumbling between the patients or the patients and the nursing staff rather than to those involved in the catering. Another important aspect of the meal is the service. As mentioned earlier in this chapter meal service is a duty which often falls to the nursing staff. The Chief Nursing Officer, Nuffield Hospitals, highlights this, pointing out that:

"The caterers are totally absorbed in meal preparation and cannot appreciate that to a nurse, patient food is an interruption in an already very busy routine. The ideas of careful service and presentation are frequently cast aside, which is the basis of many confrontations and misunderstandings between the caterers and the nurses." (Davies in Heppell 1983)

This is perhaps a plea for a rethink of meal service practices but also suggests the need for nursing staff to be involved in some food service training and to be allowed more time for what is a very significant part of the patient's day.

e) Staff.

A great many aspects of staff behaviour influence the satisfaction of the patient whilst in hospital, including, how patients are addressed, whether the staff are
considerate of the patients in their work practice, whether the staff show interest in the patient's conversations with them, whether the staff present a professional attitude, etc. Of great importance, when considering the interdependent nature of the staff roles, is efficient and effective communication between both staff and patients. This is stressed by several authors, including; Tomlinson (1985), Maguire (1985), MacLeod (1985), Barnes (1961), Bruce (1987), Burton (1965), Cartwright (1977), and Dainton (1961).

Where the hospital communications are successful the patient will be reassured by an atmosphere which presents clarity and consistency.

With both staff and patients a smooth running organisation will prove to be more relaxing. More than with other hospitality, relaxation is important. Bennet (1979) proposes the use of relaxation techniques by doctors and suggests that their use should be recommended to patients. Other exponents of relaxation include Hewitt (1985), Trimmer (1985), Lidell (1983), Wood (1974) and Hoare (1983). Relaxing the guests is considered as very important by the owner of the Park Hotel, (Hotel of the Year 1988) who states:

"If a guest has a problem, something wrong with the car for example, it's solved for them. "We do everything to make the guests relax..."(Brennan in McKay 1988)

f. Entertainment.

Patients often bring some forms of entertainment into hospital with them but variety is important as the usual daily activities of the patients are suspended and boredom is particularly likely as many medical conditions reduce mobility.
g. Privacy.

Mihill (1987) stresses that privacy is very important to many patients who feel threatened by the hospital situation. As mentioned earlier in this chapter the need for privacy tends to be cultural and will vary with individuals.

From the 'rich picture' factors can be drawn out which sum up the essence of hospitality within the hospital context, as a starting point from which individuals can focus on the determination of additional aspects and with which individuals can distinguish those factors which they consider to be of greatest importance.

3.5 Significance to Management

In presenting the elements of hospitality in hospitals it is clear that a major difference between this setting and other hospitality settings, (for example, hotels), is that hospitality is not the sole, or even the most important, function of the organisation and as a result does not receive the same focus as hospitality in other establishments. Therefore, there are a number of implications for hospital management should they seek to improve the hospitality offered by their hospital, these include:

a) the need to define the objectives of the hospitality within the particular hospital,

b) the need to determine contributions and roles of the staff members in terms of hospitality. (This concurs with a suggestion of a recent report by the King Edwards Hospital Fund for London (1986), particularly in respect of the recruitment of hotel managers into the hospital management team). The suggestions are being taken up, as is the case in the Waltham Forest Health Authority:
"...has just appointed, on a consultancy basis, a
director of "hotel services," to improve catering,
cleaning, laundry, reception and transport."
(Cunningham 1986)

c) the need to assess the success of hospital hospitality,
including some gathering and assessment system for
feedback, for example, adopting the use of guest
questionnaires instead of the more anonymous complaints
box.

3.5ii Quality, Standards and Monitoring

In considering the hospitality of a particular hospital
the establishment and maintenance of a recognizable
standard of quality or service is important for several
reasons. Firstly, to ensure that the patients receive a
consistent service which is of an acceptable standard,
this has the affect of enhancing public relations and
improving the hospital's public image, which in turn
should tend to improve the confidence of patients being
admitted. Secondly, the hospital staff, in being aware of
the importance of hospitality, will be trained to carry
out the practical duties required of them, to ensure that
the patients receive the predetermined standard of
hospitality during their hospitalisation. Thirdly, the
management benefit from having a recognised standard of
hospitality by having a clear target for staff training,
and a clear understanding of the acceptable standard to
which achieved performance can be compared.

The method for setting a standard is complicated by the
fact that the standard is subjective and dependent upon a
group, (the patient group at a particular hospital at any
one time), which is both homogeneous and, in all but long-
stay establishments, frequently changing. The standard
therefore is not as useful or reliable as a parametric
measure, however the benefits of having such a standard
remain as long as the limitations are taken into consideration when it is applied.

The subjectivity of the standard requires that a sample of the patient group be questioned to assess the nature and strength of their feeling about the hospitality offered by the hospital. There are several approaches which may be adopted for carrying out this questioning. First, the one-to-one interview between each patient and a researcher might be expected to give a richness of response. The interview could be conducted around the framework of a questionnaire. However, this method has to disadvantages of being labour-intensive, (therefore expensive), and of requiring some disruption of the ward routine which may be tiring to the patients and inconvenient to the medical staff. To counter this first disadvantage the researcher might undertake to interview a proportion of the patient group simultaneously. However, this approach is considered to be unsatisfactory as it may dissolve into a 'complaints session' and the more vocal patients might dominate the discussion giving a skewed impression of the patient's feelings. The approach considered to be most appropriate is that of the self-administered questionnaire which could be distributed on the wards and collected later, after completion. This approach has the advantage of being less expensive and less disruption of the other activities in the ward.

To be effective the monitoring should be reasonably frequent, this is because the patient group is frequently changing and it is important that the management can develop a profile of the trend, from which to assess causes, rather than reacting to individual isolated results. Following the data collection prompt analysis and feedback are essential, without these the monitoring will breakdown as the staff become complacent. Where respondents repeatedly highlight difficulties some action
to investigate and solve the problems must be evident. Although it may be that individual patient groups will not see this action, the staff will be aware of the situation and the action will serve to reinforce the importance placed on hospitality. Indeed, some patients may be re-admitted and may benefit from their involvement with the monitoring system.

In conclusion the factors of hospitality have long been part of hospitals but a current development is for management to see the factors as contributing to a whole which is important. Once the existence of hospital hospitality is established, the application of systematic management techniques can be expected to bring about increasing efficiency. Indeed, management attitudes have undergone a great change in recent years, particularly with the appointment of hospital General managers and with the application of ideas from business and commerce to hospital settings. (See Chapter 4, sections 4 and 5.)
CHAPTER 4 The Development of the Hospital Service

4.1 Introduction

As a basis for studying the present-day hospital it is useful to review the background from which our hospitals have evolved. For this review a chronological approach begins with the basic reason which led to the need for hospitals to be established.

"Illness creates dependency. The sick need not only medical treatment but also personal care and shelter." (Rosen 1963)

If this dependency is met in the home a certain quality of care is achieved. This includes the food, the physical environment (decor, furniture, familiar surroundings etc.), and the emotional care and support of loved ones, as well as the available medical assistance, knowledge and skill. Whenever a patient is removed from the home the quality of the care will change. The places to which patients are moved, the hospitals, through the ages have been the focus of some study. On the whole these studies have taken either a medical viewpoint, looking into the progress and achievement of medical knowledge and expertise.

"Most studies of individual hospitals have been concerned to describe the character and achievements of the doctors who staffed them and have emphasised the impact of changing medical techniques and medical knowledge" (Abel-Smith 1964)

Other studies have looked at the sociological context of the hospital, especially regarding the medical personnel and focusing on aspects such as; the role of nurses, problems associated with recruitment, training and background research giving information to assist with pay negotiation. (See Chapter 5).
Some researchers have looked at the hospital from the patient's viewpoint. It is this perspective which is used in the present study. The immediate difficulty with this approach is the lack of documented evidence and records. Such constraints have meant that the perspective is that of Western society, focusing on England. However, other cultures and countries are mentioned when developments and events taking place have bearing on English hospitals and their development.

In modern times the hospital, as the cornerstone of health care systems has been the centre for a great proportion of health care (and, consequently, the hospitals have taken the largest share of health care budgets.) Traditionally however, most health care has been carried out in the home. Obviously, ever since mankind began there have been diseases and sickness. When early man became ill he or she would presumably have been cared for within the normal family group.

"...nursing as a practice originated in the dim past where some mother among the cave dwellers cooled the forehead of her sick child with water from the brook..." (Osler in Dolan 1978)

It was only after cultural groupings became more complex that society would have any reason to establish places specifically for the care and/or treatment of the sick. Thus, it is reasonable to assume that the quality of care would be dependant upon many factors, not least; the group's attitude to the sick members, the group's priorities (eg. whether they were about to move to pastures new, whether they were involved in fighting, etc.), and the general level of the group's resources.

4.2 Earliest Hospitals

The first known centres of medical care were in Babylonia at around 2000 BC. Medical knowledge and treatment was primitive.
"The notion persisted that illness was caused by sin and by displeasure of the gods; that disease (dis-ease) was inflicted as a punishment for sinning. The sick person was unclean and needed purification, and temples therefore became the centers of medical care." (Dolan 1978)

The ancient Egyptian temples contained a medical area which might be said to resemble a large out-patient clinic. This area was divided such that physicians specialised, and patients would attend the section which offered treatment which was relevant to their complaint. The physicians would examine the sick whilst medical students observed.

In ancient Greece there were temples which offered health care. Although mainly religious these temples were dedicated to Aesculapius (Askelepios), chief god of healing in the Greek pantheon. They offered treatments which were based on magic and religion.

"The temples were sited in peaceful surroundings, in woods or on mountainsides, close to a source of pure water or a mineral spring. Here the sick came for 'temple sleep' or 'incubation'. The sufferer made prayer and sacrifice, was purified by lustration, a ceremonial washing with water from the spring, and received preliminary treatment of massage and inunction with oils. He then lay down to sleep in the sanctuary where a priest appeared to him in the guise of the god...

...Incubation has existed as a method of treating illness from about 1000 BC until the present day, for it is still practised in the Greek Islands." (Cartwright 1977)

These idyllic sites were chosen with the intention of selecting places where the gods might dwell, (or might be disposed to visit), rather than from a direct concern for the patient's comfort. Religious attitudes in society have often affected health care. Around 1000BC the Hebrews had a religious duty to visit and care for the sick, which meant that they were exemplary in the practice of hospitality and there were a great many houses of hospitality, the forerunners of both hotels and hospitals. The dichotomy into recognizably separate establishments is difficult to date as many hotels also offered provision
for the sick. This was particularly necessary because journeys took considerable periods, were relatively dangerous, and there was quite a considerable likelihood of illness during a journey. Thus a need had to be met throughout most towns and villages, particularly on the popular routes.

It is not certain when the first hospital opened in the British Isles but Dolan (1978) mentions that in 300BC Princess Macha built a hospital in Ireland called Broin Bearg, or the House of Sorrow.

The Romans built their hospitals in pleasant sites and their medical practice also was strongly influenced by their religious beliefs. Nursing seems to have been undertaken with less than direct concern for the patient, indeed there was often an ulterior motive on the part of the health carers.

"For a short period nursing seems to have had a vogue among disillusioned upper class Roman women who, as the temporal world of Rome fell about them, tried to find salvation through works of charity... However as Christianity became official, devout men and women fearing material corruption, began to move into isolation. At first they were eremites, then later monasteries were established the early Christian tradition of nursing the sick in their own homes was lost." (Baly 1980)

Along with the influence of religion on health care the general state of society appears to determine how the sick are regarded. During the decline of the Roman empire, people became very disillusioned and insecure, (the family unit was unstable and Christians were being persecuted).

"The value of the individual had fallen very low, and it is no wonder that the only hospitals of note were built for the military. Nursing homes, *valetundinarta*, were established for sick slaves because they were considered valuable property." (Dolan 1978)

From remains which have been found both at Inchtuthill, in Perthshire and in Wales, it is known that the Romans ran military hospitals in Britain. It is suggested that,
despite the lack of relics to date, it is most probable that the Romans also built hospitals in England.

This early connection between religion and hospitals has persisted throughout history. There is no doubt that health care was a concern of the monasteries, but there is difference of opinion regarding the extent of that concern. Some authors suggest that the local community were cared for.

"...some orders, particularly those of St. Benedict (480-544) the first of the great Western Church orders, and later the rule of St. Augustine, extended their ministrations to care for the sick who lived nearby. Care was now given to pilgrims and later monasteries began to provide buildings called nosokomeions - from the Greek 'nosos' meaning disease, the remains of which can sometimes be seen in the ruins of dissolved monasteries." (Baly 1980)

Whereas, others suggest that the health care practised in monasteries was mainly directed towards those brothers of the monastery who had become ill.

"There is a commonly held fallacy that every monastery, priory and abbey administered a hospital. The mistaken belief has arisen because monastic houses usually contained an apartment known as the infirmary. The infirmary existed for the use of sick monks or nuns, although occasional travellers may have been admitted. Since members of the Order entered the house for life, a special place for their care in sickness and approaching death was obviously essential." (Cartwright 1977)

The earliest known evidence of an English hospital dates back to Saxon times. Dainton (1961) records evidence of an institution at St Albans in 794, but Woodward (1974) considers the earliest authenticated hospital in Great Britain to be St Peter's Hospital founded by the Canons of York Minster in AD 947. Other writers regard a grant of land, (made by Athelstan to an already existing hospital), as the first authentication of an established hospital at York. This grant occurred in 937.

Mediaeval hospitals were very religious institutions.

"...to make clear what the hospital was, and what it was not. It was an ecclesiastical, but not a medical institution. It was for care rather than cure: for the relief of the body, when possible, but pre-
eminently for the refreshment of the soul. By manifold religious observances, the staff sought to elevate and discipline character. They endeavoured, as the body decayed, to strengthen the soul and prepare it for the future life." (Clay 1909)

Hospitals during the middle ages were set up to receive anyone in need of shelter.

"...early hospitals, were not intended solely for sick people. Their purpose was indicated by their name, which was derived from the Latin adjective hospitalis — concerned with hospites or guests." (Dainton 1961)

Indeed at Battle Abbey in Sussex the monks built 'a house of pilgrims' which was known as 'the hospital'.

Medicine was viewed with some suspicion; there was a papal prohibition of surgery from 1165 to 1215. During the twelfth and early thirteenth centuries the crusades (1095-1271), caused increased travel and a greater need for hospitals providing both their nursing and hotel functions. Consequently there was an increase in the number of hospitals. However, this was short-lived due to wars, economics, changing religious ideology and the fourteenth century depopulation of Europe. Around this time there were many different Orders and types of monks two of which, the Carmelites and the Austin Friars provided most of the organised care for the sick in the fourteenth century.

Medical knowledge during this period was severely limited and there was a great amount of illness. This was partly due to the increased amount of travel undertaken by the crusaders and to the general movement of people fleeing from the Black Death.

"Medieval people believed that the chief means of defense from the disease was to flee from the infected persons and from the location of the outbreak. Thus families fled from their loved ones, leaving them to die unattended.

The disease reached pandemic (world-wide) proportions eventually and when the plague ended, India was reputed to have been depopulated; China lost thirteen million persons; Cairo was supposed to have lost daily from ten to fifteen thousand lives
and altogether at least a quarter of the then-known world had perished." (Dolan 1978)

England was suffering from numerous scourges besides the bubonic plague, for example; leprosy, tuberculosis, smallpox, syphilis and Rickettsial diseases, (these were known as 'fevers'). As many diseases, (especially 'fevers'), were prevalent in gaols, asylums and hospitals, hospitals became places of last resort.

"For the most part the sick were cared for in their homes, which in spite of their prevalence of rats and other animal vectors of disease in their daub and wattle dwellings, was probably the safest place." (Baly 1980)

From about 1535 dissolution of the monasteries began, following an edict from Henry VIII. This brought extreme suffering and hardship to groups who were already needy, in that the sick, the aged and orphans were dispossessed. Many starved and many more became homeless, having to beg to survive.

No hospitals or homes were set up to accommodate those leaving the monasteries, this was chiefly because of the general attitude that illness was 'predestination'. Those hospitals which did exist were unhealthy places, made worse by the effect of the window tax. (Which caused people to brick-up the windows of hospitals to reduce the amounts levied).

However, in France in the mid-sixteenth century attitudes to the care of the sick were becoming more favourable. This was helped greatly by the work of St. Francis de Sales (1567-1662), who encouraged visiting and nursing the sick, and St. Vincent de Paul (1567-1669), who introduced principles of visiting nursing and social service.
By this time some excellent hospitals did exist. (For example one cited by Dolan (1978) referring to the writings of W. Blunt. This hospital was built in Portuguese Goa during the seventeenth century.) On the whole care in the home was the world-wide norm. The French had now, established much better hospitals than were found in England, and in 1708 The French Protestant Hospital was founded by Huguenots who wanted the institution to serve their fellow country men while staying in England. The sum of money given at its founding was inadequate, and had to be supplemented by voluntary contributions. This set a trend for many other similar institutions.

The authoritative work on the history of hospitals by Abel-Smith (1964) begins at the eighteenth century. He considered that prior to this, the hospitals had not come to play an important role in the treatment of the sick. The eighteenth century has been called the 'Age of Hospitals' because it saw the beginning of the great voluntary hospital movement which led to the founding of a great many hospitals. Such hospitals tended to be very general in their treatment of patients.

"They provided accommodation which was adequate according to the standard of the time, but the inmates were thought and spoken of as 'poor objects' rather than as individual men and women. Patients were admitted suffering from every kind of disease - infectious and non-infectious alike - and, except for segregation of the sexes, no attempt was made at segregation and classification." (Turberville 1933)

From this period, there are a great many more records of hospitals. However much of the record is less than objective:

"... [nursing history tends to] focus upon individuals, leaders in the field, exceptional people who struggle against the odds and win and it is evaluative, indeed largely congratulatory, in so far as it sees the history of nursing as an advance, as
Guys Hospital was opened in 1726 and, like other hospitals at this time, there were strict codes of conduct for both the staff and the patients.

"The regulations laid down by the governors included measures against swearing, smoking and gambling. A patient found smoking or gambling was discharged. The rules regarding swearing were not quite so harsh: the user of bad language was not discharged until his third offence. On the first occasion he was heard swearing he would be deprived of food for one day, and on the second occasion he would get no food for two days." (Dainton 1961)

At this time the role of the nursing staff was most unclear. The London Hospital, which opened in 1740 originally did not employ any nurses (a situation which was later remedied). The regime undergone by the patients was also strict.

"The dietary was very poor: 'milk pottige' or water gruel for breakfast, boiled meat or a boiled or baked pudding for dinner, and broth or 'milk pottige' for supper. If a patient did not like these dishes, he had to go without; even if, because of his illness, they were quite unsuitable for him, no alternatives were provided, for, according to the minutes, 'it was agreed that no other diet be expected or allowed on any account whatever'...

... there are [were] no towels allowed in of the women's wards, no soap for the hands, etc., of any of the patients." (Dainton 1961)

Outside London the move towards establishing hospitals for the poor began with the opening of a public hospital at Winchester in 1736. Estimates of the Hospital's capacity to care for the sick were not realistic.

"This was intended to serve the needs of the entire country; the funds for it were raised by public subscription among the wealthier inhabitants - a method followed by most subsequent institutions of a similar kind." (Turberville 1933)

Up to this time hospitals treated a wide range of conditions, although some conditions which are generally considered to warrant hospitalisation today were not so considered at that time, for example:
"A step taken in 1747 was of importance in the history of English hospitals. It was decided to reserve five beds for lying-in cases. The Middlesex thus became the first lying-in hospital in the country. Soon the number of maternity beds was increased,..." (Dainton 1961)

Not all benevolent intention was well thought through however, one such instance is cited by Trevelyan (1948). The Foundling Hospital, established in 1745 by Thomas Coram, a sea captain, (1668 - 1751), received a grant to its funds from Parliament, in 1756. The grant came with the condition that all children brought to the hospital should be admitted. The hospital was inundated, it could not cope and the death rate became disastrous.

"Between 1756 and 1760, when it became plain to Parliament that this was a bad system, nearly 15,000 children were admitted, of whom only 1,400 lived to be apprenticed. Parliament, having given in all £570,000, ceased to make grants after 1771, and the hospital became again a private charity. Indiscriminate admission had ceased in 1760, and the death rate had fallen." (Turberville 1933)

At first all hospitals were free to any applicant who was ill provided he/she could obtain a letter of introduction from the Governors. Whilst the hospitals were small and the Governors were both well-known and accessible to the community this system worked well enough. As soon as the towns and hospitals increased in size the system was so complicated that it meant the poorest patients were not admitted. As for the voluntary, private hospitals there was a complicated method of payment. Each aspect of the patient's treatment and care had to be paid for so having an operation, for example, became very expensive.

"The Sister of the Cutting Ward - it would now be called the operating theatre - was allowed to take half a crown from each patient under her care in return for which she provided the necessary dressings, whilst her helper or nurse had one shilling for her trouble. The Sisters in the other wards took a shilling from each patient; the Beadle had sixpence for carrying the patient to the ward, and his helper also had sixpence." (Turberville 1933)

This complicated method of payment continued until the Royal Free Hospital was founded in 1828. This shamed the
other hospitals into stopping their charges. At this time hospitals were undergoing considerable change.

"Within less than a century the charity hospitals of the middle eighteenth century had changed their character. From being the havens for the poor sick, the non-pauper class fallen on hard times and with some affliction, they became, together with the newer foundations of teaching hospitals, hospitals for the acute and esoteric." (Baly 1980)

This was the age of specialisation; prompted by medical advances. Over 70 specialist hospitals were founded in England between 1800 and 1860. The impact of these advances is highlighted by Woodward (1974) who outlines three distinct periods regarding the patient's risk of infection in hospitals. The first, before 1800, when few operations were performed (and those which were, required express permission of the governors) and there was little overcrowding. Patients were not at great risk of infection through surgery. The period after this, until the late 1860s, was one of overcrowded hospitals. The practice of anaesthesia, which began during the mid-1840s, increased the number of operations being carried out. This led to greater incidence of 'hospital diseases', often occurring in fatal bouts of great infection spaced by periods (of, in some hospitals, several years), of little trouble with infection. The third period occurred after Joseph Lister pioneered antiseptic technique.

"... Although antisepsis was superseded by the principle of asepsis, i.e. a completely germ-free environment so there is no need for antiseptic measures to be taken, the work of Joseph Lister proved to be a turning point in the development of modern surgery. It was during the last quarter of the nineteenth century and the first quarter of the twentieth that great advances were made. These could only be undertaken without the fear of one of the 'hospital diseases' supervening." (Woodward 1974)

Lister's own records show that amputations he undertook without the use of antiseptics; that is between 1864 and 1866, the death rate was 46%. Whereas, amputations he performed between 1867 and 1870, using antiseptic, had a death rate of 15%.
Historians reporting on hospitals of this period have often exaggerated the scourge of 'hospital diseases' to the extreme of describing hospitals as 'gateways to death'. Woodward refutes this claim, stating that the original records show that English hospitals at this time did have problems with infection but that historians have exaggerated the situation. Hospitals did offer medical help to the population, especially the poor, and were also responsible for a great deal of education of the masses regarding hygiene and sanitation. A leading physician of the late eighteenth century, Issac Lettson, describes the effect of this education.

"In the space of a very few years I have observed a total revolution in the conduct of the common people respecting their diseased friends, they have learned that most diseases are mitigated by a free admission of air, by cleanliness and by promoting instead of retaining the indulgence and care of the sick." (Lettson in Woodward 1974)

The terminally ill were a group of patients not welcomed by the hospitals, because the doctors preferred to build a reputation for curing people and resources were directed to this end, also the hospital was required to meet the funeral expenses of poor patients. (This led to many hospitals only admitting patients who could bring such an amount with them.) Not until 1854 did this change when Dr Andrew Reed founded the Royal Hospital and Home for Incurables at Putney.

The passing of the Poor Law Amendment Act of 1834 led to a great deal of suffering on the part of the sick as well as influencing the whole of the health and welfare services in the twentieth century. This Act set up the principle of 'less eligibility' whereby only the barest of essentials for life were allowed to the poor in order that their situation remained less desirable than that of any worker. The appalling conditions in which the sick were left remained until the 1867 Metropolitan Poor Act
which set up the Metropolitan Asylums Board which provided and maintained hospitals for the Poor and Insane.

Reformers working in the mid-nineteenth century effected changes in attitudes to the care of the sick. Notably, Elizabeth Fry (1780-1845) who opened a training school for nurses in London. Also Florence Nightingale who is reported to have had a remarkable empathy for both her family and her friends.

"Her influence was extraordinary and all-pervading, the men described her as 'full of fun' and kissed her shadow: but perhaps her greatest contribution was that she was one of the first people who regarded the British soldier as having a dignity of his own and not 'the scum of the earth enlisted for drink'."

(Longford in Baly 1980)

Besides her caring attitude for her patients. (Which was most famously demonstrated at Scutari in 1854, during the Crimean War.) She is also credited with an exceptional belief in what medicine could achieve.

"She could not bring back the thousands of dead to life, but she inspired the living with a new hope and a trust in medical care which had hitherto been unknown whether within the Army or without."

(Young 1934)

The nursing historian Baly, discusses the myth and reality of Nightingale nurses and suggests that a great deal of Florence Nightingale's reputation has been built up from reports by historians who have not studied the relevant archive material.

"Instead of seeing the Nightingale reforms for what they were, a humble experiment, a compromise, and a battle between the Nightingale Fund and St. Thomas's, the experiment was lauded into the 'Nightingale System' and ossified as tradition. Those who elevated the 1860 scheme into a blueprint for nurse training forgot that Miss Nightingale herself said 'we must proceed slowly and by experiment.'" (Baly in Maggs 1987)

She also highlights how over-stated Miss Nightingale's achievements have become.
"If we examine what the Nightingale school achieved in the early years, it was in fact very little. Most of the recruits were of much the same standard as nurses before the reforms, they did little formal training but they were subjected to greater discipline. Some had a vocation and learned what there was to learn and made good nurses. But after ten years Mr Bonham Carter was to write 'we have hitherto turned out only two good superintendents.'" (Baly in Maggs 1987)

The 'Nightingale System' has become an accepted tradition although it never existed to the satisfaction of it's supposed author.

"... The public relations machine is not new...
... the experiment was being trumpeted in the general press and the medical journals as a great success. In history what people think is happening is often as important as what actually happened...
... What is interesting is that superintendents who came after Mrs Wardroper, and were trained nurses, saw no need to change the system. Obedience breeds an unquestioning conformity." (Baly in Maggs 1987)

Nevertheless, the writings left to us by Miss Nightingale do show the clear thinking and direct manner she exhibited. An important principle is set down in Miss Nightingale's "Notes on Hospitals" published in 1859.

"It may seem a strange principle to enunciate of the first requirement in a hospital that it should do the sick no harm. It is quite necessary nevertheless to lay down such a principle, because the actual mortality in hospitals, especially those in large crowded cities, is very much higher than any calculation founded on the mortality of the same class of patient treated out of the hospital would lead us to expect." (Dainton 1961)

Miss Nightingale certainly had strength.

"... the population was increasing fast, its health needs changing and medical knowledge increasing at such a rate that the nursing needs of the community, and of hospitals, could not be met by devotion or religious orders alone and it was Miss Nightingale's strength that she saw this, and her good fortune that she launched her campaign when the time was ripe." (Baly 1980)

It is also certain that she had a very great interest in hospitals, Pollard (exact date not given, 1900's) describes how she travelled great distances at some
personal risk in order to compare a great many hospitals in different countries.

Medical knowledge was certainly expanding dramatically, as described by Sylvester (1979), particularly with the development of the germ theory and with the immense contributions of such men as Pasteur and Koch. Consequently the scourge of infectious disease was being countered. As medicine became more respected demand for treatment increased and the task of health care changed. Health care now demanded medical staff to possess special skills not hitherto required. A recruit's ability to learn became important and the educational standard of entrants to the medical professions, (particularly nursing), improved.

Before the end of the nineteenth century a different type of nurse came into existence.

"She came from a better class of family than most of her colleagues and was known as a lady-pupil. She paid for her training, and because of her higher standard of education this lasted only twelve months. As was to be expected it was from the lady-pupils that most of the sisters were selected." (Dainton 1961)

By the end of the nineteenth century, although they were not organised into a system there were a great many hospitals in England. Generally these were in one of three branches; voluntary hospitals, private asylums or local authority hospitals, (most of the latter tending to be Poor Law Infirmaries). Note - An excellent chart showing the growth of the health services is given in Baly (1980) and is reproduced in Figure 4.1.
Figure 4.1 The Growth of the Health Services

From Baly (1980)
The general attitude to medicine had also undergone a transformation.

"Within a matter of forty years there was a new public expectation of what medicine could do - and what it could do in the future. For the first time in history people began to see medicine as scientific and therefore the new image of the hospital nurse was associated with doctors, science and ‘a cure.’" (Baly 1980)

Improved technique and new techniques such as; pasteurisation, vaccination, antisepsis, asepsis and immunisation changed the public's image of health care.

After the First World War hospital financing was a problem. Costs had increased and the donations received by the voluntary hospitals had fallen. Many charities were established to raise funds. Friendly societies were set up such that people saved a proportion of their wage on a regular basis intending to pay for treatment if and when they required it. These schemes, (for example, the Hospital Saturday Fund), were the first medical insurance schemes. Their operation was not universal or equitable to the population. The schemes did vary but generally they benefited only the breadwinner of the family, (not paying out when dependants became ill).

By 1937 the health service needed systematic organisation, a survey of the British Health Services suggested a single regional authority would be the most efficient and economical way to administer the hospitals.

Urgency due to the threat of war prompted a form of regional organisation and the Nuffield Provincial Hospitals Trust was established in 1940.

4.4 1948 TO THE PRESENT DAY

The Second World War and political circumstances meant that the foundation of the National Health Service did not
occur rapidly, not commencing until 5th July 1948. The voluntary hospitals were incorporated into the national system despite the opposition of many people.

"Among the general public there were many critics of the National Health Service Act who felt that its passing would mean the end of the voluntary spirit which had done so much for the hospitals through so many centuries. The critics were soon shown to be wrong. For example, the ten thousand members of the Boards and Committees who administer the hospitals are all unpaid volunteers." (Dainton 1961)

The inclusion of the voluntary hospitals was significant, bringing 'goodwill' to the National Health Service at its formation.

"The Health Service worked but the Government, the public and many doctors overlooked one essential point. The Service only worked because of inherited goodwill and almost any system, however bad, can be made to function if all are willing. We must remember that every doctor is trained in a medical school and that, until 1948, all medical schools were attached to voluntary hospitals. The student was 'reared in the spirit of the voluntary hospital'. Voluntary hospitals ran on a shoestring. The hospital could only exist if every one was prepared to help. Everything non-essential to the patients' welfare had to be cut to a minimum." (Cartwright 1977)

Generally the spirit at this time was one of goodwill and of rebuilding. The military model, (demonstrated on the battle field), presented a tested solution to the problem of a mass of patients with varying degrees of invalidity and ailment, to be dealt with by limited resources. The solution being immediate assessment followed by on-the-spot treatment by medical staff. Following this cases which required further treatment would be sent to remote specialist medical staff. The success of the military model meant that it was generally accepted that large health care systems could operate both effectively and efficiently.

The War won, people looked to the Welfare State for the better future for which they had fought. The National Health Service was regarded as a central pillar of the
Welfare State. In fact, the social climate exerted a very strong influence on the formation of the National Health Service. The planning and formation of the Service was not approached in a systematic manner but rather the service was established with a view to carrying out refinements as seemed necessary. This was realised by Aneurin Bevan (1897 – 1966), Labour's Minister of Health and the architect of the National Health Service.

"Aneurin Bevan, for one, knew that he was launching a dream with an innate capacity to become a nightmare."

(Garner 1979)

Garner (1979) goes on to quote from Michael Foot's biography of Aneurin Bevan giving part of a speech which Aneurin Bevan made at a meeting of nurses in 1948.

"It [postponement] is stupid nonsense,... We never will have all we need. Expectation will always exceed capacity." (Garner 1979)

At this point, if not before, the health service's development becomes inextricable from the politics of the time. (A brief discussion of which follows in the next section of this chapter).

However it was the founding of the National Health Service which finally removed the principle of 'less eligibility'. During the 1950's a considerable amount of upgrading went on in hospitals. Kitchens were centralised and centrally planned. Much of the catering, domestic and laundry service was automated for the first time, incorporating such things as; heated trolleys, conveyor belts, vending machines, centralised dish washing machinery, centralised laundry facilities and industrial laundry equipment.

Upgrading also began in the hospitals of the chronic sick. This neglected group had largely been forgotten. Uninteresting and unglamorous to medical science and unrewarding to treat for the cure-focused medical profession. Surrounded by 'Poor Law' stigma, these
patients were accommodated in some of the poorest most prison-like of medical institutions.

"...many hospitals for the chronic sick] were on the outskirts of the town, which made visiting difficult, and the patients, whose needs were often more social than medical, were made even more isolated." (Baly 1980)

Although funds were usually too low to allow the hospitals to be demolished and rebuilt on better sites, efforts were made to cheer-up these environments. The use of soft furnishings, brighter paintwork, deodorants and potted plants were at least a statement of some change of attitude.

An in-patient's day through the 1950's tended to be long and tiring. Early morning bed-making being the norm, often started before 7am. A committee set up in 1958, by the Central Health Services Council, recommended that as far as possible a patient's day in hospital should be arranged along the lines of the patient's home life.

The 1960's saw general concern regarding standards of care. This is a difficult issue because measurement is highly complicated and there are no established baselines. Research had not been carried out and the evaluation of such a standard is as varied as the numbers of people looking into the question.

"Each generation has its own standards. It was possible that a generation inured to the chilly ablutions when on service with the ATS or even Civil Defence, were less worried about privacy than their mothers. On the other hand there is evidence to suggest that pain and discomfort were less well tolerated." (Baly 1980)

A worrying development of medicine's advance was that with some treatments the therapy was so effective that patients could be cured even without careful nursing.

"Now the patient was cured by antibiotics whether he was nursed or not; if his meals were badly served and he had no opportunity to wash his hands after using a
bedpan he would soon be home and cured - and probably
grateful." (Baly 1980)

The new demands of medicine had led the hospitals to
become highly complex establishments, this made the
staff's duties more demanding and created the need for new
and additional posts. Hospital staff, both nursing and
non-nursing, increasingly became unionised. It became
increasingly difficult for hospitals to find willing
recruits to fill, in particular, the senior posts. This
led to, (in 1963), the government employing a committee of
management experts and nurses to study the problem. The
committee reported in 1965. The resulting Salmon Report
proposed rationalisation and suggested a simplification of
hospital organisational structure to give a more logical
system of line authority. This went along with a
suggestion to establish logical pay differentials.
Although the report was accepted in principle, by 1966
there was a 'Sterling' crisis and no money was forth­
coming to set up the proposals.

A particular area where complaints and dissatisfaction
were being voiced was that of the geriatric patients of
mental hospitals. After Mrs Barbara Robbs' book, "Sans
Everything", (1967), described malpractice, (giving
evidence of ill-treatment throughout the country),
feelings ran high, particularly in Parliament. The book
was to some extent, discredited but investigations were
undertaken and the public-eye was focused on the problem.
From this time a series of inquiries were held to
investigate a number of institutions. A detailed
chronology of these inquiries is set out in "Hospitals in
Trouble" by Martin (1984). Generally the problems
highlighted were related to standards of care by medical
staff. Accusations included; callousness, brutality,
pilfering by staff, ignorance of (or vindictive silencing
of) complaints and in some instances financial
irregularities. Following one case during 1969, a nurse at the Whittingham Hospital was convicted of committing manslaughter. The relevant inquiry also commented that staff were either inadequately trained or completely untrained. Often they had lengthy service at the hospital which led to the staff becoming as institutionalised as the patients. This tendency was noted in several cases.

"It was not only the patients who suffered from being in isolated institutions." (Martin 1984)

Indeed this sector of the patient population is recognised as an especially difficult nursing problem. Martin quotes from the introduction of the Farleigh Hospital Report.

"For most of them [the mentally handicapped male patients] it is the only home they are ever likely to know. Few of them ever receive visits from relatives and friends. They are, therefore, to an exceptional degree dependent upon their nurses for their happiness, contentment and well being. Since almost all of them possess the bodies of grown men and the minds of small children they present a nursing problem which calls for a high degree of skill, compassion and patience." (Martin 1984)

The structure of the National Health Service had remained unchanged for twenty years, (a fact which might well have surprised the original founders). The existing structure was proving to be inadequate to meet the needs of the organisation. A reorganisation was called for and after a process of lengthy and involved planning the first reorganisation occurred in 1974. A very detailed account of the National Health Service structure is given by Ruth Levitt and Andrew Wall in "The Reorganised National Health Service". However, essentially the effect was to include, for the first time, Area Health Authorities between the Regional and the District Authorities. The aim of this move was to improve intergration between the community services, general practitioners and the hospitals. The reorganisation took two years to implement, and cost
around £9 million. It changed the organisation from being largely autocratic, with decisions being made by comparatively few people, comparatively quickly, into a much more democratic organisation where many more people were consulted before a decision was taken. The effect of this was to make the decision process long and draw out.

"Everyone is now entitled, indeed, obliged, to express an opinion on everything. The structure of authority and decision making is such that everyone has to be asked their opinion before any decision can finally be taken. This has paralysed minds and committees and services and produced a crisis of authority from the highest to the lowest...

...Nobody, it seems, can make a simple decision without informing twenty other people, or attending six different committees, or obtaining the consensus of at least a dozen statutory bodies. If anybody has an idea it may take two years to put into practice by the time it has risen up the levels of decision-making and sunk back down again." (Garner 1979)

In an attempt to redress the unfortunate effects of the reorganisation the government set out their view that the Area Health Authorities be removed in the consultative paper "Patients First", published by Patrick Jenkin in December 1979. The major part of this consultative document was adopted in the reorganisation of 1982, the thrust being one of simplification. The Area Health Authorities were removed, (with the additional effect of reducing the numbers of additional staff required).

With the 1982 reorganisation came considerable discussion about privatisation. The government sought to reduce some of the ever-increasing costs of the National Health Service in several ways. Firstly to reduce the demand by encouraging patients to move to private health care. This was achieved by offering incentives for establishing and running private hospitals and nursing homes. Secondly the government sought to alter the supply by putting pressure on the health authorities, in the form of a Department of Health and Social Security circular issued in 1983, which strongly proposed the contracting-out of support services,
such as; domestic, laundry, catering to commercial companies.

After this reorganisation there were staffing cuts and financial cuts which caused considerable unrest. Also the government continued to be critical of the National Health Service management.

This criticism led to an inquiry, set up by the Secretary of State, and conducted by a team led by the Managing Director of Sainsbury’s, (a national supermarket chain), Mr Roy Griffiths. This inquiry indicated that the National Health Service lacked drive and it highlighted the difficulties inherent in the democratic decision-making process. It proposed the appointment of General Managers at the Unit, District and Regional level with the intention of improving overall efficiency. It also proposed the establishment of a Health Service Supervisory Board with a Management Board responsible to it. The role of these Boards being to determine objectives and direction for the health service, to approve budget and resource allocation, to make strategic decisions and to monitor performance. These proposals caused much discussion. They were implemented in June 1984. With them came a new era in the National Health Service, with terms from commercial business management being applied where they never had been before. One such example being the conference held at Hotelympia in February 1986, entitled "Marketing Hospital Catering". At which Dyson and Rushworth, (Catering Managers from the National Health Service), pursued the practical application of ideas put forward by Middleton (1983) regarding the marketing and selling of output from hospital ancillary services. With ideas for the catering service for example producing takeaway meals to sell to the staff and local population
For a clear recognition of the current climate in the hospital service it is important to recognise the significance politics has played, and continues to play, in the health service. The government will always be concerned about the health service if for no other reason than it's size and demand on public spending resources.

"The NHS is one of the largest employers in the world with a staff of nearly a million people. For this reason alone it will remain a matter of consuming interest for any British government." (Levitt 1984)

Iliffe (1983) traces the beginnings of health politics back to the Industrial Revolution where migration of large numbers of people to the cities led to social problems of poor housing, inadequate sanitation and massive spread of disease. But a marked polarisation of political views occurred with the advent of the National Health Service.

The 1911 National Health Insurance Act set up the 'Panel System'. Which was a type of subsidised medical insurance. Here a manual worker would pay 4d a week to an approved society, to which his employer would contribute 3d and the State 2d. The worker then received a free choice of doctor from those named on the 'Panel', which was organised by local insurance commissions and pharmaceutical services at a subsidised rate. Although this only nationalised a system which was already operating some regard it as the beginnings of the National Health Service. Whereas other suggest that it was prompted by the government's concern to make medical preparation for the coming war. Iliffe (1983) argues that the Welfare State was being used as a carrot in the war effort and that, had the government really been intent on improving the nation's health, it would have tackled the social conditions of the country, (especially the standards of nutrition, housing and work safety).
Between the Wars medical care was very diverse and funding became a crucial problem. After the Second World War the population expected a benefit for its war effort. The Conservatives suggested a cautious change to the existing health care system, - little more than an extension of the National Health Insurance. Whereas Labour proposed the Welfare State with the National Health Service as the 'Jewel in Labour's Crown'. Aneurin Bevan was left with the difficult task of reconciling the conflicting wants. On the one hand the T.U.C. who wanted free health care for all, and on the other hand the B.M.A who sought to maintain the professional power of the General Practitioners. The compromise solution, (which has had far-reaching consequences), being for the General Practitioners to be independent contractors to the National Health Service, and not salaried employees of it.

A wrong assumption made at the time of setting up the National Health Service was that it would make the nation healthier and after a time it's costs would decrease. Budgets were exceeded from the outset.

"At the time of the Beveridge Report it had been estimated that the future NHS would cost £170 million to run each year. By the time the NHS Act was introduced, in 1946, the estimate had increased slightly to £180 million per year, with less than 70% of this coming from the Exchequer. The actual cost in the first year of the NHS was £402 million, with £305 million contributed by general taxation."

(Iliffe 1980)

In 1949 the government passed legislation to enable it to impose a shilling prescription charge. By 1951 charges were also being made for dental work and the optician service. This move led to the resignation of Aneurin Bevan.

"...[Bevan] resigned when the second series of charges were introduced on the grounds that it marked the "beginning of the destruction of those services in which Labour had taken a special pride and which
were giving to Britain the moral leadership of the world." (Briggs 1983)

From then onwards costs escalated and the Conservatives were able to argue that resources were finite, whilst demand was infinite. In 1953 the Conservative government set up an inquiry into the costs of the National Health Service, the Guillebaud Committee. Far from condemning the National Health Service as wasteful the Committee found it to be 'very cost-effective', which may indeed still remain the case today. There was no possibility of abandoning the National Health Service at this point, it had become an institution. Controlling finances was one problem, another was controlling demand. Klein (1983) indicates the irony that the National Health Service was set up with very little control over its gatekeepers - the general practitioners.

"Professional perfectionism, clearly, was not compatible with public financing of the NHS: a source of stress and tension throughout the history of the NHS - as doctors discovered that a hospital service, which many of them had entered on the presumption that it would free them from all financial inhibitions in the exercise of their craft, had in practice turned them into the State's agents for rationing scarce resources." (Klein 1983)

The problem of determining when a person is ill, (and therefore a patient), is left to doctors. Often this is not a clear-cut decision, there is no clear boundary. To further complicate the picture there is debate over the definition of such words as "health", "disease" and "illness".

"...the World Health Organisation's definition of health as 'not the mere absence of disease, but total physical, mental and social well-being'. This definition, however, so far from serving as a blueprint for planning and policy, whether for governments or doctors, is often held up for ridicule, even by doctors." (Kennedy 1981)

The definition is indeed broad but for any holistic approach to health care concern for the patient's social
well-being is essential and it is suggested that such concern is fundamental to the concept of hospitality in hospitals, see chapters 2 and 3.

No health system can be expected to furnish all it's population with continual perfect health and yet it is difficult to establish what is a realistic expectation for a health service. The politics of health has the central dilemma that attitudes towards health care tend to differ when considering the general and the individual. For example; generally one might consider expensive, high-technology operations to be wasteful of scarce resources. Yet, should a member of our own family, or ourselves, need such a treatment we would probably be very anxious for it to be carried out. How the resolution of this dilemma is financed remains the source of a deep political divide. Some see that a National Health Service is the most appropriate framework.

"...the NHS represents an attempt to accommodate the conflicts between competing values and interests that characterise all pluralistic societies. It remains, as it began, a monument to political compromise." (Klein 1983)

Whereas others suggest that the American system of health care is superior.

"The National Health Service as it stands, with its monopolistic obstruction of beneficial competition, its stifling of innovation, and its inbuilt tendency to under-provide for the sick due to budget constraint, is beyond redemption." (Green 1986)

Eminent members of the medical world met in 1984 to discuss the future of the National Health Service. They concluded that change was indeed needed but that any change should be undertaken gradually.

"The changes over the next twenty years should be achieved by evolution rather than revolution. It is by no means disrespectful to say that progress in health care should be achieved by continuing to tinker with the existing structure, rather than
trying to dismantle and reconstruct it." (Teeling-Smith 1984)

More recently considerable concern has been expressed about the 'Crisis in the National Health Service'. Mrs Thatcher and the Conservative slogan that, 'the health service is safe in our hands', is being challenged with urgent cries of 'under-funding' from all quarters; doctors, consultants, professors and patients alike. One particular orthopaedic surgeon, Mr Nigel Harris, who appeared on the Conservative platform during the election has since changed his opinion about the National Health Service's safety in the hands of the Conservatives. In the Observer (20.12.87), Mr Harris is quoted saying:

"The Government's policy is one of deceit."

The general level of concern about funding the National Health Service led to something of a rethink within the government: The day after Mrs Thatcher had said that she was satisfied that the financing of the National Health Service was adequate, Mr Anthony Newton, Minister for Health, announced that an emergency extra £100 million had been made available. This was viewed with scorn by many observers. Ferriman described the general response to the extra funds by entitling her article in 'The Observer' (20.12.87), 'the Sticking Plaster Service'. Some commentators point to the Irish system, where a National Lottery helps to finance the health service. They suggest that we might adopt a similar approach. Others have taken practical steps. 'Health Aid' launched in the middle of December 1987, (by Barking, Havering and Brentwood Health Authority) is the first independent charity set up to raise extra money to buy necessary high-technology equipment. Donations are expected to come from the local business community and the Chairman to the Trustees, Mr Sidney Shaw, hopes to raise £250,000 in the first year for heart monitoring equipment, special baths, etc. Recently
announcements that charges are to be levied for sight
tests and dental check-ups were not generally welcomed.
(The Daily Telegraph Gallup Survey (December 1987) showed
that people questioned were strongly in favour of keeping
these examinations free of charge.) In November 1987 Mr
Newton announced the Health and Medicines Bill. This will
give the Health Authorities new powers to raise funds by,
for example, leasing space to commercial outlets, selling
spare capacity (such as beds) to the private sector. The
crisis of funding the National Health Service will
certainly be the subject of hot debate for some time to
come.

Against this background it is debatable whether the
concept of hospitality will be considered a sufficiently
important priority by those in a position to promote
hospitality within hospitals, particularly National Health
Service hospitals. Nevertheless, it may be that research
in the field and practical application of the ideas of
hospitality can highlight areas of improvement which are
inexpensive and cost-effective.

Decisions of financing will remain political. With the
additional complication of the aging population and the
threat of new infectious disease (for example A.I.D.S.)
and the increasingly technical nature of some treatments,
the future certainly looks challenging.

However it seems safe to suggest that there will continue
to be hospitals which will run with careful budgetary
control. As discussed in Chapter 3 the output of a
hospital is difficult to define and quantify, nevertheless
some aspect of patient satisfaction is essential.
Therefore it is useful to gain an appreciation of what the
patients regard as important to ensure that their stay in
hospital is satisfactory. With this knowledge funds might
be directed towards the aspects about which patients feel
most strongly. A clear understanding of the evolutionary
process which our present-day hospitals have undergone highlights the problems caused when people become patients. It emphasises that the modern hospital, offering a wide range of treatments (from for example bandaging cuts in casualty to high technology laser surgery), is a complex establishment. It is of some concern that this complexity is not the cause of a depersonalisation of health care to the extent that the patient's comfort is considered as anything less than central to the aim of the hospital service.
CHAPTER 5  

Other Research Studies

5.1 Introduction

Cassee and Reuland (1983) have highlighted, (as discussed in chapters 1 and 2), that, the topic of hospitality in hospitals is one which has not been researched in great detail to date. However, hospitals are regarded as areas of public domain and as justifiable areas for study and research.

"Hospitals represent institutions which the public regard as their own, about which it is acceptable to inquire." (Dolan 1978)

Consequently, much research has been undertaken within the hospital setting, studies for a wide range of purposes which can be grouped as follows:

1. Medical research, this may involve the setting-up of clinical trials and seeks to test, for example new medical treatments or new drugs. One such study, Jones (1975), looked at the nutrition of patients incapable of eating and drinking in the normal manner.

2. Personnel related research, this area includes investigation of methods of training, education, recruitment, incentive, etc. An example of this research, Halsbury (1974), inquired into the pay and conditions of a midwives and nursing staff.

3. Social research, this research is concerned with the effect the hospital, or work carried out within the hospital has on people, including the patients, the local community, the staff, visitors etc. An example of this research, Altshul (1972), looked at the interaction of patients and nurses.

Baly (1980) classifies research workers in the field of nursing into two groups; firstly social scientists, who apply general social research techniques to the subject,
and those whose basic training is other than social science but who learn the techniques of social science for application to their basic specialism. Researchers (such as Baly (1980) and Reid and Boore (1987)), suggest that increasingly those carrying out nursing studies are primarily specialists in fields other than social science.

The concept of hospitality in hospitals, which is discussed in chapter 3, presents a broad set of factors many of which have been investigated, (often in somewhat different contexts) by other studies. This chapter describes and discusses some of these, (particularly those which are considered to be similar to the current study), with the purpose of providing a background to this investigation survey, results and conclusions, presented in chapters 6, 7 and 8.

5.2 Some Other Studies

McGhee (1961), funded by a grant from the Rockefeller Foundation, carried out a study on patient's attitude to nursing care, part of this study looked into non-medical aspects of the patient's stay in hospital. The study was conducted within a teaching hospital in Edinburgh. The field work involved the researcher in;

a) contact with the staff on the wards,

b) contact with patients on the ward, where patients were introduced to the study and permission was requested for a follow-up home visit.

A pilot study was conducted involving 200 patients selected randomly, a free interview was conducted with the intention of assessing patient co-operation rate and also to determine the topics which the patients considered important. For the main study it was decided to continue with the free interview approach but to use a framework of
the topics highlighted by the pilot study. These topics were:

1. Structure (e.g. washing accommodation, lighting, colour scheme, etc.),
2. Equipment (e.g. lockers, bed curtains, etc.),
3. Amenities (e.g. visiting hours, radio, etc.),
4. Noise,
5. Food,
6. Nursing care,
7. Medical care,
8. Communication,
9. Other.

Interviewees were required to assess each category as either 'good', 'fair' or 'bad'. Where relevant the interviewer would also record any comments that the interviewee made. The main study was conducted on a random sample of 490 patients from the four wards in which 60% of all the patients admitted to the hospital stay; male surgical, female surgical, male medical and female medical.

The more important findings included;

1. 'Ideal' ward size was considered to be 12 - 15 beds.
2. A sitting room away from the ward was considered therapeutic.
3. Lack of or bad design of equipment was highlighted.
4. Patients acknowledged the need for routine but looked for flexibility rather than rigidity.
5. Patients were tolerant of inherent hospital noises but not of noises caused by lack of thought/care.
6. the high quality of the food was praised by all the patients.

7. The researcher emphasised that patients have a need for communication.

Although this study was carried out in 1961 and therefore the comments and criticisms collected relate to a system which has by now almost certainly been greatly changed, it does however indicate concerns which are still important in hospitals today. These concerns could be classified in the terms suggested by Reuland and Caesee (1983), (see chapters 2 and 3), these being:

Environment - ward size, existence of day room facilities, equipment design, etc.

Product - ward routine, noise levels, meal service, etc.

Behaviour - communication need, intolerance of noise caused by carelessness.

McGhee does not distinguish between medical and non-medical aspects within her study and when discussing the patient's need for communication refers entirely to communication about the patient's illness and not about other concerns such as the hospital routine, information regarding meal times, introduction to the hospital environment, etc.

Another study carried out in the early 1960's, (Cartwright (1964)), presented a much wider overview of patient attitude at the time. Funded by the Nuffield Provincial Hospitals Trust, the Joseph Rowntree Memorial Trust and the National Association for Mental Health and assisted by a team of eight researchers Cartwright selected a random sample from the electoral registers. The initial postal inquiry approached 29400 people to indicate those who had been hospital in-patients during the previous six months. (That is between October 1960 and March 1961.)
response rate was 87% and, of those who had been in-patients during the period under investigation, 81% (739 people) were subsequently interviewed in their homes. Unlike McGhee, Cartwright conducted very structured interviews, requiring the interviewees to reply to 124 questions. A parallel survey was also conducted on a random sample of 144 General Practitioners.

The subjects under investigation were; admission to hospital, nurses and ward routine, patients and privacy, ward size, the desire for information, doctors as sources of information, other sources of information, improving communications, the General Practitioner and the in-patient, families and friends, work and wages, variations between hospitals, the particular problems of maternity patients and the influence of social class.

In general the findings were that most people were completely satisfied with the hospital service.

"The majority of patients were satisfied with the medical treatment they received in hospital and had nothing but praise for the nurses and the way they looked after them. In view of this it may seem that too much attention has been paid to the patients who were dissatisfied. Statistical analysis should put these criticisms in perspective, and when particular emphasis is put on the shortcomings of the service, this is in the hope that more can be learnt from the occasional criticisms than from the general chorus of praise." (Cartwright 1964)

As with McGhee's study the detailed criticisms are of less interest today than the concerns that were considered crucial. Again, no distinction was made between medical and non-medical aspects of the patient's hospital stay but again too, the classification of environment, product and behaviour could be applied.

"Altogether two-thirds made some favourable comment about the people in hospital or the personal atmosphere. The other items mentioned favourably with any frequency were the food, by 22%; the physical surroundings, by 10%; and their medical treatment by, 5%.

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Just under a fifth of the sample were mainly critical. The doctors or nurses were criticised by 11%, while 8% commented that the hospital was understaffed. Six per cent were critical of the food and similar proportions of the physical conditions, the other patients and early wakefulness. Four per cent mentioned noise, 3% restrictions and regulations, and another 3% their medical treatment. So looking back on their hospital experience, it was the people they met who made the most vivid impression, and they spoke about the nurses more frequently than the doctors." (Cartwright 1964)

A more recent study concerned with patient's feelings, particularly on admission to hospital, was carried out under the administration of the Royal College of Nursing by Franklin (1974). This study, financed by the Department of Health and Social Security, emphasised the anxiety hospital admission caused patients. Four London non-teaching hospitals with over 100 beds were selected for study. From these 40 male patients, who were at least 16 years of age and who had been admitted within the last 48 hours to the surgical wards of each hospital were interviewed, at the hospital. (The interviewed patients had not been admitted to hospital before during the previous five years.) To measure anxiety the scale devised by Cattell and Scheir (1961), was used (this scale is discussed more fully in Chapter 6). Following this questionnaire questionnaires to investigate nursing quality and patient knowledge were administered. In total interviewees were required to answer 117 questions. The questionnaire on the quality of nursing care included a section which asked the patient to state their agreement, (on a five point scale from strongly agree to strongly disagree), with such statements as:

"1. The nursing staff have made me feel 'at home' here...
   ....7. Some of the nurses here are unfriendly.
   8. The nurses always call me by my name."
   (Franklin 1974)

The findings suggested that the sample of patients interviewed had 'normal' anxiety scores but that one in
five of the sample had significantly higher anxiety scores than was average for their section of the population. Also the findings indicate that generally there was a high level of satisfaction with the nursing care received by the patients.

"...most patients expressed satisfaction with the quality of nursing although a significant number of patients expressed a low enough level of satisfaction to indicate room for improvement. A nursing quality questionnaire should be designed strongly to encourage critical comment which will otherwise not be forthcoming." (Franklin 1974)

Once again, the medical and non-medical aspects of the patient's hospital experience have not been divided.

More recently still, a study was carried out for the Royal Commission on the National Health Service by Gregory (1978) and a team of interviewers. The sample selection was made by including a question on the General Household Survey of 1977, (carried out by the Social Survey Division), which would identify a group with recent in-patient experience and who could be interviewed at a later date. (A group of out-patients was already identified by a question in the previous year's survey). Northern Ireland, (where no such survey is conducted), was sampled by a postal inquiry. Two questionnaires were designed for the study, one for those with in-patient experience (this required the interviewees to answer 158 questions), and the other, for those with out-patient experience (this required the interviewees to answer 148 questions). The study sought factual information about the hospitals in which the patients had been treated and also sought to discover how satisfied the patients were with the existing provisions. This study did distinguish between the medical and the non-medical aspects of the patient's hospital stay, although certain medical aspects were excluded:
It was decided not to ask patients about their satisfaction with their actual treatment and with the standard of medical care they had received, for two reasons; firstly there was no objective standard against which to set their answers and secondly, it was felt that the patient's own views on his treatment would not be a sound basis on which to make recommendations for changes or improvements."

(Gregory 1978)

A total of 791 people with in-patient experience (that is 91% of those eligible), were interviewed and 2267 people with out-patient experience were interviewed (that is 88% of those eligible).

The subjects under investigation were: admission to hospital, facilities provided for patients, the hospital ward or room, it's comfort and the daily routine, out-patient's appointments and waiting to see the doctor, privacy, communication, relationships between patients and hospital staff, discharge from hospital and after care.

The findings relating to the group with in-patient experience are of most interest here, these included:

waiting to be admitted - overall one in five patients were distressed or inconvenienced by the wait for admission, and among those who had waited for over three months the proportion rose to one in three.

facilities provided for in-patients - one in five in-patients complained about the inadequacy of washing and toilet facilities and there was wide support for hospital shops or ward trolley services.

ward routine - nearly half the patients complained of being woken too early, noise disturbance during the day was complained of by 13% of patients and 27% complained of noise disturbance at night, one in eight patients found their hospital bed to be uncomfortable, nearly a third of patients found the ward to be too hot, the meals were criticised by about a quarter of the patients, the usual reasons for criticism were: unsuitable meal times, lack of
choice and the quality and serving of the food itself, a quarter of patients felt that their visiting times lacked privacy, nearly 90% felt that they had been given sufficient privacy during examinations and treatment sessions, the vast majority found that all or most of the staff were considerate.

The actual proportions of criticism are of limited interest as, again, the study took place a decade ago. However, the detail gathered by the investigation incorporates much of the hospitality concept discussed in chapter 3.

Several studies suggest that hospitals are often viewed by patients as having 'halos', and that the patients are grateful for having been treated, and often cured, they would not criticise anything to do with the hospital. Where researchers have conducted their inquiries away from the hospital to avoid interviewees being intimidated by the association of researcher and hospital this 'halo' still appears to be a factor.

It is considered that research relating to individual hospitals, such as McGhee (1961) and Revans (1972), can more realistically approach a larger proportion of their population and can therefore provide a clear view of the individual nature of one institution and very useful insights for the management. Studies which inquire into more than one institution provide comparative material but if they are to be as detailed as the studies of individual hospitals this will entail an expenditure of both time and money which is likely to be prohibitive. However, with the increased political attention on the National Health Service, (which was discussed in chapter 4), including the financing dilemma, it is to be hoped that such aspects as hospital hospitality will be considered as worthwhile areas of concern. This is because, although such studies need to be large-scale and will have to compete for research
resources, (the difficulties of which are indicated by Ferrer (1972), Mumford and Skipper (1967), and Luck et. al. (1971)), it is essential to maintain sight of the fundamental purpose of all hospitals - the health of the patients despite the complexity of the institutions. This is in order that patients are presented with a recognizably acceptable quality of service (regardless of the method by which they pay), and that both management and staff have clear standards to work towards achieving and maintaining. This clarity regarding the quality of provision is important despite the difficulties in quantifying an absolute standard for this aspect. The acknowledgement of the fundamental importance of the human experience whilst in hospital has to be fully appreciated when looking into the more easily quantifiable indicators, such as bed numbers, waiting lists and economic efficiency when any appreciation or assessment of a hospital's success (or, ultimately the success of all hospitals) is being considered.
CHAPTER 6

Pilot Study

6.1 Introduction.

The aims of the pilot study were first to determine whether or not patients were suffering anxiety due to their hospitalisation, with the idea that anxiety might be reduced by improving the hospitality. Second to determine hospitality factors which patients considered to be important to their satisfactory stay in hospital. A third aim was to test the study tools.

From these aims the following objectives were formulated;

- to measure patient anxiety
- to determine whether particular hospitality factors were considered, by a group of patients, to be important
- to collect any additional non-medical factors which were highlighted by the study
- to test the study tools
- to make proposals towards the design of a study suitable for wider application

6.2 Description of Procedures and Techniques.

The pilot study used two types of questionnaire with each patient, the first was usually completed by the patient before being interviewed. The second questionnaire was used as the basis for a 20 - 25 minute interview and was filled in by the interviewer.

In order to assess how at ease and comfortable patients were feeling a standardised measure, in the form of the Cattell and Scheier (1963), Institute for Personality and Ability Testing (IPAT), Anxiety Scale Questionnaire (ASQ)
was selected. This forty question questionnaire has been widely used since 1965 and, therefore, has the advantage of being tried and tested giving a standard anxiety measure allowing any particular population to be compared to population norms. Once the questionnaire has been completed, answers score 0, 1 or 2. These scores are then totalled to give a raw score. In order to compare a raw score with the prepared tables of population norms supplied by Cattell and Scheier, it must be converted into a standard score. This standard score is used to indicate what percentage of individuals tested will receive a particular score and is described by what is referred to as the Sten Scales. The Sten Scales are standard scores with a 10 point range, as illustrated in Figure 6.1 which is derived from Cattell et al (1976).
Figure 6.1 The Relationship between Standard Scores and STENS

As derived from Cattell et al (1976, p.15)
This standardisation makes it possible to compare respondent's anxiety levels with the recognised norms to be expected in adult populations. A general interpretation of the Sten scores is described by Cattell et al:

"Generally a sten score of 4, 5, 6 or 7 indicates an average level of anxiety. Scores of 1, 2 or 3 are typically found in unusually relaxed, secure, phlegmatic individuals. A score of 8 indicates a person whose anxiety level would be getting serious while stens of 9 and 10 are found in only about 1 of 20 cases." Cattell et al (1976)

However a range of norm tables have been compiled because factors such as respondent's age and sex have been shown to affect the precise norms to be found in different groups of the population.

The ASQ has been designed with such flexibility that it can be self-administered. Or where, for example, the respondents are too ill or handicapped to be able to exercise sufficient reading and writing skills to complete the questionnaire unaided, it can be read out to the respondent who's answers are recorded by the interviewer. Both methods were used in this study, depending on the needs of the individual patients.

After the ASQ a second questionnaire was used to investigate more specific aspects of the patient's hospital stay and to determine what factors patients considered were important to allow the patients to feel 'at home' in hospital. For the complete questionnaire see appendix 6.1. This questionnaire served as a basis for the interview and as a framework for recording responses, but it was not used as a rigid format. The intention of this approach was to create a conversation between the researcher and the patient. It being felt that this approach would be most likely to gather feedback relating to; a patient's anxiety, whether the patient considered the idea of hospitality applicable to the setting, and
whether there seemed to be aspects of the subject which patients highlighted but which had been omitted from the questionnaire. Also this technique allowed valuable non-verbal and verbal vocal feedback which could not be gathered without an interview.

The second questionnaire begins by gathering some information about the respondent which is used to help classify the results. The first question then links the two questionnaires together by asking the patient to state how apprehensive they feel about their hospital stay. It might be expected that those patients who had high anxiety scores on the first questionnaire would also state that they were more anxious than those who had low anxiety scores on the first questionnaire. The second question is an attempt to compare anxiety felt regarding the non-medical aspects of hospitalisation with the anxiety felt regarding the medical aspects of hospitalisation.

Question 3 focuses on the patient's previous hospital experience, and the preparation undergone prior to admission. It might be assumed that the greater number of hospital experiences undergone the less anxious a patient would feel during the current hospital stay. Questions 4, 5 and 6 are designed to gather any criticism, (both positive and negative), which the patient feels they would like to make about specific non-medical aspects of their hospital stay. These questions also include prompts which the interviewer might use if the patient seems unresponsive. The patient is also asked why they give particular answers in an attempt to gather detail and to stimulate greater involvement by the patient. Question 7 is a more general question, asking the patient to rank ten specific hospitality factors which generally must be provided by any hospital to make the patient feel as at home as possible. The patient is then asked to give any other factors they feel have been omitted. In a second
attempt to collect over-looked hospitality factors which the patient considers important, the patient is asked to list any things which they miss due to their hospitalisation. The questionnaire ends with a 'catch-all' question which is to find, and hopefully answer, any questions which the patient might have regarding the study, this is in order to dispell any worry that the study itself might have caused the patient.

Several methods of obtaining a sample-frame were considered, including a random sample of patients across the hospital to be interviewed at a specific point in their hospital stay. This was considered to be impractical because;

a. The frequency of emergency admission prevents prior allocation of particular patients to the test group.

b. The variety of ailments and treatments within the hospital would also restrict the possibility of ensuring a sufficient proportion of the elected sample could be interviewed as required.

c. The uncertainty of whether a particular patient would be willing to participate might require the study to take more time than was available to carry it out.

A quota sample, taking one or two patients from each ward was considered to have the advantage that the survey would be a general look at the hospital. However, the limitations discussed relating to random sampling were also considered to apply to quota sampling with the additional complication that including all the wards would involve considerably more of the nursing staffs' time. Also it was suggested that some of the staff who would have to be involved would be those who were not sympathetic to having any involvement with research studies.
Finally it was decided that the pilot study should be an unrepresentative group which would nevertheless, be a test of the study tools and which might also highlight some additional hospitality factors.

The method of sample selection has the drawback that nursing staff may, understandably, choose to approach the patients whom they consider most likely to co-operate. These patients may well be a more content group than an average group of patients. Also patients may feel somewhat intimidated because it is the nursing staff who request their co-operation with the study. A further influence may be environmental, in that the patients may be less inclined to criticise the hospital whilst in the hospital setting. Nevertheless, the drawbacks of the method of sample selection are out-weighed by the advantages that this method offers over alternatives. These advantages include;

a. the inexpensive nature of the test,
b. the greater spontaneity of the responses,
c. this ensures that the study impinges as little as possible on those patients who, either due to illness, handicap or unwillingness, do not wish to participate in the research,
d. the more individual approach to the patients, (some patients might well prefer the conversational style of the interview),
e. less involvement of nursing staff time than some other study designs might require.

The hospital approached for conducting the pilot study was Saint Mary's Hospital, Portsmouth, part of the Portsmouth and South East Hampshire Health Authority.

Patients were first admitted to the hospital in 1883, at this time it was referred to as, to quote Mearns Fraser
(1914): 'the Milton Hospital', standing as it does on Milton Road. As Mumby (1891) indicates the establishment was founded to treat only patients with infectious diseases and for several years this was the focus of most treatments that were administered. In the "Report on the Health of Portsmouth in the Year 1893", Mumby (1893, p. 39), sets out a table showing that of the patients admitted during the first ten years 97% were suffering from scarlet fever, enteric or typhoid or diptheria. Throughout its history the hospital has evolved with new building, modernisation and development. It can be seen from the "Portsmouth Group Hospitals Management Committee Secretary's Outline Report" (1953, p. 11), that at one time efforts towards self-sufficiency made the hospital profitable in poultry-farming! As early as 1954 concern over public relations was evident with a series of articles being sent to the local newspaper, which over several weeks showed the work of different groups of the staff. It appears to have been a successful campaign but the importance of every member of staff being continually aware of their influence on public relations was stressed. To quote the Secretary of the Portsmouth Group Hospital Management Committee (1954, p. 12):

"It is well to be remembered, however, that public relations is something which goes on all the time. It is through the continued courtesy of all who represent the Management Committee - be it the member, or the maid - that the best possible public relationship is built up and maintained."

A similar public relations exercise was undertaken during 1986 with St Mary's Hospital taking part jointly with another large Portsmouth hospital, Queen Alexandra's, in the BBC television's series of broadcasts, "Hospital Watch" (through autumn 1986). This showed interviews with some of the patients and followed several of the staff carrying out their day's work.
Today many of the old-style Nightingale wards have been replaced with smaller wards which might present a less daunting and somewhat more home-like environment to the patients but which create different staffing requirements by increasing the time certain tasks take to carry out. As a large general hospital a wide range of complaints and conditions are treated at St. Mary's including; geriatric, surgical, gynaecological, maternity, urinary/genital, paediatric, medical, radio-therapy and thoracic.

Standing in the city of Portsmouth land is at a premium price and consequently careful use of space is important. A common complaint of people who use the hospital, patients, visitors and staff alike is the difficulty of car parking. The car parking spaces are laid out around the hospital complex but are not controlled, (beyond having some sites labelled for specific members of staff, or to be kept free for ambulances etc). This means that spaces filled early in the morning often remain occupied all day leaving little opportunity of parking easily later than 9 am. In fact the idea of a fee charging multi-storey car park on the site has been suggested at management level. Certainly the best use of land would be afforded by using tiered parking. It is only in recent years, with the great increase in domestic car-ownership, that such needs have become apparent.

The initial contact for arranging the study was made with the acute services and support services management who expressed interest in the patient-centred approach. An initial meeting held between several of the hospital management team and the researcher had the outcome of a general feeling that the more information patients can give as honest feedback to the management staff the more the service could be improved to satisfy patients. Practical constraints to the study were also discussed.
Particular concerns were:

a. That the study should not be too extensive. This limitation was mostly due to the concern, felt by management staff, that there were a great many research projects run at the hospital and this made non-nursing demands on staff time as well as being potentially tiresome for the long-stay patients who might feel obliged to participate in all the studies. Additionally resources restricted a large, time-consuming survey.

b. That only willing volunteer patients should be included.

c. That staff involvement both in time and inconvenience should be restricted.

It was also considered important that the exercise of applying the questionnaires should not be seen as any part of the usual hospital routine. It being felt that this approach would yield more reliable and useful results.

As with any study within hospitals, authority was required from the General Manager, he was happy to give his permission and expressed interest in the project regarding the investigation of patients' opinions.

The pilot study was conducted during autumn 1986. Due to the small number of patients involved with the pilot study the sample was not to be in anyway representative of the whole hospital but rather what Reid and Bourne (1987), describe as a 'convenience sample'. Although this restricted the survey to a study of a few individuals this aspect was accepted for two reasons. First because it was considered a central feature that the research should be patient-centered. And second in the belief that the pilot study would give valuable information for designing a main study which could be suitable to apply to a larger group of patients, even though the results could not be used to
generalise to any wider population. The precise make-up of the pilot study sample is shown in Figure 6.2
Figure 6.2 A Histogram Showing the Age and Sex Make-up of the Pilot Study Sample

Key

- Male
- Female

Gy = Gynaecological
M = Medical
S = Surgical
G = Geriatric

NB. Sample size = 15 (one female patient on the geriatric ward declined to give her age)
Figure 6.2 shows that patients were selected from four different ward types, across a wide adult age span and from both sexes, this was an attempt to investigate the hospital as broadly as possible.

The Acute Services Manager introduced the researcher to the ward staff who were given no prior warning that the test was to be carried out. This was considered desirable as it reduced the time between any possible notification of patients and the test being conducted. This was to permit a more spontaneous conversation and to avoid a preconception by the patients that the study was directed by the nursing staff. The selection of particular participating patients was made by discussion with the ward staff immediately prior to the testing and with consideration of the practical constraints of; patients' physical ability, (some patients being too unfit to be involved), patients' willingness to be involved, and the routines being carried out on the ward, (some patients could not be questioned as they were undergoing treatments throughout the period of the test). All the testing was carried out during the afternoon as this was most convenient to the hospital staff and despite an open-visiting policy, was considered the least inconvenient time for the patients.

The testing was carried out in the hospital during the patient's hospital stay and in the patient's usual/familiar hospital environment, (either at the bedside, in a day room or in a side office).

To ensure that patients were likely to feel as relaxed as possible an empty room, or a quiet corner of a room was chosen for each interview. Wherever possible, both the patient and the researcher were seated in an adjacent orientation in order to promote a conversational, less interrogational atmosphere. When paraplegic patients were interviewed the researcher ensured that the seating
permitted the same amount of eye-contact as when interviewing the ambulant patients.

To initiate the interview the researcher made a brief introduction, describing the study and emphasising that the project was not directly under the auspices of the hospital. Any questions which patients asked were answered even if these were not strictly relevant to the study. The researcher proceeded to the structured questionnaire only when the patient appeared both happy to proceed and relaxed. The researcher recorded the patient's responses to the questions and also any signs of distress, confusion or other factors considered relevant.

6.3 Results

The results of the ASQ as shown in Figure 6.3
### Figure 6.3 Anxiety Scale Questionnaire Results

<table>
<thead>
<tr>
<th>Patients by Ward Type</th>
<th>Sex</th>
<th>Raw Score</th>
<th>Sten Value (see key)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecological</td>
<td>F</td>
<td>43</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>Medical</td>
<td>F</td>
<td>31</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Surgical</td>
<td>F</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Medical</td>
<td>M</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>Surgical</td>
<td>M</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Sub Total 38</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(mean = 4.75)</em></td>
<td></td>
</tr>
<tr>
<td>Geriatric</td>
<td>F</td>
<td>38</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>39</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>32</td>
<td>6</td>
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<td></td>
<td>M</td>
<td>18</td>
<td>4</td>
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<td>M</td>
<td>33</td>
<td>7</td>
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<tr>
<td></td>
<td>M</td>
<td>30</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td><strong>Sub Total 43</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(mean 6.14)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Grand Total 77</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(mean 5.13)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This patient is grouped with geriatric patients as he is 82 and has difficulty hearing, seeing and comprehending.

Key to sten scores:
1, 2, 3 = unusually relaxed and secure
4, 5, 6, 7 = average
8, 9, 10 = very anxious people
From Figure 6.3 it can be seen that the patients generally do not have abnormally high anxiety scores when compared to the norms. Of the 15 respondents two patients achieved anxiety scores normally attributed to unusually relaxed and secure individuals, twelve fell into the average category and only one achieved an anxiety score normally attributed to a very anxious person.

Figure 6.3 also shows that of the group tested the patients in the geriatric wards show higher anxiety levels than the other patients.

As with Figure 6.3, Figure 6.4 shows that anxiety scores were not abnormally high but that patients in the geriatric wards typically had higher anxiety scores than the patients tested in the other wards.
**Figure 6.4 Analysis of Anxiety Scale Questionnaire Scores**

<table>
<thead>
<tr>
<th>Patient type</th>
<th>No. of Patients</th>
<th>Total Score</th>
<th>Mean Score</th>
</tr>
</thead>
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<tr>
<td>All</td>
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<td>81</td>
<td>5.4</td>
</tr>
<tr>
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<td>37</td>
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<tr>
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<td>8</td>
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<td>5.5</td>
</tr>
<tr>
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<td>43</td>
<td>6.1</td>
</tr>
<tr>
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<tr>
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<td>4.8</td>
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<tr>
<td>All Non-Geriatric Females</td>
<td>5</td>
<td>24</td>
<td>4.8</td>
</tr>
</tbody>
</table>
The connection between the two questionnaires focused on the patient's statement about their anxiety. Figure 6.5 shows the relationship between each patient's anxiety score on the first questionnaire with their expressed anxiety. As can be seen in from Figure 6.5 only a few patients stated that they were apprehensive and generally anxiety scores did not correlate with the expressed anxiety. It is considered that the size of the sample has a great influence on this finding. With the study carried out by Franklin (1974) which is discussed in the previous chapter, which included similar questioning with a larger sample, such correlation was seen to exist.

"There is a definite correlation between the patient's opinion and his actual score in the anxiety test." (Franklin 1974)
Figure 6.5 A Scattergraph to show the relationship between stated anxiety and anxiety score

KEY
V = Very apprehensive
Q = Quite apprehensive
H = Hardly apprehensive
N = Not at all apprehensive

Stated Anxiety

* Line shows the expectation if high stated anxiety = high sten score
When the patient's anxiety scores are compared with their replies to the question, (Second questionnaire, question 2):

"Many people are anxious in hospital. If the medical side concerns you to a value of 10, what value would you give your concern over the non-medical side?"

The magnitude of the patient's comparative concern over the medical and the non-medical aspects of their hospital stays can be assessed. As can be seen from Appendix 6.2 patient's concern over the medical aspects were of greater magnitude than their non-medical concerns. On average patients considered that their non-medical concern was approximately two thirds that of their medical concern.

The correlation between patients' expressed anxiety and past experience of hospital is shown in Figure 6.6.
Figure 6.6 A Scattergraph to show the relationship between stated anxiety and number of hospital experiences

**KEY**
- V = Very apprehensive
- Q = Quite apprehensive
- H = Hardly apprehensive
- N = Not at all apprehensive

* Line shows the expectation if low stated anxiety correlates with many hospital experiences
As can be seen from Figure 6.6 the sample showed no correlation between stated anxiety and past experience of hospital. However, patients in the geriatric wards expressed a higher degree of apprehension than other patients.

Having looked at the patient's general anxiety, questions relating to specific aspects of the hospital were asked. This was partly to assess specific elements of hospitality within the hospital but mainly to stimulate discussion to bring out any factors that had not been included but which the patients considered relevant. The questions about the non-medical aspects of St. Mary's Hospital were organised broadly into the three categories of product, environment and behaviour. Generally patients were not only satisfied but positively pleased by the provision which the hospital made for them and by the behaviour shown towards them by the staff.

Figure 6.7 shows the responses to question 7, which required the patients to rank a list of hospitality factor in descending order of the importance which they attached to them.
Figure 6.7 Patients' Responses to Question 7

<table>
<thead>
<tr>
<th>Patient</th>
<th>A</th>
<th>F</th>
<th>I</th>
<th>C</th>
<th>M</th>
<th>FM</th>
<th>R</th>
<th>D</th>
<th>P</th>
<th>FN</th>
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<td>10</td>
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</tr>
</tbody>
</table>

| G 9     | 8 | 5 | 7 | 3 | 4 | 1  | 9 | 6 | 10| 2  |
| G 10    | 1 | 9 | 2 | 5 | 7 | 4  | 10| 6 | 3 | 8  |
| G# 11   | 3 | 4 | 8 | 6 | 5 | 1  | 8 | 10| 2 | 8  |
| G# 12   | 7 | 7 | 7 | 1 | 7 | 1  | 7 | 7 | 3 | 7  |
| G# 13   | 7 | 7 | 7 | 1 | 7 | 2  | 7 | 7 | 7 | 3  |
| S# 14   | 6 | 6 | 6 | 6 | 6 | 1  | 6 | 6 | 6 | 6  |

KEY: A = smooth admissions procedure
F = comfortable furniture
I = information regarding daily routine
C = plain cooking
M = varied menu choice
FM = friendly medical staff
R = recreational facilities
D = attractive decor
P = privacy
FN = friendly non-medical staff

*These results must be interpreted with caution. The questioner felt that these patients had a great deal of difficulty in answering this question, in most cases the patient was unable to distinguish between the importance of most of the factors, preferring instead to state which factor seemed the most important. In order to complete the results table the totals for the undistinguished factors were added together and divided evenly between the outstanding factors.
From Figure 6.7 it can be shown that some factors were generally considered to be more important in making the patients feel at home than other factors were. The analysis of these results, (see appendix 6.3), shows that patients did have some significant agreement on the ranking of hospitality factors. On average the factors were ranked in the following order, (from the most important to the least important);

1. Friendly medical staff
2. Friendly non-medical staff
3. Smooth admissions procedure
4. Information regarding daily routine
5. Varied menu choice
6. Plain cooking
7. Privacy
8. Comfortable furniture
9. Recreational facilities
10. Attractive decor

6.4 Discussion of Results

The ASQ results showed that, in general, anxiety levels were not abnormally high, particularly in the wards other than the geriatric ward. It seems reasonable to expect that anxiety levels would be affected by many factors, including;

a) patients' illness and stage of treatment,

b) time lapse since the patients' admission,

c) amount/nature of pre-hospitalisation preparation undergone by the patient,

d) nature of the nursing care,
e) the general behaviour shown by all the staff to the patients

The interviews revealed that patients had rationalised their need to stay within the institution and would, to a certain extent, go along with the uncomfortable aspects of not being at home.

The patients not in the geriatric wards seemed generally to view the future in a positive light due to their expected health improvement.

Typically the group of patients in the geriatric wards had greater anxiety. This finding may seem unexpected especially as these patients tend to be long stay patients, and might be expected to have got used to the situation more than short stay patients. The greater anxiety may be due to some aspect of the geriatric ward but it is thought that other significant reasons need to be considered.

Although age variance is noted by Cattell and Scheier (1963), as a possible "unwarranted contaminant", norm tables for the elderly are not available. The greater anxiety levels may be due to this group's generally less optimistic prospects for the future and the disturbing characteristics of many of their illnesses (especially when considering degenerative disease and loss of faculties). Furthermore most of this group were unsure of when, (and in some cases whether), they were likely to be discharged. During the interviews patients mentioned other causes of anxiety;

a) fellow patients were often very difficult to live with,

b) some had domestic worries, (due to the uncertainty about being discharged), concerning keeping property.
c) many mentioned their lack of friends and relatives, (often resulting from them having out-lived most of their closest circle), leading to a reduction in their visitors.

That the group of patients in the geriatric wards appears to be more anxious suggests that this might be an area on which to focus a further study to determine whether an alternative, or additional treatment might be prove helpful to reduce these patients' anxiety. (Indeed, during the interviews, several of these patients said that they felt that they would have preferred a fuller explanation of the implications of admission prior to entering the hospital.)

The subject of the elderly in hospital is an area where hospitality appears to be particularly apposite because the individuals are long stay and the nature of the institution has a greater influence on their general happiness and well-being than on any short stay patient. Elderly patients coming into hospital do face special problems due to the fact that their self-image has probably been fixed for some time and may now appear to become threatened.

"Preserving a person's dignity, individuality and independence must be considered when admitting anyone to hospital. With the elderly, the situation is even more complicated because, whoever the patient may be, he has a lifetime of experiences, emotions and habits behind him and so will have a very fixed idea of who and what he is, and will be keenly sensitive with regard to the respect he considers his due." (Burns 1980)

This acknowledgment of the importance of a patient's self-image is fundamental to preserving their dignity whilst they are in hospital. Practical considerations need to be made at ward level to ensure that patients do not feel depersonalised by their hospitalisation. Such
considerations were highlighted by Professor Millard (1984) who, whilst on a trip to Denmark noticed that his perception of the long-stay patients there was quite different to his perception of long-stay patients at his own hospital, Bolingbroke Hospital, London. This difference he attributed to the fact that the Danish patients were surrounded by their personal possessions, making them appear first and foremost as individuals. Whereas the Bolingbroke patients, at that time, were always seen in stark hospital surroundings, without personal possessions on view. Following an experiment which involved showing students two photographs of the same patient, first in the stark hospital environment and the second exactly the same but with personal possession on view as well, Professor Millard concluded that there were many positive benefits from maximising the individuality of elderly people in hospital. He went on to establish an action research at the Bolingbroke Hospital. This project involved extensive conversion of part of the hospital, to set up ten single rooms, decorated to the tastes of the individual long-stay patient and furnished in part with their own furniture. The concern with individuality goes beyond the fabric and furnishings of the ward.

"To increase the homely atmosphere a front door complete with bell and knocker will be fitted at the entrance to the ward. Visitors will ring to be admitted and will enter directly into the day area; the bedrooms will therefore remain protected territory, access to them being impossible without the patient's knowledge and consent....

...Patients will be helped and encouraged to make choices in deciding when they take a bath, which interests they pursue, what clothes they wear, when they go to bed and so on." (Millard 1984)

The project was ambitious as previous decisions regarding ward design, ward routines etc., were usually made with regard to the practical difficulties of caring for elderly patients. Allowances for these difficulties still had to
be made whilst opting for more aesthetic surroundings. Professor Millard and his research assistant, Ms Horsfall had to carry out a considerable amount of pioneering work.

"Manufacturers and specialist organisations are being consulted about aids, equipment and interior design materials. These will be assessed and evaluated in the project area and reports made available." (Horsfall 1983)

Prior to the Bolingbroke project such individualised care of the elderly was the preserve of some private nursing homes. Since the success of the Bolingbroke research there has been much interest in improving the facility and service of other long-stay sections of the National Health Service. At St. Mary's Hospital, Portsmouth such a project is underway, (one of the three currently being run in the National Health Service). Jubilee House is a twenty five bed nursing home which aims to give the patients a say in the way their life is organised.

"It allows elderly people to make decisions about their daily routine, social events, decoration and care of the building, and selection of staff." (Weaving 1987)

Ruth Sander, the nurse in charge stresses that the patients have a high level of disability and yet the project is proving to be a success.

"Their achievements include changing the structure of meal times and what they eat ordering new chairs, and having a greenhouse built." (Weaving 1987)

Despite these successes there is much work to be done in this field, not least because of the trends regarding the age structure of the country. However it is considered that this topic is beyond the bounds of the present study. Although the use of the ASQ in the pilot study did bring out insights regarding some patients the disadvantage of
this technique is that there is no specific, known anxiety norm for each patient with which to compare that prevailing at the time of the questioning. Without this norm it is not possible to say whether or not the hospitalisation has altered any individual's anxiety level. This problem was also encountered by Franklin.

"The major difficulty in measuring anxiety in hospitals, a difficulty encountered with the IPAT Questionnaire and likely to be encountered in use of physiological techniques, is to distinguish between the short term changes in anxiety state produced by hospitalization and the natural tendency of the patient towards a higher or lower level of anxiety. To measure changes in anxiety level one must measure a 'norm' for each patient before this base level has been affected by his illness or impending admission. This presents obvious practical difficulties. The alternative is to compare the average anxiety levels for a moderately large sample of patients from a hospital ward with average levels for the general population as a whole. Use of this technique, rather than a study of individuals, requires a large sample of wards each containing a sufficient number of patients, if differences in anxiety levels between wards are to be measured." (Franklin 1974)

As the anxiety level of the patient is a lesser concern than the patient's specific feelings about their hospitalisation the main study will not pursue this aspect.

The main part of the second questionnaire found that the patients were, on the whole, both satisfied and pleased by their hospital stay.

The factors which contributed to hospitality within a hospital could be ranked in order of importance. This ranking showed that the friendliness of staff was generally considered to be the most important factor. None of the patients, (when asked), suggested that there were any other factors which had not been included.
Almost all the patients said that the greatest drawback with being in hospital was that they missed their family, their friends and their pets.

The outcomes of the pilot study were:

a. The patients had considered that all the hospitality factors which were mentioned were relevant, therefore all these factors would be retained in the follow-up study.

b. Two additional factors were highlighted during the pilot study, and would therefore be incorporated in the follow-up study. The first, namely, 'adequate provision for visitors and visiting', was considered necessary due to the large numbers of patients stating that due to their hospitalisation they primarily missed their family and friends. It was suggested that this particular hospital's open policy towards visitors might have led to this aspect being not being specifically highlighted by this sample of patients, and also this aspect was cited by several patients as a problem in other hospitals. The second additional factor, namely, 'clear sign-posting', was included because management staff thought this to be a highly significant aspect to hospital users. They mentioned that in their experience patients frequently complained of deficiencies regarding sign-posting. It was generally thought that had the pilot study sample been either larger or different this aspect would have been highlighted.

c. The pilot study tools had been tested, with the result that it was decided not to pursue the investigation of patient anxiety. This was for two reasons namely; the difficulty of measuring a reliable, objective control anxiety level for each respondent, and because this was not seen as a central question of the study, particularly because patient's anxiety over medical concerns vastly out-weighed their anxiety over non-medical concerns.
Thus, non-medical changes could not be expected to yield a great change in the patient anxiety. Although this may suggest that an investigation in the area of reducing medical concerns might prove useful this is considered beyond the scope of this study.

d. From the experience of the pilot study it was decided to omit the interview approach, in the belief that a larger survey would be possible as a result.

e. It was decided to omit questions which applied to a specific hospital, in order that the study could be applied more generally.

f. It was also decided to focus the main study on the collection of any hospitality factors which might still remain overlooked and on the ranking of the known hospitality factors.

g. It was further decided to include an assessment of the factors' relative magnitudes of importance highlighted by the pilot study is that the ranking approach gives no indication of the magnitude of the importance a patient feels about any particular hospitality factor. Although this aspect frequently became obvious during the interviews, concerning some of the factors an attempt to quantify the magnitude might give extra data from which to discuss each factor's relative importance. It might also be possible to draw up a spectrum of the hospitality factors' importance, giving more substance to the findings.

Thus it can be seen that the aims of the pilot study had, within the constraints of the small, unrepresentative sample, been met.
CHAPTER 7  
Main Study

7.1 Introduction
The aims of the main study were first to assess whether the hospitality factors determined within the pilot study, would be considered, by a larger group of in-patients as important to a satisfactory hospital stay.

Second to determine whether a magnitude of importance to the hospital stay of patients might be ascribed to the identified hospitality factors.

From these aims the following objectives were formulated;
- to determine whether particular hospitality factors were considered by a group of in-patients to be important.
- to determine whether the importance of particular hospitality factors could be given a magnitude
- to collect any additional non-medical factors which were highlighted by the study.

7.2 Methodology
The main study used an adapted version of the second questionnaire used in the pilot study. The aspect of patient anxiety was not investigated (for the reasons detailed in chapter 6), instead it focussed, on ranking the identified hospitality factors, gathering any additional hospitality factors, and on assessing whether any magnitude of importance could be determined. It was considered that an important feature of the main study was that it should gather data from a large group of hospital in-patients. To enable a large group to be approached the questionnaire was designed so that it could be distributed by the nursing staff, to those patients willing to be
involved. After completion the questionnaires would then be gathered back by the nursing staff.

Several characteristics were considered to be important to the questionnaire. These included:

a) Brevity - it being considered, from the pilot work, that a larger number of more complete questionnaires would be collected from a short questionnaire, and that ideally, patients should not be required to be involved for longer than approximately ten minutes.

b) Clarity - clear format and style facilitates the accuracy of both the completion and the analysis of questions.

c) Patient anonymity - patients may be more willing to be involved if their names are not required.

d) No medical questions - patients may be discouraged from participating in a questionnaire which they felt included personal/medical questions.

e) Self-administerable - this is seen as having the advantage of increasing the size of the group involved, and is also economical of limited resources. However, it does limit the group to those who are capable of a reasonable standard of reading and writing. (This leads to some unfortunate exclusions, for example all blind patients, some geriatric patients and some psychiatric patients. To reach these patients the questionnaire would have to be administered on a one-to-one basis by a questionner).

f) General - applicability to most types of hospital permits the study to be conducted in several hospitals and may encourage respondents to consider more than just the specific hospital in which they are staying.
g) Focusing on hospitality factors - reduces the size of the questionnaire and concentrates the resources on the central question of the study.

h) Information to assist the analysis - this information is required for classifying and grouping the results.

For the complete questionnaire see Appendix 7.1.

Following a short introduction to the project the questionnaire rapidly focuses on the ranking of hospitality factors (Question 4).

"4. Generally speaking any hospital must provide certain non-medical things to make a patient feel as at home as possible. Please put the following list in order of importance, numbering from 1 to 12 (starting with "1" as the most important).

- SMOOTH ADMISSIONS PROCEDURE
- COMFORTABLE FURNITURE
- INFORMATION ABOUT HOSPITAL ROUTINE
- PLAIN COoking
- ATTRACTIVE SURROUNDINGS/DECOR
- FRIENDLY MEDICAL STAFF
- ADEQUATE RECREATIONAL FACILITIES (T.V., RADIO etc)
- VARIED CHOICE ON THE MENU
- PRIVACY
- FRIENDLY NON-MEDICAL STAFF
- CLEAR SIGN-POSTING
ADEQUATE PROVISION FOR VISITORS AND VISITING" (Main Study Questionnaire).

The respondent is required to rank twelve hospitality factors. Question 5 requires the respondent to think about the hospitality factors for a second time but to consider each one independently and to rate each factor's importance on a five-point scale, from 'essential' to 'not-necessary'.

"5. You may think some factors are much more necessary, to make a patient feel at home, than other factors are. Please tick the appropriate box for each factor given below;

i. SMOOTH ADMISSIONS PROCEDURE

essential  very important  important  unimportant  not necessary

ii. COMFORTABLE FURNITURE

essential  very important  important  unimportant  not necessary...

This attempts to give a magnitude to the relative importance of the hospitality factors. Additionally, the comparison between the answers to question 4 and the answers to question 5 might be expected to indicate whether the respondent's assessment of the hospitality factors is consistent and logical. Question 6 is an attempt to collect any over-looked hospitality factors which the patient considers important, and also gives scope for more lengthy general comment than is allowed for anywhere else on the questionnaire.
"If you think that there are other important factors which have not been mentioned please write them here..." (Main Study Questionnaire)

Other information gathered by the questionnaire was to facilitate the analysis of the results by permitting results to be grouped according to specific patient characteristics. These include; ward type, sex, date when the patient completed the questionnaire, time when the patient completed the questionnaire, patient status (N. H. S. or private), previous experience of hospitals, previous experience of the particular hospital, stage of current hospital stay, age group and social class. (Social class was determined by the occupation of the head of the patient's household under a six point classification system devised by Reid (1981) from appendixes of the Classification of Occupations 1970.)

It is considered that the questionnaire has, as far as possible, the characteristics considered desirable. Although in questions 4 and 5 there are twelve hospitality factors to consider, which adds to the task of the pilot study group (who were required to consider ten hospitality factors), the overall involvement of the patient is greatly reduced: from approximately 30 - 35 minutes in the pilot study to approximately 10 minutes in the main study.

Although it was intended to conduct part of the main study at Saint Mary's Hospital, Portsmouth, (the site of the pilot study), it was also considered important to approach other hospitals in order to broaden the study and to introduce an element of comparison between different localities and hospitals. A further three hospitals were approached, of which two agreed to be involved with the study. First, the Royal Surrey County Hospital, Guildford, a new, purpose-built hospital one section of which had only recently opened, with other sections still in the process of completion. Second, the Stafford
District General Hospital, Stafford, a 250 bed hospital dealing largely with emergency admissions, in the West Midlands.

As with the pilot study, several methods of selecting the sampling frame were considered. However, it was decided that to use either a random sampling technique or a quota sampling technique would be impractical for the reasons identified in Chapter 6 (section 2). A further difficulty in selecting the sample was that of defining the population. The population being approached for study was the in-patient population of three general hospitals in England during the time of the field work, (between July 1987 and February 1988). However, because of the general nature of the inquiry, the study tool would have been applicable to any group of people who held a concept of 'a hospital stay' as such, the target population, (which would then include all potential in-patients), would be considerably larger. Thus before a true sample could be identified the question of target population would require clarification. It was considered that the definition of the target population was in this instance, neither very meaningful nor very helpful as it would entail the erection of arbitrary boundaries. Even if it was possible to produce a statistically representative sample,

a) this would be constrained by the available resources, and

b) it would result in a comparatively small number of respondents.

Furthermore any study which is not specific to a particular hospital (or group of hospitals), and which requires the assistance of hospital staff necessarily has to be highly flexible.

The nature of the study caused dependence upon the assistance of the nursing staff of several hospitals
devoting some of their time to what could not be considered nursing duties. Consequently the sample was not statistically representative of a particular population. This has the disadvantage of restricting the analysis which can meaningfully be undertaken, but nevertheless permits a larger, more general group to be approached for their opinions.

Analysis of the opinions of a large group of people who are involved in the daily life of hospital as in-patients is considered to be a worthwhile contribution to the debate at this stage in the development of the concept of hospitality in hospitals.

Analysis of the data was conducted with the aid of computers, this was first to speed the processing of large quantities of data and second to increase the likelihood of maintaining accuracy throughout the large number of calculations required. For this study the "Minitab" programme was used as this programme has the capacity to deal with the quantity of data, can perform the statistical operations required and is comparatively 'user friendly'. Despite this the analysis did take longer than was predicted.

7.3 Results

The results have been recorded as three data sets (one for each of the three hospitals), as this records the individuality of each hospital and permits comparison between the hospitals. The full results are tabulated in Appendix 7. However a large proportion of the results are presented below in graphical or tabular form.

The line graph presentation has been selected to enable clear visual comparisons to be made between the three
different samples. The vertical axis represents the average ranking, or in some cases the average magnitude, awarded by the sample, and ranges from 0 to 12 (although in practice this has not exceeded 10). The horizontal axis represents the hospitality factors, which are listed, for consistency, in the same order as they appear in the questionnaire. Thus, where a hospitality factor is considered to be particularly important this will be represented by a dip on the graph.

Frequently, to emphasise the comparison between different hospital samples, graphs have been plotted for each of the samples separately, for example, Figure 7.1, followed by a graph, for example, Figure 7.2, in which the same data for each of the three hospitals in replotted on the same axes.

Hospitality factor abbreviations are given below.

**KEY**

- A = Smooth admissions procedure
- F = Comfortable furniture
- I = Information about hospital routine
- C = Plain cooking
- D = Attractive surroundings/decor
- M = Friendly medical staff
- R = Adequate recreational facilities
- V = Varied choice on the menu
- P = Privacy
- N = Friendly non-medical staff
- S = Clear sign-posting
- X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer.
Hospitality factor abbreviations are given below.

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- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.1 Graphs to show the average ranking given to each hospitality factor by the three samples.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.3 A Graph showing the comparison between the average rankings given to each hospitality factor by each of the three samples.
From these graphs it is clear that from the results of question 4 there appears to be considerable agreement between average rankings awarded to each of the hospitality factors by all the respondents in the three different samples. To determine whether this agreement is also evident with the alternative approach to the questioning it is necessary to plot the results of question 5.
Hospitality factor abbreviations are given below.

**KEY**

- **A** = Smooth admissions procedure
- **F** = Comfortable furniture
- **I** = Information about hospital routine
- **C** = Plain cooking
- **D** = Attractive surroundings/decor
- **M** = Friendly medical staff
- **R** = Adequate recreational facilities
- **V** = Varied choice on the menu
- **P** = Privacy
- **N** = Friendly non-medical staff
- **S** = Clear sign-posting
- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.3. Graphs to show the average magnitude given to each hospitality factor by each of the three samples.
Hospitality factor abbreviations are given below.

**KEY**

- **A** = Smooth admissions procedure
- **F** = Comfortable furniture
- **I** = Information about hospital routine
- **C** = Plain cooking
- **D** = Attractive surroundings/decor
- **M** = Friendly medical staff
- **R** = Adequate recreational facilities
- **V** = Varied choice on the menu
- **P** = Privacy
- **N** = Friendly non-medical staff
- **S** = Clear sign-posting
- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.4 Graphs to show the ranking of the average magnitudes given to each hospitality factor by each of the three samples.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear sign-posting

X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.5 A graph showing the comparison between the ranked magnitudes given to each of the hospitality factors by each of the three samples.
From the graph of the results to question 5, (Figure 7.3) it is clear that again, as with the results to question 4, there appears to be considerable agreement between the average magnitudes awarded to each of the hospitality factors by all the respondents in the three different samples. Due to the reduced spread of this question the data has been ranked and replotted (Figures 7.4 and 7.5), making the presentation similar to that of the question 4 results. With both types of presentation the agreement between the samples is striking.

When considering the average results given by each of the three total samples it is not possible to assess whether different groups within each sample are closely in agreement or whether groups of a similar size within the sample are in disagreement, (possibly even, polarised at two ends of the spectrum). Consequently to determine the nature of agreement within each sample a series of characteristics have been isolated and the data has been plotted according to these characteristics as they appear in each sample.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/en inappropriate answer
Fig 7.6 Graphs to show the average rankings given by the Guildford sample grouped according to the sex of the respondent.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear sign-posting

X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig. 7.7 Graphs to show the average rankings given by the Portsmouth sample grouped according to the sex of the respondent.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.6 Graphs to show the average rankings given by the Stafford sample grouped according to the sex of the respondent.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer or an inappropriate answer
Fig 7.9. Graphs to show the average rankings given by the Guildford sample grouped according to the age group of the respondents.
Hospitality factor abbreviations are given below:

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
K = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.10 Graphs to show the average rankings given by the Portsmouth sample grouped according to the age group of the respondents.

-163-
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear sign-posting

X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer.
Fig. 7.11 Graphs to show the average rankings given by the Stafford sample grouped according to the age group of the respondents.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear sign-posting

X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.12 Graphs to show the average rankings given by the Guildford sample grouped according to the stage of the respondent's hospital stay.

-165-
Hospitality factor abbreviations are given below.

**KEY**
- A = Smooth admissions procedure
- F = Comfortable furniture
- I = Information about hospital routine
- C = Plain cooking
- D = Attractive surroundings/decor
- M = Friendly medical staff
- R = Adequate recreational facilities
- V = Varied choice on the menu
- P = Privacy
- N = Friendly non-medical staff
- S = Clear sign-posting
- X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.13 Graphs to show the average rankings given by the Portsmouth sample grouped according to the stage of the respondent’s hospital stay.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Fig 7.14 Graphs to show the average rankings given by the Stafford sample grouped according to the stage of the respondent's hospital stay.

-167-
From Figures 7.6 to 7.14 it can be seen that across the different characteristics of the samples there still appears to be a large amount of agreement concerning the importance of the hospitality factors. (The dissimilarities are discussed with the analysis of the results in Chapter 7.4.)

The results were also grouped according to further characteristics including, ward type and respondent's previous experience of hospital, for brevity these are presented in tabular form.
KEY TO TABLES

H = Hospital

Hospitals:  G = Guildford
            P = Portsmouth
            S = Stafford.

x = Mean ranking/magnitude for all the respondents to
question/part of question

Columns:  A = Smooth admissions procedure
         F = Comfortable furniture
         I = Information about hospital routine
         C = Plain cooking
         D = Attractive surroundings/decor
         M = Friendly medical staff
         R = Adequate recreational facilities
         V = Varied choice on the menu
         P = Privacy
         N = Friendly non-medical staff
         S = Clear sign-posting
         X = Adequate provision for visitors and visiting
Hospitality factor abbreviations are given below.

**KEY**

- **A** = Smooth admissions procedure
- **F** = Comfortable furniture
- **I** = Information about hospital routine
- **C** = Plain cooking
- **D** = Attractive surroundings/decor
- **M** = Friendly medical staff
- **R** = Adequate recreational facilities
- **V** = Varied choice on the menu
- **P** = Privacy
- **N** = Friendly non-medical staff
- **S** = Clear sign-posting
- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
## QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENT'S WARD TYPE

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As results show great similarity across ward types graphic presentation was considered inappropriate.
Hospitality factor abbreviations are given below.

KE Y  
A = Smooth admissions procedure  
F = Comfortable furniture  
I = Information about hospital routine  
C = Plain cooking  
D = Attractive surroundings/decor  
M = Friendly medical staff  
R = Adequate recreational facilities  
V = Varied choice on the menu  
P = Privacy  
N = Friendly non-medical staff  
S = Clear sign-posting  
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENT'S TOTAL HOSPITAL EXPERIENCE

Key: S = hospital stay number

Table 7.4 Guildford

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Table 7.5 Portsmouth

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Table 7.6 Stafford

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NB: In each sample 1 interviewee did not state their previous hospital experience.

As results show great similarity, graphical presentation was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENT'S PREVIOUS EXPERIENCE OF PRESENT HOSPITAL

Table 7.7 Those who have stayed in the particular hospital before.

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Table 7.8 Those who have NOT stayed in the particular hospital before.

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</table>

As results showed great similarity graphical presentation was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure  
F = Comfortable furniture  
I = Information about hospital routine  
C = Plain cooking  
D = Attractive surroundings/decor  
M = Friendly medical staff  
R = Adequate recreational facilities  
V = Varied choice on the menu  
P = Privacy  
N = Friendly non-medical staff  
S = Clear sign-posting  
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer or an inappropriate answer
QUESTION 5 RESULTS GROUPED ACCORDING TO RESPONDENT'S SEX

Table 7.9 Female Respondents

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Table 7.10 Male Respondents

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As results are very similar to those of the alternative question type further graphical representation (beyond that given in Figure 7.8 p161) was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**

- **A** = Smooth admissions procedure
- **F** = Comfortable furniture
- **I** = Information about hospital routine
- **C** = Plain cooking
- **D** = Attractive surroundings/decor
- **M** = Friendly medical staff
- **R** = Adequate recreational facilities
- **V** = Varied choice on the menu
- **P** = Privacy
- **N** = Friendly non-medical staff
- **S** = Clear sign-posting
- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 5 RESULTS GROUPED ACCORDING TO RESPONDENT'S AGE

Table 7.11 Age group 1 (18-40)

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Table 7.12 Age group 2 (41-64)

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Table 7.13 Age group 3 (65 and over)

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As results are very similar to those of the alternative question type, further graphical presentation (beyond that given in Figure 7.9 p. 262), was considered inappropriate.

Figure 7.10 p. 163.
Figure 7.11 p. 164.
Hospitality factor abbreviations are given below.

**KEY**
- **A** = Smooth admissions procedure
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- **I** = Information about hospital routine
- **C** = Plain cooking
- **D** = Attractive surroundings/decor
- **M** = Friendly medical staff
- **R** = Adequate recreational facilities
- **V** = Varied choice on the menu
- **P** = Privacy
- **N** = Friendly non-medical staff
- **S** = Clear sign-posting
- **X** = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 5 RESULTS GROUPED ACCORDING TO THE STAGE OF THE RESPONDENT'S HOSPITAL STAY

Table 7.14 Those who have 'just arrived' in hospital (stage 1)

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Table 7.15 Those who are 'in the middle' of their stay in hospital (stage 2)

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Table 7.16 Those who are 'about to leave' hospital (stage 3)

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As results are very similar to those of the alternative question type, further graphical presentation (beyond that given in Figure 7.12, Figure 7.13, Figure 7.14, p 165-167), was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**
- A = Smooth admissions procedure
- F = Comfortable furniture
- I = Information about hospital routine
- C = Plain cooking
- D = Attractive surroundings/decor
- M = Friendly medical staff
- R = Adequate recreational facilities
- V = Varied choice on the menu
- P = Privacy
- N = Friendly non-medical staff
- S = Clear sign-posting
- X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 5 RESULTS GROUPED ACCORDING TO RESPONDENT’S WARD TYPE

**Key:** W = Ward Type

**Table 7.17 Guildford**

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As results show great similarity across ward types graphic presentation was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear sign-posting
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
QUESTION 5 RESULTS GROUPED ACCORDING TO RESPONDENT'S TOTAL HOSPITAL EXPERIENCE

Key  S = hospital stay number

Table 7.20  Guildford

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NB: In each sample 1 interviewee did not state their previous hospital experience.

As results show great similarity graphical presentation was considered inappropriate.
Hospitality factor abbreviations are given below.

**KEY**

- A = Smooth admissions procedure
- F = Comfortable furniture
- I = Information about hospital routine
- C = Plain cooking
- D = Attractive surroundings/decor
- M = Friendly medical staff
- R = Adequate recreational facilities
- V = Varied choice on the menu
- P = Privacy
- N = Friendly non-medical staff
- S = Clear sign-posting
- X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
**QUESTION 5 RESULTS GROUPED ACCORDING TO RESPONDENT'S PREVIOUS EXPERIENCE OF PRESENT HOSPITAL**

**Table 7.23 Those who have stayed in the particular hospital before.**

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</table>

As results showed great similarity graphical presentation was considered inappropriate.
With the Stafford sample additional information was collected regarding the number of patients present on the ward at the time the questionnaires were given out. This information indicated that across all three wards, when the study was carried out, bed occupancy was 96%. Questionnaires were given to 85% of all the patients in the wards. Of the questionnaires issued 89% (127), were returned completed. Of this number five were not suitable to be included in the analysis (having been spoiled or left incomplete). This indicates that a large proportion of the in-patients at the time of the study, in these wards were sufficiently interested in the topic of the study to participate.

7.4 Analysis of results.

As pointed out in the previous section there appears to be considerable agreement between the respondents regarding the importance of the hospitality factors and this is despite the variability within and across the samples. The finding of considerable agreement is further supported by statistical analysis, presented fully in Appendix 7.3.

The full information regarding the make-up of the samples is given in Appendix 7.4, however, some of the data is presented below to highlight some of the specific characteristics and to indicate the varied nature of the samples.

7.4(i) Characteristic of Respondent's Sex

The first characteristic to be considered is the sex of the respondent, the vast majority of patients did state their sex although some omitted to answer this question.
Fig 7.1 GUILDFORD

Fig 7.1 PORTSMOUTH

Fig 7.1 STAFFORD

Fig 7.15 Pie charts to show the three samples divided into males and females.
As shown in Figure 7.15, in all three samples the majority of the respondents were female, the Guildford and Portsmouth samples being very similar, (Guildford 58% female, 41% male and Portsmouth 57% female and 43% male). The Stafford sample contained a larger proportion of female respondents (68% female and 31% male).

Referring back to Figs 7.6, 7.7 and 7.8 it can be seen that overall there appears to be considerable agreement regarding the importance of the hospitality factors among both the males and the females of each of the samples. For example, in the Stafford sample, on average, the women, considered that 'plain cooking' was less important than did the men did, however even this difference was only 1.34 of a rank point. However the differences which did exist will be highlighted in order to assess whether any particular characteristics appear to determine the importance respondents attach to the different hospitality factors. In the Guildford sample of females consider 'smooth admissions procedure', 'information about daily hospital routine' and 'friendly non-medical staff' as more important than the Guildford male sample do.

Across the three hospitals it can be seen that each of the three female samples consider 'information about daily hospital routine' as more important than do their corresponding male sample. This may imply that more attention needs to be paid to this factor with female patients and could indicate a priority for staff dealing with female patients or particular for wards, such as gynaecology or maternity wards. Agreement regarding importance was found for 'attractive surroundings/decor', 'friendly medical staff' and 'adequate recreational facilities' across both males and females in all three samples. No consistent sex group considered 'friendly non-medical staff' and 'clear signposting' as more important than did their corresponding sex group.
Of the three hospital samples two of the male groups considered 'smooth admissions procedure', 'plain cooking', 'adequate provision for visitors and visiting' and 'varied choice on the menu' as more important than did their corresponding female group. This may indicate that more attention should be paid to these areas with male patients however further research would be required into this aspect before this could be asserted. More research would also be required to determine; whether the Portsmouth sample of females considering 'comfortable furniture' as more important than did the Portsmouth male sample, (despite agreement in both male and female samples of the other two hospitals) had any significance, or whether, that the Stafford sample of females considering 'privacy' as more important than did the Stafford sample of males, (despite agreement in both male and female samples of the other two hospitals) had any significance or implications for the treatment of maternity patients.

7.4(ii) Characteristic of Respondent's Age Grouping

Another grouping within each of the samples could be made with respect to the age of the respondents. A large majority of patients did specify their age grouping although some patients declined to answer this question.
Fig 7.16 Pie charts to show the three samples divided into age groups.
From Figure 7.16 it can be seen that the Stafford sample was generally younger than those of the other two hospitals and the Portsmouth sample was generally older than those of the other two hospitals. However, the ages were wide ranging. The Stafford sample was composed of 56% 18 - 40, 22% 41 - 64 and 30% 65 or over. The Guildford sample was composed of 39% 18 - 40, 26% 41 - 64 and 30% 65 or over. The Portsmouth sample was composed of 21% 18 - 40, 35% 41 - 64 and 41% 65 and over.

Referring back to Figures 7.9, 7.10 and 7.11 it can be seen that once again there is generally a high level of agreement regarding the importance of the hospitality factors. Where there are differences, these tend not to be consistent across the three samples. For example, in the Stafford sample 'adequate provision for visitors and visiting' was considered especially important by the youngest age group (2.09 rank points higher than the Stafford 41 - 64 age group), this was not true of either the Portsmouth or Guildford samples.

Although this was not the case in respect of either: 'plain cooking', which was considered less important by each of the three 18 - 40 age groups than it was by the older groups, or 'adequate recreational facilities', which were considered more important to the 65 and over age group than to any of the other age groups in each of the three samples.

Two of the three 18 - 40 age groups considered 'smooth admissions procedure' to be less important than did the other age groups within their hospitals and 'comfortable furniture' was generally considered to be more important by the 18-40 age group. This may relate to the wards being studied, possibly maternity patients, who would generally be in the 18-40 age group may be more concerned
about furniture than other groups however, as further research would be required before this could be asserted.

7.4(iii) Characteristic of Social Class and Employment Position of Respondent's Head of Household

The questionnaire included several questions to determine the respondent's social class however, these questions were frequently left unanswered or prompted uninformative answers. Consequently, most of the respondents, 33% of the Stafford sample, 38% of the Guildford sample and 52% of the Portsmouth sample, could not be grouped according to social class. Frequently the respondents had simply described their head of household as 'retired' or 'unemployed'. Of the respondents whose social class could be determined the majority of the Stafford sample (31%) were of social class II. The majority of the Guildford sample (20%) were also from social class II. Whereas, the majority of the Portsmouth sample were from the social class IIIM.

A more complete response was achieved with the question regarding the head of household's employment position, (in none of the samples was the level of non-response above 9%). In each of the three samples the majority of household heads were either employed or retired. (Stafford sample employed 51% and retired 22%, Guildford sample employed 38% and retired 32% and Portsmouth sample employed 28% and retired 47%).

7.4(iv) Characteristic of Respondent's Previous Hospital Experience

Of the less general, more hospital related, characteristics the samples were most similar regarding the patient's previous hospital experience.
Fig 7.17 Pie charts to show the three samples divided into those who are staying in hospital for the first time and those who have stayed in a hospital before.
Fig 7.17 shows that in both the Stafford and the Guildford samples 20% of respondents were undergoing their first hospital stay, whereas this group in the Portsmouth sample represented 11%. By referring to the tables 7.4, 7.5 and 7.6 it can be seen that generally there is a high level of agreement regarding the importance of the hospitality factors, however, there are some differences. The average ranking given by each sample of first time in-patients and the average ranking of other patients in each corresponding hospital is the same for both 'varied choice on the menu' and 'adequate provision for visitors'. In all three samples the first time in-patients considered that both 'adequate recreational facilities' and 'attractive decor' were of more importance than did the other patients in each of their hospitals. In two hospitals the more experienced patients considered that 'smooth admissions procedure', 'friendly medical staff' and 'privacy' were more important than did their corresponding group of first time in-patients. In two hospitals the more experienced patients considered that 'friendly non-medical staff' and 'comfortable furniture' were less important than did their corresponding group of first time in-patients. For the factors 'information about daily routine', 'plain cooking' and 'clear signposting' there was no clear pattern across the three samples. From this further research may be undertaken to determine whether the factors considered to be more important by the experienced patients are those factors which have been less in accordance with the first time in-patient's expectation on admission than the factors which the experienced sample consider to be less important. That this is the case, areas where extra attention should be placed may be highlighted. This could lead to changes being made to improve these factors or more education
being available to patients before admission so that their expectations are more realistic.

7.4(v) Characteristic of Respondent's Previous Experience of the Particular Hospital

Another characteristic which was highlighted was that of the in-patient's previous experience, or lack of experience) of the particular hospital.
Fig 7.18 Pie charts to show the three samples divided into those who are staying in the particular hospital for the first time and those who have stayed in the particular hospital before.
From Fig 7.18 it can be seen that the proportion of patients who had not stayed at the particular hospital before was greatest in the **Guildford** sample 65%, least in the **Portsmouth** sample 26%, and represented 49% of the **Stafford** sample. This result is to be expected as at the time of the study the **Guildford** Hospital was partially under construction and those wards which were open had only recently started admitting patients. By referring to the tables 7.7 and 7.8, it can be seen that there is general agreement concerning the importance of the hospitality factors. Some differences can be seen but generally the pattern of the differences is not consistent across the three hospital samples which suggests that the previous experience of a hospital is not in itself influential regarding the ranking of hospitality factors more likely this is dependent upon the nature of that previous experience, once again this indicates an area where more research would be required before firm conclusions could be drawn. However, from this study it can be seen that, for two hospitals those with previous experience of the particular hospital considered that 'information regarding daily hospital routine' was more important than did the corresponding inexperienced patients. Whereas, in two hospitals those who had no previous experience of the particular hospital considered that 'attractive decor', 'adequate recreational facilities', 'friendly non-medical staff' and 'clear signposting' were more important than did the corresponding group of patients with experience of the particular hospital. This may suggest that those with previous experience of a hospital, being familiar with such things as the decoration, the recreational facilities etc. are more concerned with aspects of the changing daily routine, whilst the patients who have not been to the hospital before are more concerned about signposting and
7.4(vi) Characteristic of the Stage of the Respondent's Hospital stay

Another characteristic looked at was that of the stage at which the patients were, in their hospital stay, at the time of completing the questionnaire. For both the Stafford and Portsmouth samples the majority of respondents were in the middle of their hospital stay (Stafford sample 56%, Portsmouth sample 54%), and the least number of patients had just arrived in hospital (Stafford 18%, Portsmouth 16%). However, of the Guildford sample 40% had just arrived, 31% were in the middle of their hospital stay and 28% were about to leave. This illustrates that the respondents represented the spectrum of the hospital stay with similar proportions from each stage. The respondents showed a high level of agreement. The greatest dissimilarity between the responses of the samples grouped in this way was that of the Guildford sample in the middle of their hospital stay, this group ranked 'adequate recreational facilities' equally with 'friendly medical staff' as the most important of the hospitality factors. In the Stafford sample the group which was about to leave considered 'adequate provision for visitors and visiting' less important than did the other groups, (differing by 2 rank points from the Stafford sample who had just arrived). However, the other hospitals did not show this difference.

7.4(vii) Characteristic of Respondent's Ward type

Generally the groupings according to ward type showed considerable agreement concerning the importance with which they regarded the hospitality factors. However,
the Portsmouth sample from the thoracic ward considered both the 'attractive surroundings/decor', (average ranking 1.89), and especially the 'plain cooking', as more important than the 'friendly medical staff' (average ranking 4.13). For them, the 'plain cooking' was considered the most important factor, with an average ranking of 1.11 being 6.94 rank points less than the average ranking given by the other wards.

7.4(viii) Sample Characteristics; National Health Service/Private Patients

None of the samples had a large proportion of private patients (Stafford 0.8%, Guildford 2.6% and Portsmouth 2.5%).

7.4(ix) Analysis of Question 5

The primary aim of question 5 was to determine whether the importance of a particular hospitality factor could be awarded a magnitude. The results were taken from the completed questionnaire by assigning numbers to the five point scale in the following manner;

- essential = 1, very important = 2, important = 3,
- unimportant = 4, not necessary = 5.

Thus a low score represented a hospitality factor considered to be of great importance and a high score represented a hospitality factor considered to be less important. This method was selected as it gives consistency with the format of the results to question 4. The results show that generally respondents could assign magnitude to the hospitality factors and that the scores given tended to be consistent over different groupings of respondents in each sample and across the three samples. Some dissimilarities were noted, for example the Guildford
sample considered 'clear signposting' to be more important than either the Portsmouth or Stafford samples. The Stafford sample considered that 'comfortable furniture' was more important than did either of the other two hospitals' samples and the Guildford sample considered that 'clear signposting' was more important than did either of the other two hospital samples.

The different sex groupings showed a high degree of agreement in all three samples, however, the women in the Guildford sample considered that 'adequate provision for visitors and visiting' was less important than did the Guildford sample of men. The women in the Portsmouth sample considered that 'privacy' was less important than other groups did.

In all three hospitals the youngest age group considered 'plain cooking' to be less important than did the other age groups.

The respondents in the Stafford sample who were about to leave considered 'adequate provision for visitors and visiting' to be less important than did either those who had just arrived or those in the middle of their hospital stay.

The results of question 5 also serve as a method of checking whether the respondents replies, regarding the importance of hospitality factors, are consistent with a different style of questioning to that used in question 4. (As, in question 4, patients were required to rank the twelve hospitality factors in order of importance and in question 5 patients were required to consider each hospitality factor and state whether they considered that factor to be essential, very important, important, unimportant or not necessary). The extent to which question 5 was answered logically, with regard to the responses provided in question 4, provides a check on the consistency of the
responses. Analysing the questionnaires included making an assessment of whether each individual respondent's replies to question 5 did appear to be logical. Illogical replies were received from 24% of the Stafford sample, 31% of the Guildford sample and 15% of the Portsmouth sample.

The total average magnitudes given by each sample were closely grouped (no score above 4 being assigned), thus in order to compare the results from question 4 with those of question 5 the magnitudes were ranked. This treatment made it possible to see the similarity between the pattern of responses to the two questions.

7. x Analysis of Question 6.

Question 6 sought to discover any further hospitality factors which had been overlooked but also presented an opportunity for other comments the respondent might wish to make.

Comments were received from 20% of the Stafford sample, 21% of the Guildford sample and 25% of the Portsmouth sample. Comments were made on a wide range of subjects. Of the Stafford sample 38% of the comments related to the patient's concern for medical information/communication. Examples include:

"Patients should be given adequate information about medical condition, how operation went, healing time, etc."

"More information is needed about the treatment undergone - doctors avoid giving you clear answers."

"Not enough information is given to the patient who is wanting to know what is going on with themselves."

Two patients commented that they felt there were insufficient staff, for example;

"During my stay it appears there are not enough
staff. More are needed to support the already over-worked personnel at this huge, vast complex."

Other comments, by individuals, were concerned with:
- more access to library and shop trolleys,
- adequate heating levels being maintained,
- more tightly controlled television viewing,
- lower lights at night,
- the desire for 'better' special diets,
- the need for hygiene and food checks,
- the need for improved car parking facilities for visitors.

One patient expressed a preference for head-phones rather than the ear-phones supplied for listening to the radio. One patient suggested that visitors should not be allowed on the wards, or in the day rooms for half an hour either side of each meal-time. Some of the comments were difficult to analyse, for example;
"If possible people, or patients, should be put in wards with people around their age. This would be better than young and old mixed."

Like the Stafford sample the comments made by the Guildford sample were also mainly concerned with medical information, this being the topic of 22% of the respondents comments. One example, from a patient in the eye surgery ward, expresses the feelings of other patients;
"Let the patient know what is being done to, and for him, don't speak to other staff as if he is not there. He or she is afraid of being in the dark. His imagination works overtime. "Will I be cured? will I be blind? can nothing else be done for me?" So they go into their shell, all hope is gone - speak to them PLEASE !!"

The second subject most frequently commented upon was that of nurses' pay, patients felt that nurses were underpaid.
This subject was indeed highly topical at the time with considerable media and press coverage generally.

Two patients suggested that the washing and toilet facilities needed improvement. Some of the comments included general praise, one in particular expressed appreciation that, 

"...the present part of the hospital is non-smoking."

Another complained;

"...need more adequate facilities for smokers."

There were several comments relating to the catering, these concerned;

- the menus being written in 'plain english',
- meals being served hot,
- the adequacy of the dishwashing, highlighting the cutlery in particular,

One patient commented;

"A vegetarian diet is not provided in this hospital; only occasionally vegetarian dishes on some days. If only from a health point of view, patients should be encouraged to eat less meat."

Other comments were concerned with;

- the inconsistency of naming used on name cards above the hospital beds, on some first names were used while on others the title and surname,
- the importance of 'friendly and patient' replies to visitors enquiring, by telephone, about the condition of patients,
- access to fresh air,
- the importance of a quiet atmosphere to permit sleeping,
- the importance of darkness during the night,
- the adequacy of the heating,
One patient suggested that visitors should be supplied with transport and that they should also receive a hot drink during their visit or at least have access to a vending machine. Another commented;

"More provision should be made for longer beds. Say an add on section. This is very important to myself and to all other tall people."

Whereas another states;

"To ascertain the nervousness or otherwise of the patient by providing counsellors (if necessary), to talk through problems, so leaving other staff free for other duties. Christian name terms amongst the staff and patients are essential for good communications."

This comment supports the suggestion that patient anxiety is a cause for concern (Chapter 6) and offers a possible solution.

Unlike the other two hospitals, medical information is not the most frequent subject of the comments of the Portsmouth sample, this subject representing only 7% of the comments. Instead the popular topics were whether there were enough staff and concern that nursing staff were not paid enough. Two patients suggested that an 'appreciation box' be available so that patients could show their appreciation of the nursing staff as they left. Several comments related to the catering and included concern over: the quality and presentation of the food, the food not being hot enough, one patient suggested serving hot milk with coffee and another suggested putting ice into the water jugs. Other individuals commented on:

- the adequacy of the washing and toilet facilities,
- the need for adequate car parking facilities,
- a desire to have access to a laundry for the patients to use personally,
- the need for lights to be very low at night,
- the need for comfortable beds,
the praise-worthy work of the volunteers working within the hospital.

Three women from Portsmouth sample, Droxford ward, commented that they required 'adequate provision for non-smokers'. This complaint was made as they frequently found visitors smoking in the only day room to which the patients from the ward had access.

One patient made a very practical suggestion regarding the design of hospital lockers; "Re-design the lockers i.e. have the top section facing the patient for easy access from bed, without having to ask somebody else for help. This is particularly important after an operation."

Another commented; "An important factor is care and attention given to patients by medical staff - this is quite different from friendliness..."

It would appear that, as only one patient commented to this effect, most patients interpreted the 'friendly medical staff' hospitality factor as incorporating these aspects.

Another patient commented on the need for; "Help etc. for the first time admission and hospital stay, to ease confusion and ill-at-ease feeling, to ease the tension."

The suggestion that patients feel tension and anxiety when they come into hospital (chapter 6) is supported by the above comment, and it is considered that techniques of relaxation and yoga (chapter 3), may have useful application in this context.

Beyond the subject of medical information the comments did not show any consensus and it is considered that no "overlooked" hospitality factor was identified.
8.1 Introduction

Having set out the analysis of the main study, several conclusions can be drawn. These often highlight other areas of study which might usefully be carried out. This chapter looks in detail at the conclusions to this study and describes suggested further studies, within the field.

8.2 Conclusions

The main conclusion relates to the central question of whether a group of factors could be identified as generally considered to be those of prime importance to a satisfactory hospital stay. It has been found that there is consensus regarding these fundamental factors. As shown by the close correlations of the results in Figures 7.1 to 7.14 in chapter 7, and by the lack of consensus over any further factors in the independent comments of the respondents. Individuals can suggest additional factors, for example head-phones may be preferred to ear-phones, however such aspects were not highlighted by a group of patients and this suggests that this factor would not make the patient feel appreciably less 'at home' as they might if, extending this example, no radio were supplied. When additional factors have been mentioned by respondents there has not been any suggestion that the added factor reduces the importance of the other factors.

Some groups may find certain factors of particular importance to them, for example those in the thoracic ward studied were very concerned to have plain cooking, this may well be due to their medical condition. Those patients undergoing lengthy hospital stays (this group is
assumed, for the purposes of this study, to be those in the older age groups), may be more concerned with recreational facilities than those patients undergoing short hospital stays. However, generally some agreement was found regarding the sequence in which patients regard the hospitality factors as important to a satisfactory hospital stay. The average sequence was arrived at by adding the total answers to question 4 given by each of the three hospital samples (that is the total rankings assigned to each hospitality factor) and dividing by the total number of respondents. This gives a set of average rankings which are sequenced, (for full detail see Appendix 8.1). This resulting sequence represents the average importance all respondents, from all three samples assign to each factor, in response to question 4, starting with the factor considered to be most important and progressing to the factor considered to be least important. The rankings are listed below in Figure 8.1. As can be seen from Appendix 8.1 (table 8.2), the same calculation carried out on the results to question 5 results in a different sequence, this is also presented below in Figure 8.1.
### Figure 8.1

Comparison of Rankings Sequence for Questions 4 and 5

<table>
<thead>
<tr>
<th>Question 4</th>
<th>Question 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly medical staff</td>
<td>Friendly medical staff</td>
</tr>
<tr>
<td>Smooth admissions procedure</td>
<td>Smooth admissions procedure</td>
</tr>
<tr>
<td>Friendly non-medical staff</td>
<td>Adequate provision for visitors...</td>
</tr>
<tr>
<td>Information regarding routine</td>
<td>Friendly non-medical staff</td>
</tr>
<tr>
<td>Varied choice on the menu</td>
<td>Information regarding routine</td>
</tr>
<tr>
<td>Adequate provision for visitors...</td>
<td>Varied choice on the menu</td>
</tr>
<tr>
<td>Comfortable furniture</td>
<td>Clear signposting</td>
</tr>
<tr>
<td>Privacy</td>
<td>Comfortable furniture</td>
</tr>
<tr>
<td>Plain cooking</td>
<td>Privacy</td>
</tr>
<tr>
<td>Attractive surroundings/decor</td>
<td>Attractive surroundings/decor</td>
</tr>
<tr>
<td>Clear signposting</td>
<td>Plain cooking</td>
</tr>
<tr>
<td>Adequate recreational facilities</td>
<td>Adequate recreational facilities</td>
</tr>
</tbody>
</table>
Question 4 and Question 5 presented similar content but with very different formats, (see chapter 7). Question 4 required the respondent to rank the identified hospitality factors, whereas question 5 required the respondents to consider each hospitality factor independently and to assess its importance on a five point scale from 'essential' to 'not necessary'.

The differences highlighted by Figure 8.1 suggest that certain hospitality factors can be assigned easily to a ranking, particularly those at the two extremes (most important and least important) but that those factors which are considered as necessary but are not of obvious primary concern are more difficult to assign to a rank. There are several reasons for this difference. It may be that the respondents found that, having answered question 4 they were more familiar with the factors being discussed which led them to increase the importance they assigned to, for example 'adequate provision for visitors and visiting'. Certainly the different question types seem to have affected the numbers of respondents. More patients did not respond to the whole, or parts of question four than was the case with question 5 and more inappropriate responses were received in answer to question 4 than were received in answer to question 5.

This suggests that the requirement to rank factors is more demanding than stating the importance of independent factors (of those replying 4% fewer answered question 4 than answered question 5).

With question 4, as all the items had to be ranked the full 12 point scale was used, giving a wide spread to the resulting data. Whereas, the format of question five gave rise to bunching of results as respondents tended not to use the extreme positions.
Also, it may be the case that although some factors were ranked as less important they can also remain, in the opinion of the respondent, essential, suggesting that all the factors were essential but that the assigning of magnitude to the importance is not meaningful. Question 5 appears to have highlighted that the factor rankings remain reasonably consistent but that the measurement of magnitude is less distinct, this may be due to differing expectations. It is suggested that people expect, and are therefore dissatisfied when they do not find, such things as: smooth admissions procedure, information about hospital routine and clear signposting. Although people may be very unsure of what to expect about the friendliness of the medical staff, they prefer to encounter friendliness and are satisfied when this is the case. This theory was first suggested by Hertzberg (1963) who identified 'satisfiers' and 'dissatisfiers', stating that these were not necessarily the opposite of one another but that they were just different. The original context was motivation theory and the theory has also been applied (by Venison 1983), to hotel guests. It may also be seen to apply in this instance to hospital patients. Indeed, Cassee and Reuland (1983) make this suggestion, "The SATISFIERS are those which are related to the higher needs, the DISSATISFIERS are those with a relation to the lower needs." (Cassee and Reuland 1983)

They go on to say:
"...bad quality of the food will deeply dissatisfy the patient, but a high quality will, in most cases, hardly give the patient a feeling of satisfaction." (Cassee and Reuland 1983)

This means that magnitudes are influenced by people's expectations and the degree to which these are met or not met, they are almost certainly specific to the individual and to the specific hospital experience. However, once identified, the group of factors considered important to hospitality can form a useful basis for management
attention when considering the allocation of resources. Also the factors should be considered in any attempt to measure the quality of service offered by hospitals, and they serve as a useful starting point for appraisal and comparison of the service offered within the same hospital at different times or across a group of hospitals. The factors could serve as criteria for assessing a change, such as the implementation of a new training programme, redesigning the hospital signposting, upgrading of surroundings etc.

Several other aspects of interest were raised by the study. First the aspect of patient anxiety on admission and during the hospital stay, highlighted in other studies. This aspect was not the main focus of this study, however awareness of this problem by all the hospital staff seems to be very important to ensure that patients are received smoothly and put at their ease as quickly as possible. There was also evident concern regarding the medical information/communication which often appeared to add to the patient's anxiety. It is surely not coincidental that there was a high degree of consensus in placing the only factor which contained a clearly medical bias as the most important. It could be construed that the medical aspect is of overriding importance to all patients. This is unsurprising as it is a medical reason that they are at the hospital. The subject was highlighted in the patient's comments, even though all medical concerns were expressly not within the scope of this study. Nevertheless it appears that extra attention paid to this area would reduce patient anxiety. It may be that additional medical-social worker/almoner involvement with patients would reduce the worry felt by patients, by backing up or reinforcing the medical information which is given out to patients. The notion of an additional worker is to ensure that patients
feel relaxed and responsive at the time of such discussions. Frequently patients are over-awed by consultants and doctors to the extent that they are not as receptive or inquiring during their discussion with these professionals as they later wish they had been. Support workers could visit the patients to discuss any anxieties or be available to patients with questions. A role traditionally taken on by almoners.

"In London hospitals the position of the almoner as guide, philosopher and friend was established in the dark days of war." (Moberly Bell 1961)

As medical science becomes increasingly more complex with sophisticated techniques and more availability of alternatives it is inevitable that the rift of knowledge and communication, between professional and the layman, becomes increasingly difficult, and yet increasingly important to bridge. Additional staff may go towards easing the problem but it is the researcher's opinion that awareness of all staff, by training and refresher courses to counter complacency is most important.

A further question raised by this study is that of the extent to which it is possible, within the hospital context, to educate people. Although there are some patients who prefer not to know the detail of their medical condition, a large number wish to understand their illness clearly and treatment and, so are both motivated and receptive. However, regarding other issues they may be much less receptive, such issues include smoking and diet. Within the study a group of patients from one particular ward highlighted the lack of provision for non-smokers and in another hospital one patient expressed appreciation of the no-smoking policy. However, in the same hospital another patient complained about the lack of provision for non-smokers. Health is damaged by smoking and for this reason it might be expected that hospitals
should be seen to discourage the habit, as social
atitudes change people are becoming less tolerant of
smoking and smokers are being more restricted. The debate
will continue and may present a worthwhile topic for a
general survey of hospital users. The new Unit General
Manager of the Queen Alexandra Hospital, Portsmouth (the
sister hospital to St. Mary's Hospital, Portsmouth), has
enforced a strict no smoking policy since March 9th 1988.
He compared the entrance to the hospital, prior to the
ban, with a "smoke-filled third class railway station
waiting room", he goes on to say;

"Some say we should ban all smoking, but we are
going to be realistic and allow some people who feel
they need to smoke because of anxiety, to do so in
restricted areas," (Mote 1988)

The issue of diet is less clear cut. Following the
publication of reports by such bodies as the Committee on
Medical Aspects of Health (C.O.M.A.) 1984, and the
National Advisory Committee on Nutrition and Education
(N.A.C.N.E.) 1983, which present dietary advice designed
to improve the nation's diet with a view to reducing the
'diseases of affluence', there has been a growing
awareness of 'healthy eating'. Gosden (1985) reports a
study conducted at Bradford University which indicates
that the public are concerned about diet, disease and the
side-effects of additives, and Nutall (1985) describes
the food buying trend as a 'health food boom'.

In the light of these trends many health authorities are
reacting by making alterations to their hospital catering
provision. For example, Wessex Regional Health Team
(1984), set out a detailed report advocating dietary
change requirements for the Wessex population, in line
with available scientific evidence. They proposed mass
education and widespread alteration of the existing
services.
Some researchers are less enthusiastic however, O'Donnell and Wordsworth (1985) suggest that N.A.C.N.E. proposals are not necessarily appropriate in full, to the elderly.

Food habits should not have to undergo extensive change on admission to hospital for several reasons:

- the body requires a reasonable time in which to adapt to dietary change, that change is gradual is important, (for example, those on high fibre diets who change to a low fibre diet are likely to suffer from constipation, a condition which may be aggravated by the reduction in physical exercise which often accompanies a hospital stay).

- even when dietary change does not cause physical illness, psychosomatic illness may occur from eating disliked foods.

- where disliked foods have to be selected because of menu limitation, plate waste is likely to increase and the nutritional adequacy of the patient's diet may be jeopardised.

- religious taboos which are not catered for may leave patients anxious that their religion is inconvenient to the hospital.

- some illnesses affect the patients' appetite and attitude to foods, making patients less able to cope with foods they are unused to.

- an increasing number of people suffer from food allergies.

Dramatic dietary changes on admission to hospital are therefore, not practical or desirable and the variety of diets which are eaten in Britain today leave the caterer with the only alternative of having to provide a varied menu, it being essential to present the patients with a choice of several possible alternatives so that each
individual can select meals to suit their own preferences. After all many people have willingly adopted 'healthy' eating patterns and will expect to be able to continue with their chosen diet during their hospital stay. Recognising the difficulty of reconciling the problem of resistance to dietary change with the need to reduce the 'diseases of affluence' has led to widespread policy changes within the National Health Service;

"By August 1985, 66 of the 192 local health authorities in Britain were known to have a formal policy, and a further 72 were in the process of developing one." (Montague 86)

Generally three different approaches have been made;
- 'low key' substitution of some food stuffs, for example some of the white flour being replaced by wholemeal flour, with an appraisal of, and where necessary changes to, methods of food preparation and cooking.
- additional items being included in menus to offer a 'health food choice'
- publicity to inform hospital users of the changes.

For example, at the Royal Surrey County Hospital considerable work has been undertaken to implement healthy eating policies including publicity displays in prominent areas of the hospital, leaflets and the more subtle menu changes aimed to,

"...encourage the choice of a healthy diet by changing the order of items listed on the menu card." (Hamilton & Wordsworth 1985)

However, despite these attempts the Catering Manager, remains realistic, suggesting that as the patients are 'acute' they usually only stay in the hospital for five days, in which time they undergo surgery and are therefore not very interested in eating for two of the five days,
under these circumstances there is little or no opportunity for dietary education.

Education within hospital is, therefore, a worthy aim and that the hospital is seen to set a good example of healthy behaviour seems very reasonable, however the extent of its success, with respect to long term changes within a community cannot be other than limited.

The study also set out to assess the extent to which the concept of hospitality could be applied to the hospital situation. The conclusion must be that when hospitality is defined as when the patient feels,

"as 'at home' as possible during their hospital stay." (Chapter 2)

the concept of hospitality can be applied to hospitals. The study showed that those non-medical aspects of hospitals which are important to making patients feel 'at home' in hospital can be identified and do meet with agreement from a relatively large sample of patients expressing their feelings during a hospital stay. The study also suggests that of the hospitality factor groupings suggested by Cassee and Reuland (1983), of behaviour, product and environment, the hospitality factors which relate to behaviour are considered to be the most important.

8.3 Criticisms of the Study.

The major difficulty with this study was the limited resources which, as described is chapter 7, led to the samples being statistically unrepresentative of a specified population. That being so it is not possible to use more powerful statistical analysis. However, from the statistical analysis undertaken (Chapter 7, Appendix 7.3) it can be said, with 99% certainty, that for each of the
three hospital samples, patients showed significant agreement when ranking the hospitality factors.

The study has developed a concept of hospitality within the environment of hospitals and has put forward a working definition of hospitality. From this background a study methodology was formulated, and carried out, producing useful results.

It would have been preferable to have conducted a second pilot study, which would have involved the main study questionnaire being used on a small group of patients. This test would have been useful in that the main study questionnaire may have been further modified.

However, the main study did involve almost 400 respondents, from three different hospitals in three geographically different areas. It is suggested that within the constraints the study met the aims it set out to achieve with the minimum of involvement from both individual hospital staff and patients. The study tool does appear, from analysing the data, to have been highly flexible, permitting a wide range of days and times to be available so that the questionnaire could be completed at the convenience of the respondents and the hospital staff. It could also be applied widely within the hospital across many groups of patients: for patients in different wards and ward types, for both males and females, for both long-stay and short-stay patients, across different social classes, for both first time in-patients and returning patients and across a range of age groups. This flexibility is detailed in the make-up of the samples presented in Chapter 7 Appendix 7.4.

8.4 Suggestions for further study.

The questionnaire used in the main study could be used as a management tool, which could be adapted or lengthened to
become specific to one hospital or a group of hospitals. The use of such a questionnaire at regular intervals would give management useful feedback regarding patient satisfaction, this could serve as a quality measure for the hospital support services and would give patients a forum for airing their suggestions and impressions.

The study could usefully be applied to the private sector. The comparison between the attitudes of those involved in a direct payment system would be of considerable interest, especially in the light of recent political notions – for example the suggestions of the government think-tank, to make people more aware of the cost of the health service and to encourage more people to become involved in private health schemes possibly by awarding tax rebates for those who 'opt out' of the National Health Service.

A further area of interest is to determine to what extent hospital hospitality is unique, for this the main study questionnaire, after slight adaptation i.e. appropriate re-wording of such phrases as 'friendly medical staff', could be applied in a hotel context. This could serve as a preliminary study, investigating to what extent the hospitality factors identified by this study are generalisable to other forms of hospitality and the study could go on to focus on additional hospitality factors considered important within different sectors of the industry.
List of Appendixes

6.1 Pilot Study Second Questionnaire

6.2 Comparison of Medical and Non-medical Anxiety

6.3 Analysis of Responses to Question 7

7.1 Main Study Questionnaire

7.2 Tables of Results

7.3 Analysis of Responses to Question 4

7.4 Table of the Make-up of the Samples (taken from the three hospitals)

8.1 Determining the Average Sequence of the Hospitality Factors
Appendix 6.1 Pilot Study Second Questionnaire

INTERVIEW RECORD SHEET

Patients Name: NHS/Private  
Marital Status: Ward/Ilness:  
Age:  
Time of Interview:  

1. Generally speaking how apprehensive are you about your hospital stay?
   a) not at all apprehensive  
   b) hardly apprehensive  
   c) quite apprehensive  
   d) very apprehensive  
   [if (a) omit Q2]

2. Many people are anxious in hospital.  
   If the medical side concerns you to a value of 10, what value would you give your concern over the non-medical side?

3. i) Have you stayed in hospital before?  
       maternity/emergency/in-patient/abroad  
       YES / NO  
   [if no omit 3ii]

   ii) How many times have you stayed in hospital?
iii) When were you admitted for this hospital stay?

iv) Were you ever sent or given a book or leaflet, which told you about the hospital, its facilities, visiting arrangements and so no?
  YES / NO
  [if no go to Q3viii]

v) Did you receive the leaflet/booklet before or after you were admitted?
  BEFORE / AFTER

vi) Did you find the booklet/leaflet;
   a) very useful
   b) fairly useful
   c) not useful at all  [if (c) ask Q3vii]

vii) What makes you say that?

viii) Did you find the admissions process satisfactory?
  YES / NO
  [if no ask Q3ix]

ix) What makes you say that?

4. i) Do you find the meals in hospital satisfactory?
   Prompts: timing, quality, choice, style, service,
   YES / NO
ii) Why do you say this?

iii) Do you find the beds here comfortable? YES / NO

iv) What makes you say this?

v) Do you find the other furniture here comfortable? YES / NO

vi) Why do you say this?

vii) Do you find the domestic/cleaning service in the hospital satisfactory? YES / NO

viii) What makes you say this?

5. i) Do you find the wards and day areas satisfactory?
    Prompts: size, layout, decor, visiting times, routine, privacy, noise, lighting & lighting regime.
    YES / NO
    [If no ask Q5ii]

ii) What makes you say this?
iii) Do you find that the facilities provided for recreation and patient use are adequate?

Prompt; telephones, library, mobile shop, T.V., radio.

YES / NO

[if no ask Q5iv]

iv) What makes you say this?

6. i) Thinking about the staff in the hospital, how do you find the medical staff?

a) all of them are considerate
b) most of them are considerate
c) only a few of them are considerate

ii) How so you find the non-medical staff? (porters, cleaners, receptionists)

a) all of them are considerate
b) most of them are considerate
c) only a few of them are considerate

iii) Do you feel that the staff make you feel 'at home'? YES / NO

iv) Why do you say this?
7. Generally speaking any hospital must provide certain non-medical things to make a patient feel as at home as possible.

Please put the following list in order of importance starting with "1" as the most important;

1. smooth admissions procedure,
2. comfortable furniture
3. information regarding daily routine
4. plain cooking
5. a varied choice on the menu
6. friendly medical staff,
7. adequate recreational facilities (T.V., radio etc.),
8. attractive surroundings/decor,
9. privacy,
10. friendly non-medical staff,
ii) If there are any other factors which you feel are important but which are not included in the list state these with their number of importance.

iii) Being in hospital are there any things that you miss? YES / NO
   [if yes ask Q7iii]

iv) What are those things?

8. Finally, apart from the things we have discussed already is there anything else that you would like to say about your stay in hospital?

THANK-YOU FOR YOUR CO-OPERATION
Appendix 6.2 Comparison of Medical and Non-medical Anxiety

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Medical Magnitude</th>
<th>Non-medical Magnitude</th>
<th>Non-medical as a proportion of medical</th>
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<td>0,3</td>
</tr>
<tr>
<td>Gy</td>
<td>10</td>
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<tr>
<td></td>
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<td><strong>Sub Total</strong> 8,1</td>
</tr>
</tbody>
</table>

Patients answering this question = 13

Thus average proportion of non-medical anxiety to medical anxiety =

8,1 / 13 = 0.62

Key:
- Gy = Gynaecological
- M = Medical
- S = Surgical
- G = Geriatric

NB. X = could not answer the question

Thus on average patients concern over the non-medical aspects of hospitalisation are approximately two-thirds of their concern over the medical aspects of hospitalisation.
Appendix 6.3 Analysis of Responses to Q7

To determine whether the patients showed any significant agreement in the rankings given to specific hospitality factors,

The total ranks for each judge; \( 1 + 2 + 3 + 4 + 5 + 6 + 7 + 8 + 9 + 10 = 55 \)

\( n = \) no. of hospitality factors  
\( m = \) no. of patients judging  
Total ranks = \( 55 \times m \)

A. Significance of all patients’ discrimination,

Thus \( n = 10 \), \( m = 15 \)

If judges could not discriminate between the factors each factor would receive a tenth of the total ranks available, i.e.,

\[
\frac{m(n+1)}{2} = \frac{15(10+1)}{2} = 82.5
\]

The measure of agreement of the judges is taken as the difference between the observed rank totals and the expected rank totals. The maximum sum of the squares of the difference between the observed and expected rank totals under the null hypothesis of no agreement follows the ratio;

\[
S_{\text{max}} = \frac{m^2(n^3-n)}{12} \cdot \frac{15^2(10^3 - 10)}{12} = \frac{225 \times 990}{12} = 18562.5
\]

To measure the degree of agreement between the judges the coefficient of concordance \( (W) \), is used,

\[
W = \frac{S}{S_{\text{max}}} = \frac{128}{125(1000-10)} \approx 0.31984
\]

(Where \( S \) = the sum of the squares of differences between the observed and the expected rank totals.)

On the null hypothesis the expected value for each factor = 82.5

Thus;

\[
S = (67.5 - 82.5)^2 + (101.5 - 82.5)^2 + (78.5 - 82.5)^2 + (92.5 - 82.5)^2 + (79 - 82.5)^2 + (26 - 82.5)^2 + (104.5 - 82.5)^2 + (112 - 82.5)^2 + (98.5 - 82.5)^2 + (65 - 82.5)^2
\]

\[
S = 225 + 361 + 16 + 100 + 12.25 + 3192.25 + 484 + 870.25 + 25 + 420.25
\]

\[
S = 5937
\]

\[
W = \frac{12 \times 5937}{15^2(1000-10)} = \frac{71244}{222750} = 0.31984
\]
In order to determine whether the coefficient is significant the F test is used.
(Before this a 'continuity correction' could be applied but is, in this case negligible and
will not be used.)

\[ F = \frac{(m - 1)\bar{y}}{1 - \bar{y}} \]

\[ F = \frac{(15 - 1) \times 0.3198}{1 - 0.3198} \]

\[ F = \frac{4.4772}{0.6802} \]

\[ F = 6.5822 \]

greater estimate of degrees of freedom = \( (n - 1) - \frac{2}{m} \)

\[ (10 - 1) - \frac{2}{15} = 8.87 \]

lesser estimate of degrees of freedom = \( (n - 1)(n - 2) \)

\[ (15 - 1)(10 - 1) - \frac{2}{15} \]

\[ ; 14(9 - 0.1333) \]

\[ ; 14 \times 8.8667 = 124.1 \]

Using F tables we estimate the probability of getting a value of F with 8.87 degrees of freedom
and 124.1 degrees of freedom greater than 2.6 is 1% by sampling fluctuations. As our statistic
is 6.5822 we reject the null hypothesis that the patients do not agree on the ranking of the
hospitality factors,
This questionnaire is part of a study being carried out from Surrey University. The study is looking at the hospital service from the patients' viewpoint. It does not include any medical questions or any personal questions. I would appreciate your help in completing the questionnaire.

**Ward:_____________  Sex: M F**

Date:_____________  Time:__________

1. Are you an N.H.S. patient or a private patient?  N.H.S  Private

2a. Is this your first stay in a hospital?  Yes  No

   b. If this is not your first stay how many other stays have you had?
      1  2  3  4  5  more than 5

   c. Have you stayed in this hospital before?  Yes  No

3. At what stage of your present hospital stay are you?
   just arrived  in the middle  about to leave

4. Generally speaking any hospital must provide certain non-medical things to make a patient feel as at home as possible. Please put the following list in order of importance, numbering from 1 to 12 (starting with "1" as the most important),

   - Smooth Admissions Procedure
   - Comfortable Furniture
   - Information about Hospital Routine
   - Plain Cooking
   - Attractive Surroundings/Decor
   - Friendly Medical Staff
   - Adequate Recreational Facilities (T.V., Radio etc)
   - Varied Choice on the Menu
   - Privacy
   - Friendly Non-Medical Staff
CLEAR SIGNPOSTING

ADEQUATE PROVISION FOR VISITORS AND VISITING
5. You may think some factors are much more necessary, to make a patient feel at home, than other factors are. Please tick the appropriate box for each factor given below:

i. SMOOTH ADMISSIONS PROCEDURE
   essential very important important unimportant not necessary

ii. COMFORTABLE FURNITURE
    essential very important important unimportant not necessary

iii. INFORMATION ABOUT HOSPITAL ROUTINE
    essential very important important unimportant not necessary

iv. PLAIN COOKING
    essential very important important unimportant not necessary

v. ATTRACTIVE SURROUNDINGS/DECOR
    essential very important important unimportant not necessary

vi. FRIENDLY MEDICAL STAFF
    essential very important important unimportant not necessary

vii. ADEQUATE RECREATIONAL FACILITIES (T.V. RADIO etc.)
    essential very important important unimportant not necessary

viii. VARIED CHOICE ON THE MENU
    essential very important important unimportant not necessary

ix. PRIVACY
    essential very important important unimportant not necessary

tax. FRIENDLY NON-MEDICAL STAFF
    essential very important important unimportant not necessary
xi. CLEAR SIGNPOSTING

essential very important important unimportant not necessary

xii. ADEQUATE PROVISION FOR VISITORS AND VISITING

essential very important important unimportant not necessary
6. If you think that there are other important factors which have not been mentioned please write them here:

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

7. To help organise the answers please complete the following:

Which age range are you in?

18 - 40  41 - 64  65 and over

What is the occupation of the head of your household?

........................................................................................................................................

In which industry/organisation does he/she work?

........................................................................................................................................

How many people work in that establishment?  1 - 24  25 or over

Which of the following is the head of your household?

unemployed  an employee  self-employed

THANK-YOU VERY MUCH FOR YOUR CO-OPERATION.
APPENDIX 7.2 TABLES OF RESULTS

List of Tables

A7.a Results for Question 4: rank totals and means for all respondents.
A7.b Results for Question 5: magnitude totals and means for all respondents.

QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENT'S SEX
A7.c Female Respondents
A7.d Male Respondents

QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENT'S AGE
A7.e Age group 1 (<18-40)
A7.f Age group 2 (41-64)
A7.g Age group 3 (65 and over)

QUESTION 4 RESULTS GROUPED ACCORDING TO THE STAGE OF THE RESPONDENT'S HOSPITAL STAY
A7.h Those who have 'just arrived' in hospital (stage 1).
A7.i Those who are in the middle of their hospital stay (stage 2).
A7.j Those who are about to leave hospital (stage 3).
KEY

H = Hospital

Hospitals: G = Guildford
P = Portsmouth
S = Stafford.

Σ = Total for all respondents
x = Mean ranking/magnitude for all respondents to question/part of question

Columns: A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear signposting
X = Adequate provision for visitors and visiting
Hospitality factor abbreviations are given below.

**KEY**

A = Smooth admissions procedure  
F = Comfortable furniture  
I = Information about hospital routine  
C = Plain cooking  
D = Attractive surroundings/decor  
M = Friendly medical staff  
R = Adequate recreational facilities  
V = Varied choice on the menu  
P = Privacy  
N = Friendly non-medical staff  
S = Clear sign-posting  
X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
Table A7.1 Results for Question 4: rank totals and means for all respondents.

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All samples considered the hospitality factor 'friendly medical staff' to be the most important.

See graphs Figure 7.1, 7.2 page 152 and 153.
KEY

H = Hospital

Hospitals:  G = Guildford
            P = Portsmouth
            S = Stafford.

Σ = Total for all respondents
\( \bar{X} \) = Mean ranking/magnitude for all respondents to question/part of question

Columns;  A = Smooth admissions procedure
            F = Comfortable furniture
            I = Information about hospital routine
            C = Plain cooking
            D = Attractive surroundings/decor
            M = Friendly medical staff
            R = Adequate recreational facilities
            V = Varied choice on the menu
            P = Privacy
            N = Friendly non-medical staff
            S = Clear signposting
            X = Adequate provision for visitors and visiting
Table A7. Results for Question 5: magnitude totals and means for all respondents.

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*All samples considered the hospitality factor 'friendly medical staff' to be the most important.*

KEY

H = Hospital

Hospitals: G = Guildford
P = Portsmouth
S = Stafford.

∑ = Total for all respondents

X = Mean ranking/magnitude for all respondents to question/part of question

Columns; A = Smooth admissions procedure
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C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear signposting
X = Adequate provision for visitors and visiting
QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENTS' SEX.

### Table A7. c Female Respondents

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<td>6.7</td>
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### Table A7. d Male Respondents

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See graphs: Figure 7.6, 7.7, 7.8 p.159-161
KEY

H = Hospital

Hospitals: G = Guildford

P = Portsmouth

S = Stafford.

\( \sum \) = Total for all respondents

\( \bar{x} \) = Mean ranking/magnitude for all respondents to question/part of question

Columns; A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear signposting

X = Adequate provision for visitors and visiting
QUESTION 4 RESULTS GROUPED ACCORDING TO RESPONDENTS' AGE.

Table A7.e Age group 1 (18-40)

<table>
<thead>
<tr>
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Table A7.f Age group 2 (41-64)

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Table A7.g Age group 3 (65 and over)

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See graphs Figure 7.9, 7.10, 7.11 p 162-164
KEY

H = Hospital

Hospitals: G = Guildford

P = Portsmouth

S = Stafford.

\[ \sum \] = Total for all respondents

\[ x \] = Mean ranking/magnitude for all respondents to question/part of question

Columns; A = Smooth admissions procedure

F = Comfortable furniture

I = Information about hospital routine

C = Plain cooking

D = Attractive surroundings/decor

M = Friendly medical staff

R = Adequate recreational facilities

V = Varied choice on the menu

P = Privacy

N = Friendly non-medical staff

S = Clear signposting

X = Adequate provision for visitors and visiting
QUESTION 4 RESULTS GROUPED ACCORDING TO THE STAGE OF THE RESPONDENT'S HOSPITAL STAY.

Table A7.1 Those who have 'just arrived' in hospital (stage 1).

<table>
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<td>5.85</td>
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<td>5.4</td>
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Table A7.1 Those who are 'in the middle' of their hospital stay (stage 2).

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<th>I</th>
<th>C</th>
<th>D</th>
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<th>R</th>
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<tr>
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</table>

Table A7.1 Those who are 'about to leave' hospital (stage 3).

<table>
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<th>I</th>
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<th>M</th>
<th>R</th>
<th>V</th>
<th>P</th>
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<th>X</th>
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<td>5.48</td>
<td>8.43</td>
<td>5.74</td>
</tr>
</tbody>
</table>

See graphs Figures 7.12, 7.13, 7.14 p 165-167
To determine whether the patients showed any significant agreement in the rankings given to specific hospitality factors,

The total ranks for each judge: 1+2+3+4+5+6+7+8+9+10+11+12 = 78

n = no. of hospitality factors
n = no. of patients judging Total ranks = 78 x n

Significance of all patients' discrimination

GUILDFORD SAMPLE

Thus n = 12 n = 148

If judges could not discriminate between the factors each factor would receive a twelfth of the total ranks available i.e.,

\[ m(n + 1) = \frac{148(12 + 1)}{2} = 962 \]

The measure of agreement of the judges is taken as the difference between the observed rank totals and the expected rank totals. The maximum sum of the squares of the difference between the observed and expected rank totals under the null hypothesis of no agreement follows the ratio:

\[ S_{\text{max}} = \frac{m^2(n^2-n)}{12} \]

The observed values are given by

\[ S = 21104 + 1728 - 12 \]

To measure the degree of agreement between the judges the coefficient of concordance (W), is used.

\[ W = \frac{S}{S_{\text{max}}} = \frac{1232}{10812} = 0.3453474 \]

On the null hypothesis the expected value for each factor = 962

Thus:

\[ S = (502 - 962)^2 + (1056 - 962)^2 + (852 - 962)^2 + (1213 - 962)^2 + (1222 - 962)^2 + (281 - 962)^2 + (1341 - 962)^2 + (328 - 962)^2 + (1018 - 962)^2 + (676 - 962)^2 + (1246 - 962)^2 + (1036 - 962)^2 \]

\[ S = 21100 + 8836 + 12100 + 251 + 676 + 463761 + 143561 + 1156 + 3136 + 81796 + 82369 + 5476 = 1081726 \]

\[ W = \frac{12 \times 1081726}{21904 \times 1724} = 0.3453474 \]
In order to determine whether the coefficient is significant the F test is used. (Before this a 'continuity correction' could be applied but is, in this case negligible and will not be used.)

\[ F = \frac{(m - 1)\hat{\mu}}{1 - \hat{\mu}} \]

\[ F = \frac{(148 - 1) 0.3453}{1 - 0.3453} \]

\[ F = 50.755 \]

\[ 0.6547 \]

\[ F = 77.53 \]

greater estimate of degrees of freedom = \( (n - 1) - 2 \)

\[ ; (12 - 1) - \frac{2}{\sqrt{n}} = 10.9865 \]

lesser estimate of degrees of freedom = \( (m - 1)\{(n - 1) - 2\} \)

\[ ; (148 - 1)\{(12 - 1) - \frac{2}{\sqrt{n}}\} \]

\[ ; 147(11 - 0.0135) \]

\[ ; 147 \times 10.9865 = 1615.0155 \]

Using F tables we estimate the probability of getting a value of F with 10.99 degrees of freedom and 1615.02 degrees of freedom greater than 2.3 is 1% by sampling fluctuations. As our statistic is 77.53 we reject the null hypothesis that the patients do not agree on the ranking of the hospitality factors.
PORTSMOUTH SAMPLE

\[ n = 12 \quad m = 103 \]

If judges could not discriminate between the factors each factor would receive a twelfth of the total ranks available, i.e.,

\[ \frac{m(n+1)}{2} = \frac{103(12+1)}{2} = 669.5 \]

The measure of agreement of the judges is taken as the difference between the observed rank totals and the expected rank totals. The maximum sum of the squares of the difference between the observed and expected rank totals under the null hypothesis of no agreement follows the ratio:

\[ S_{\text{max}} = \frac{n^2(n^2-n)}{12} \cdot \frac{10609 \times 1724}{12} = 1517087 \]

To measure the degree of agreement between the judges the coefficient of concordance \((W)\), is used,

\[ W = \frac{S}{S_{\text{max}}} = \frac{125}{567305} \]

(Where \(S\) = the sum of the squares of differences between the observed and the expected rank totals.)

On the null hypothesis the expected value for each factor = 669.5

Thus,

\[ S = (354 - 669.5)^2 + (593 - 669.5)^2 + (561 - 669.5)^2 + (826 - 669.5)^2 + (826 - 669.5)^2 + (203 - 669.5)^2 + (932 - 669.5)^2 + (603 - 669.5)^2 + (826 - 669.5)^2 + (203 - 669.5)^2 + (942 - 669.5)^2 + (673 - 669.5)^2 \]

\[ S = 95840.25 + 5852.25 + 11772.25 + 24492.25 + 24492.25 + 217622.25 + 60906.25 + 4422.25 + 24806.25 + 11130.25 + 74256.25 + 12.25 \]

\[ S = 567305 \]

\[ W = \frac{12 \times 567305}{10609 \times 1724} = \frac{6807660}{18289916} = 0.3722083 \]

\[ F = \frac{(m - 1)W}{1 - W} \]

\[ F = (103 - 1) \times 0.3722 \]

\[ 1 - 0.3722 \]

\[ F = 37.9644 \]

\[ 0.6278 \]

\[ F = 60.472 \]
greater estimate of degrees of freedom = \((n - 1) - \frac{2}{m}\)

\[
(12 - 1) - \frac{2}{103} = 10.981
\]

lesser estimate of degrees of freedom = \((m - 1)((n - 1) - \frac{2}{m})\)

\[
(103 - 1)((12 - 1) - \frac{2}{103}) = 91.02
\]

Using F tables we estimate the probability of getting a value of F with 10.98 degrees of freedom and 91.02 degrees of freedom greater than 2.3 is 1% by sampling fluctuations. As our statistic is 60.47 we reject the null hypothesis that the patients do not agree on the ranking of the hospitality factors.
If judges could not discriminate between the factors each factor would receive a twelfth of the total ranks available i.e.,

\[ m(n + 1) = \frac{117(12 + 1)}{2} = 760.5 \]

The measure of agreement of the judges is taken as the difference between the observed rank totals and the expected rank totals. The maximum sum of the squares of the difference between the observed and expected rank totals under the null hypothesis of no agreement follows the ratio:

\[ S_{\text{max}} = \frac{n^2(n^3-n)}{12} \left( \sum_{i=1}^{n} x_i - \frac{n(n+1)}{2} \right)^2 \]

Where \( S \) is the sum of the squares of differences between the observed and the expected rank totals,

On the null hypothesis the expected value for each factor is 760.5

Thus:

\[ S = (452 - 760.5)^2 + (799 - 760.5)^2 + (715 - 760.5)^2 + (938 - 760.5)^2 + \\
(961 - 760.5)^2 + (236 - 760.5)^2 + (941 - 760.5)^2 + (803 - 760.5)^2 + \\
(817 - 760.5)^2 + (628 - 760.5)^2 + (1003 - 760.5)^2 + (663 - 760.5)^2 \]

\[ S = 95172.25 + 1482.25 + 2070.25 + 31506.25 + 40200.25 + 275100.25 + \\
32580.25 + 1806.25 + 3192.25 + 17556.25 + 58806.25 + 9506.25 \]

\[ S = 568979 \]

\[ U = \frac{12 \times 568979}{13669 \times 1724} = 0.2893133 \]

\[ F = \frac{(m - 1)U}{1 - U} \]

\[ F = \frac{116 - 1}{0.289} \]

\[ F = 47.15 \]
greater estimate of degrees of freedom = \( (n - 1) - \frac{2}{m} \)

\[
; \frac{(12 - 1) - 2}{117} = 10.9829
\]

lesser estimate of degrees of freedom = \( \frac{(n - 1)(n - 1) - 2}{m} \)

\[
; \frac{(117 - 1)(12 - 1) - 2}{117} = 10.982
\]

Using F tables we estimate the probability of getting a value of F with 10.98 degrees of freedom and 1266.72 degrees of freedom greater than 2.3 is 1% by sampling fluctuations. As our statistic is 47.15 we reject the null hypothesis that the patients do not agree on the ranking of the hospitality factors.
APPENDIX 7h. TABLE OF THE MAKE-UP OF THE SAMPLES TAKEN FROM EACH OF THE THREE HOSPITALS

<table>
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<td>34</td>
<td>(1&amp;2)</td>
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Hospitality factor abbreviations are given below.

**KEY**
- A = Smooth admissions procedure
- F = Comfortable furniture
- I = Information about hospital routine
- C = Plain cooking
- D = Attractive surroundings/decor
- M = Friendly medical staff
- R = Adequate recreational facilities
- V = Varied choice on the menu
- P = Privacy
- N = Friendly non-medical staff
- S = Clear sign-posting
- X = Adequate provision for visitors/visiting

* indicates those patients giving no answer/an inappropriate answer
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APPENDIX 8.1 Determining the average sequence of the hospitality factors

KEY

H = Hospital

Hospitals: G = Guildford
P = Portsmouth
S = Stafford.

\[ \sum \] = Total for all respondents
Average = Mean ranking/magnitude for all respondents to question/part of question

Columns: A = Smooth admissions procedure
F = Comfortable furniture
I = Information about hospital routine
C = Plain cooking
D = Attractive surroundings/decor
M = Friendly medical staff
R = Adequate recreational facilities
V = Varied choice on the menu
P = Privacy
N = Friendly non-medical staff
S = Clear signposting
X = Adequate provision for visitors and visiting
Table 8.1 Results for Question 4: rank totals averaged and sequenced.

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Average Sequence = Friendly medical staff
  Smooth admissions procedure
  Friendly non-medical staff
  Information about hospital routine
  Varied choice on the menu
  Adequate provision for visitors.
  Comfortable furniture
  Privacy
  Plain cooking
  Attractive surroundings/decor
  Clear signposting
  Adequate recreational facilities

-243-
Table 8.2 Results for Question 5: magnitude totals averaged and sequenced

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Average Sequence = Friendly medical staff
Smooth admissions procedure
Adequate provision for visitors.
Friendly non-medical staff
Information about hospital routine
Varied choice on the menu
Clear signposting
Comfortable furniture
Privacy
Attractive surroundings/decór
Plain cooking
Adequate recreational facilities
Factors whose rank remained consistent in both Q4 and Q5:

Friendly medical staff = 1,
Smooth admissions procedure = 2,
Attractive surroundings/decor = 10,
Adequate recreational facilities = 12.

Factors which only differed by 1 rank point between Q4 and Q5:

Friendly non-medical staff from 3 to 4,
Information about daily routine from 4 to 5,
Varied choice on the menu from 5 to 6,
Comfortable furniture from 7 to 8,
Privacy from 8 to 9.

Factor whose rank differed by more than 1 point between Q4 and Q5:

Plain cooking from 9 to 11 (2 pts),
Adequate provision for visitors from 6 to 3 (3 pts),
Plain cooking from 9 to 11 (4 pts).
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