

Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations

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Keywords: NHS, privatisation, partnership, cooperatives, social enterprise, non-for-profit, for-profit, corporate, commissioning, private patients, patient choice.

National Institute for Health Research Policy Research Programme Project PR-X03-1113-11005

This report is independent research funded by the National Institute for Health Research Policy Research Programme («Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations», «PR-X03-1113-11005 »). The views expressed in this publication are those of the authors and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health, arms length bodies or other government departments.

Executive Summary

Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations

BACKGROUND

UK health policy includes replacing public providers of NHS-funded services with a mix of providers under more diverse ownership - corporate, voluntary, 'not-for-profit', professional partnerships, NHS foundation trusts and social enterprises.

STUDY AIMS

This research aimed to contribute to filling the gap in evidence as to what effects provider diversification is likely to have on patient experience, innovation in healthcare, and the implementation of other health policies, e.g. cost reduction and service 'integration'.

METHODS

We systematically compared case studies of differently-owned providers of hospital orthopaedics, hospital ophthalmology, community health services, and out-of-hours services in terms of their structure, management, innovations and 'market' environments, responsiveness to commissioners, and patient experiences and choice. During 2015-17 we interviewed 83 managers and 89 patients across 12 organisations (3 corporate, 3 NHS trust, 2 not-for-profit, 2 social enterprise, 1 co-operative, 1 partnership) across England. We observed 15 meetings and, to assess how typical of their kind our case-study organisations were, analysed HES (2013-14) and OPCS (2011) data. We used Donabedian's analysis of organisations as a framework to combine the data.

FINDINGS

The Diverse Provider Landscape

Non-NHS providers' share of NHS spending grew consistently over the last five years to £10 billion (9% of NHS spending) in 2013-4. Considerable 'churn' occurred among non-NHS providers, with two main elements:

1. Unstable volumes and case-mix of their NHS-funded workloads.
2. Constant entries, exits, mergers, acquisitions and re-acquisitions, in contrast to the stability of NHS trusts.

The non-NHS supply side tended to converge upon having larger, fewer, more predominantly corporate and financialised structures. Paradoxically, concentration of ownership occurred alongside de-concentration of local hospital care, with more non-NHS hospitals becoming available to NHS-funded patients.

Local quasi-market environments

Recent and current NHS budget restrictions tended to make innovation patterns converge across differently-owned providers (including NHS providers) and limit ownership diversity, especially the growth of corporate provision. Safety, quality and reporting standards were largely the same across diversely-owned providers and tended to produce convergent behaviour, but not all standards (e.g. Safe Staffing) applied uniformly to providers under different ownership.

The scale and composition of care groups for treatment-centre, out-of-hours and community health services tended to produce convergent behaviour among providers irrespective of ownership, but service development differed in character between NHS trusts and other hospitals. Providers which relied on both privately- and NHS-funded patients wanted to preserve their income from, hence differentiate, their services for privately-funded patients.

Organisational Structures

Different ownership produced divergent organisational structures at the highest level. Yet differently-owned providers had similar coordination structures at workplace (hospital, clinic, care-team or call-centre) level. In the organisations owned by doctors, doctors organised themselves

democratically and managed the non-doctors were managed through a medically-controlled hierarchy. In a few of the other organisations doctors were sub-contractors or had admitting rights but most commonly, and always for non-medical staff, bureaucratic hierarchies were used for everyday work coordination.

Innovation

National and regional mandates tended to make work processes (service location, professional demarcations) and innovations converge in our sample of organisations. Staff availability permitting - which it often did not - the two large corporations (but not the small one), the voluntary and one social enterprise in our sample paid non-medical staff less than NHS trusts did. Irrespective of ownership all providers paid under block contract made demand-containment innovations such as clinical hubs or strengthening multi-professional teams outside hospital. Non-NHS hospitals selected services which, coincidentally, could be provided on a small scale, in calm and often more modern settings. Corporate and NFP providers selected innovations by 'business case', i.e. expected profitability. Subject to that, corporate providers had quicker, easier access to capital than voluntary providers and cooperatives, and the latter had readier access to capital than the NHS trusts, social enterprises and professional partnerships did. The study period was too short to expose the long-term implications. Treating also privately-funded patients, the NFP chain hospitals were willing to market procedures of limited clinical value.

Responsiveness to commissioners

Gradually all providers came to respond to commissioners in more 'relational' ways (frequent informal contact, negotiation and collaboration) although this took time to develop, periods of formal tendering sometimes interrupted it, and the providers' starting point was often an unflattering view of CCG and CSU commissioning capacity, methods and demands for information. Providers' bargaining power depended on their 'market' share and how many commissioners they dealt with rather than their ownership. Corporate and voluntary providers were usually willing to take on additional work provided they were paid for it and it was profitable. They withdrew from, or never started, providing NHS commissioners with services whose reduced tariff no longer met their costs and (where applicable) profits. In the past NHS trusts had been more accommodating in absorbing workload increases within their existing contracts but fiscal pressures on them were reducing that flexibility. Local knowledge and networks were of practical advantage to providers in

understanding and responding relationally to commissioners' suggestions for local health system changes and developments, and that tended to favour existing providers.

Patients' experience

Competitive tendering did not usually give *patients* a choice of community health and our-of-hours services because commissioners usually commissioned a single provider, whether or not NHS-owned. Where patient choice did apply, it was constrained by what services the non-NHS providers wanted to offer, and NHS triage and referral management systems. Many patients chose not to choose; they preferred to rely on their GP's advice. Others did choose. Many of them preferred NHS providers. Choice of provider and diverse provision were not the same thing.

Once patients had chosen a provider, or had it chosen for them, there were few differences in the range of choices of treatment, practitioner, place of treatment, time of treatment or of discharge between diversely-owned providers.

In contrast, patient *experience* of secondary care especially did differ between providers. Patients described a different ambience in the corporate and not-for-profit hospitals than in NHS acute hospitals. They reported the same calmer ambience in community hospitals, whether NHS-owned or not. The difference depended upon whether emergency and unplanned urgent care took place alongside planned care, or planned care was provided on a separate site. Patient voice, through consultative mechanisms, played a minor role in the case-study sites, irrespective of ownership.

CONCLUSIONS

We found few differences in management structures at workplace level, or in care processes, between the diversely owned providers. The most evident differences arising from ownership were the differentiation of services for private patients, pay policy, and high-level organisational structure. Differences in NHS-funded patients' experience reflected provider case-mix rather than ownership. This evidence suggests that any policy rationales for diverse provision rest upon a different basis that innovation, patient experience or responsiveness to commissioners. It calls into question whether, in times of austerity, it is worth the NHS spending the additional money that would be required to induce independent, especially corporate, providers to enter the quasi-market.

Abstract

Background

NHS-funded services are provided by diversely-owned organisations: corporate, 'not-for-profit', proprietary, cooperative, professional partnerships, NHS trusts, social enterprises.

Objectives

To examine effects of diverse provider ownership on patient experience, innovation and health policy implementation (e.g. cost reduction, service 'integration').

Design

Realist mixed methods. Systematic comparison of hospital orthopaedics, hospital ophthalmic, community health and out-of-hours services sampled for maximum variation by ownership. Qualitative study of patient experience. Routine analysis of administrative data to assess generalisability of findings. Synthesis of findings by framework analysis.

Data Sources

Interviews of 83 managers and 89 patients across 12 organisations (3 corporate, 3 NHS trust, 2 not-for-profit, 2 social enterprise, 1 co-operative, 1 partnership). Meeting observation (N=15). Data collected in England, 2015-17. HES (2013-14) and OPCS (2011) administrative data.

Results

Non-NHS providers were tending to become more often corporate and financialised. Regulations and quality standards encouraged convergent behaviour among differently-owned providers. Differently-owned providers had divergent top-level organisational structures but similar coordination structures at workplace level. Innovation was largely policy led. Technical innovation tended to emerge from NHS trusts, service delivery innovations from providers of all ownerships.

Providers with private patients differentiated services for them from services for NHS patients. Patients found the ambience of secondary care in non-NHS providers – and in CHS services, irrespective of ownership – very different to that in NHS acute trusts. The difference reflected case-mix not ownership.

Limitations

Some combinations of provider ownership and service delivery were not found in the English NHS. No routine data on patient outcomes were analysed. Study period was too short to expose long-term consequences of different innovation and investment patterns across differently-owned providers.

Conclusions

Service and organisational differences across differently-owned providers appear smaller than public debates often suppose, calling partly into question the policy rationales for diverse provision.

Alphabetical list of abbreviations

5YFV	<u>Five Year Forward View</u> [policy statement]
A&E	Accident and Emergency [department, service]
ACO	Accountable Care Organisation
ALoS	Average Length of Stay
AMD	Age-related Macular Degeneration
ANP	Advanced Nurse Practitioner
APMS	Alternative Provider Medical Services [contract for primary care providers]
APPC	Alternative Provider Primary Care
AQP	Any Qualified Provider [policy]
BMI	British Medical International
BUPA	British United Provident Association
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CHS	Community Health Services [domiciliary nursing, therapy and other healthcare]
CIC	Community Interest Company
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CMA	Competition and Markets Authority
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation [payments framework]
CS	Case Study/Studies

CSU	Commissioning Support Unit
DGH	District General Hospital
DH	Department of Health [England]
DRG	Diagnostic Related Group [payment system]
DTR	Default Tariff Roll-over
EBM	Evidence-based Medicine
ED	Emergency Department
ENT	Ear, Nose and Throat
EU	European Union
FFS	Fee-For-Service [payment system]
FT	Foundation Trust
GHG	General Healthcare Group
GMS	General Medical Services [contract for general practices]
GP	General Practitioner
HCA	Hospital Corporation of America
HDU	High Dependency Unit
HES	Hospital Episode Statistics
HHI	Hirschman-Herfindahl Index
HIV	Human Immunosuppressive Virus
HMO	Health Maintenance Organisation
HRG	Health Resource Group [English variant of Diagnostic Related Group system]
HSCA	Health and Social Care Act, 2012 [taking effect in April 2013].
HSDR	Health Services and Delivery Research [programme of the National Institute for Health Research]
IAPT	Improving Access to Psychological Therapies

ICD10	International Classification of Diseases, version 10.
IMD	Index of Multiple Deprivation
ISTC	Independent Sector Treatment Centres [subcontracted to NHS; later just known as 'Treatment Centres']
IVF	In-Vitro Fertilisation
KPI	Key Performance Indicator
LA	Local Authority
LHE	Local Health Economy
LIFT	Local Investment Finance Trust
LSOA	Lower Super Output Area
MCP	Multi-speciality Community Providers
MRI	Magnetic Resonance Imaging [scan]
MSK	Musculoskeletal [disorders]
MSOA	Middle Layer Super Output Area
NFP	Not-For-Profit [organisation]
NHS	National Health Service [England]
NHSE	NHS England [executive body of the NHS]
NHSIC	NHS Information Centre [now NHS Digital]
NHSPN	NHS Partners Network
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NNC	National Negotiating Council [staff terms and conditions]
NPM	New Public Management
NQR	National Quality Requirements ['Carson standards', for OOH services]
NS-SeC	National Statistics Socio-economic Classification

OOH	Out Of Hours primary medical care services
OPCS	Office of Population Census and Surveys [Classification of Interventions and Procedures]
PACS	Primary and Acute Care Systems
PCT	Primary Care Trust
PFI	Private Finance Initiative
PHIN	Private Healthcare Information Network
PLCV	Procedure(s) of Limited Clinical Value
PMI	Private Medical Insurance
PMS	Personal Medical Services [contract for primary care providers]
PPI	Patient and Public Involvement
PRCC	NHS Procurement, Choice and Competition Regulations
PROM	Patient-Reported Outcome Measures
QIPP	Quality, Innovation, Productivity and Prevention programme
QOF	Quality and Outcomes Framework [of the GMS contract: see above]
RTT	Referral To Treatment [time]
SEM	Sub-Epidermal Moisture [scan]
SHI	Social Health Insurance
STP	Sustainability and Transformation Partnership
TUPE	Transfer of Undertakings (Protection of Employment) [Regulations, 2006]
U3A	University of the Third Age
VAT	Value Added Tax
VTE	Venous Thromboembolism

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Chapter 1. Study Aims and Research Questions

1.a. Research Aims

UK health policy aims to replace exclusively public providers of NHS-funded services with a mix of providers under more diverse forms of ownership¹ - corporate, voluntary, ‘not-for-profit’ and so on. This research aimed to examine what effects provider diversification is likely to have on patient experience, innovation in healthcare and the implementation of other current health policies, for example cost reduction and service ‘integration’. A more nuanced question is whether diversely-owned providers will diverge in some of these respects and converge in others.

1.b. Research Questions

Our study therefore addresses the following research questions.

How do differently-owned providers of NHS-funded services vary in their responses to:

1. Innovation:

- (a) Responses to potential innovations, speed of response and ensuing service changes?
- (b) Use of freedom to innovate (in particular, for NHS Foundation Trusts)?

2. NHS commissioning changes. Specifically, what:

- (a) Role do different providers play in service design?
- (b) Do provider-commissioner interactions focus upon (clinical outcomes, transactions and procurement, other matters)?
- (c) Responses do local commissioners’ requirements (e.g. accommodating changed referral patterns, collaboration with local authorities, targeting deprived populations) produce?
- (d) Responses do national policy requirements (e.g. the Fair Playing Field Review, or for productivity, impacts on outcomes, public involvement, transparency of provider activity) produce?

- (e) Differences are there between differently owned providers in terms of transparent to commissioners and the use of information for commissioning purposes?

3. Patient

- (a) Choice, including patients' rights to choose their healthcare provider?
- (b) Experience of services

We also ask:

4. What implications for commissioning and managerial practice follow from the above, enabling the NHS to make better use of provider diversity?

(We have revised the sequence, but not the content, of these questions from the research protocol to match the more logical sequence in Chapters 2-3 below.)

The different ownership types that we consider are corporate, not-for-profit (including voluntary), proprietary, partnership, cooperative, and public firm (with NHS-style 'social enterprises' as a variant). We consider both internally-generated and externally-mandated innovations. Organisational studies often have 'innovation bias'², assuming that all innovations must be good for everyone. To avoid that naïvety we also consider any unintended or dysfunctional consequences. 'Providers' role in service design' refers to how providers helped commissioners invent, then specify, new models of care or modes of treatment. We hypothesise that the narrower NHS provider freedoms are, the more convergent the differently-owned providers' behaviour is likely to be in the above respects. We take patient experience to include choice of provider, clinician, time and place of treatment; and whether their experience of a service is satisfactory (or not), and in what ways. Clinical outcomes and safety were beyond the project remit.

Chapter 2. The Policy Background

We begin by explaining more fully what the diverse provision policy is and its stated aims, from which we develop (in Chapter 3) a some initial assumptions about the policy's likely effects.

Between 1947 and 1989 various private providers had continued to exist, mainly small hospitals^{3,4} predominately treating privately-funded patients. They were free to select which services they offered to which patient groups, and have retained that freedom ever since with present-day consequences that later chapters report. Nevertheless, in an NHS previously dominated by professional partnerships (general practice) and publicly-owned providers (other services), a 'diverse provider' policy implies increasing corporate, proprietary and not-for-profit providers' shares of NHS-funded work. That arouses considerable public⁵ and Parliamentary⁶ interest and debate. It is a key source of opposition to current health policy. The 2015 public consultation about the NHS stimulated 127,400 responses (almost a thousand times more than previous consultations), the main concern among them being the extent of private sector involvement in NHS services.⁷

Provider diversity intercalates with other health policies. In 2017 other high – perhaps higher – policy priorities were financial austerity and the 'integration' (i.e. better coordination) of local health services, respectively implemented through Sustainability and Transformation Partnerships (STP) and 'Vanguard' projects, as formulated in NHSE's Five Year Forward View(5YFV).⁸

2.a. Current Policy Priorities

Public borrowing more than quadrupled in consequence of supporting the financial sector through the 2008 financial crisis⁹, leading to tighter public spending constraints outside the financial sector.^{10,11} Although the NHS was less affected than other parts of the public sector, objective 3 of the current NHS Mandate is to 'ensure the NHS balances its budget ... putting the right measures in place to help spend taxpayers' money more efficiently and reduce waste'.¹² 2010 had already seen the 'Nicholson challenge' to the NHS to achieve 'up to' £20bn of savings by 2014¹³ and now NHSE has a target date of 2020-21 for eliminating the NHS budget deficit. Some^{14,15} argue that the practical effect is a real-terms reduction in NHS spending (although that is contested¹²) and absolute cuts in social care budgets.¹⁶

The key methods for reducing the NHS deficit are the cost control, service rationalisation and care 'integration' measures. Several policy documents have elaborated this agenda over the past four years.

In 2014 the 5YFV⁸ stated the key NHS aims now are:

1. 'upgrade in prevention and public health' (p.3)
2. 'Patients will gain greater control of their own care' (p.3)
3. 'support people with multiple health conditions, not just single diseases' (p.3).
4. 'comprehensive and high quality care' (p.5)
5. 'close the £30 billion gap' in projected NHS funding 'one third, one half, or all the way' (p.5).

The document's organisational sections focussed on how organisations in the NHS need to cooperate with each other, and at times even merge into larger organisations, the 'new care models', of which the 5YFV proposes seven. They include Multispecialty Community Providers (MCP: aimed at 'horizontal' care coordination between, above all, general practice, community health services (CHS) and social care); Primary and Acute Care Systems (PACS: aimed at vertical coordination of care); Urgent and Emergency Care Networks; and Hospital Chains.⁸ The first wave of a nationwide programme to implement them are 'Vanguard' sites.⁸ This policy is designed to promote integration of care. It gives little attention to promoting competition and diverse provision, indeed only mentions the non-NHS sector in connection with comparative wage rates. The current NHS Mandate¹² requires that half the population of England have access to such services by 2020. Perhaps more relevant to provider diversity, MCPs are also to 'enable new ways of delivering care [...] become the focal point for a far wider range of care' (5YFV p.20), shift outpatient consultations and ambulatory care out of hospital, and use inputs from carers, volunteers and patients. In explicitly accommodating local variation and experiments, 5YFV comes close to implying that these new models of care might also have the structure of a social enterprise or cooperative.

Secondly, in 2015 the relevant NHS national bodies issued a further policy document introducing the concept of collaborative, place based planning, the Sustainability and Transformation Partnerships (STP).¹⁷ This planning process will involve all 'local leaders coming together as a team, developing a shared vision with the local community, which also involves local government as appropriate; [and] programming a coherent set of activities to make it happen' (NHSE et al, 2015b). Local areas were required to define their 'transformation footprint', which is needed in order to produce and deliver a local STP for the period October 2016 to March 2021. Each local economy is to designate one individual as leader for this process (NHSE et al, 2016). STP programmes address the quality and sustainability of general practice, NHS workforce, workload

and hospital infrastructure. At present it is difficult to see how, indeed whether, STPs will accommodate non-NHS providers since the latter, provider competition and provider diversity seem barely relevant to implementing these programmes: something which the NHS Partners Network (representing non-NHS, mainly corporate, providers) expressed concern about.¹⁸ Not-for-profit and other non-NHS providers have also played little role, except for one social enterprise.¹⁷

2.b. NHS Quasi-Markets and Provider Diversification

Over the longer term, provider diversification policy has been pursued by constructing and re-constructing NHS quasi-markets, which were originally¹⁹ designed for that among other purposes. However the NHS contains three different quasi-market structures²⁰, each with different implications for the scope and consequences of provider diversification.

2.b.i. *Competitive Bidding*

Competitive bidding has been described as ‘competition *for* markets’. Bidding is open to all providers equally. When, as often happens, a single provider wins the bid, a market without competition exists between bidding rounds. Whilst law, regulation and NHS guidance (see below) allow commissioners to invite a single bid without competition in some circumstances, the rules also presume that competitive tendering is usual and preferable. Insofar as services are indivisible or commissioners choose to seek just one provider to provide a given service, competitive bidding has an ‘all or nothing’ character regarding provider ownership. In those conditions service ownership can be ‘diverse’ only in a longitudinal, long term sense (over several contracting cycles) as one provider succeeds another. Optionally, competitive bidding systems can be structured so that it is GPs who collectively choose the winning bid(s), which is how CCGs were intended to function.¹³

2.b.ii. *Patient Choice*

This structure has been described as ‘competition *in* markets’. Individual patients and/or GPs choose a provider, and providers are paid per patient episode, i.e. according to how many referrals they attract and treat. The policy in England is that patients should be able to choose any ‘willing’ (later, ‘qualified’) provider in respect of certain services.¹³ The NHS Choose-and-book system, introduced for that purpose, is designed to ensure that for outpatient appointments each patient may

choose *any* ‘clinically appropriate’ provider with whom *any* ‘relevant body’ has a commissioning contract.²¹ Non-NHS-owned providers can be included if they are licensed by the Care Quality Commission (CQC). Patient choice also requires per-patient payments to providers. In the NHS as most other health systems this is accomplished by a Diagnostic Related Group (DRG) payment system, the English variant being called ‘Health Resource Groups’ (HRG) with National Tariffs set for each HRG. DRGs were invented in New York State to create a consistent payment system for all types of provider, one that promoted provider competition on the basis of quality and eliminated price competition.²² In a patient choice structure, providers under diverse ownership can coexist for each care group because this kind of healthcare quasi-market is continually open to any licensed provider.

2.b.iii. Primary Care Based Commissioning

In this structure, the GP (or equivalent) can exercise proxy choice of provider on behalf of the patient, choosing from among whatever diverse providers of non-GP services are available. GPs exercise this choice patient by patient, making primary care based commissioning similar to a patient choice structure in all main respects except that of who actually chooses the provider.

2.c. Two Over-arching Institutions

The above policies and structures operate within and are constrained by two more fundamental policies, each with implications for provider diversity.

2.c.i. Universal care

The NHS is still based on the principle that it must ensure access on the basis of healthcare needs to publicly-funded services sufficient in range and volume to satisfy those needs, and with timely enough access to do so. That implies

1. A wide spectrum of services and technical innovations, including those for small care groups.
2. Proliferation of specialities, models of care, and technical innovations, especially insofar as the medical profession is a key member of the health policy community at both national and hospital level.

3. Public hospitals functioning (as they long have done) as a carer of last resort, compensating for under-provision of other services.²³

Each of these conditions necessitates that the range of providers includes some which are willing to provide commercially relatively unattractive services, and providers (which will may but need not be corporations) willing to risk providing new healthcare technologies and models of care. In practice there is much variation in the supposedly universal service. Providers can nuance what they actually provide so as to meet their contractual requirements but in ways that minimise the offer of certain services.

2.c.ii. The Bed-Pan Doctrine

Equally fundamental is the 'bedpan doctrine', usually but probably apocryphally attributed to Aneurin Bevan.

‘Every time a maid kicks over a bucket of slops in a ward an agonized wail will go through Whitehall’.²⁴

Although the Health and Social Care Act (2012) attempted to weaken this doctrine by introducing an arms-length body (NHS England) between ministers and the NHS, it remains deep-rooted in UK political²⁵ and Parliamentary culture. Ministers remain in practice accountable to parliament, and eventually the electorate, for the state of NHS services. In turn (although the lines of accountability are less clear) so do NHS England, other national-level NHS bodies such as NHS Improvement, and beyond them NHS commissioners and, increasingly, STPs. Making providers accountable remains an explicit health policy trope:

‘The Government’s reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level’¹³ p.4.

Against this, CCGs have cited ‘commercial confidentiality’ as a reason for not publishing tender and other documents²⁶, although this reasoning has not yet (2017) been tested in court. Maintaining provider accountability, for instance through the use of contracts and information systems, nevertheless falls to NHS commissioners especially.¹³ An important aspect of diverse provision is therefore how providers under different ownership differ, in terms of their susceptibility to public accountability and their transparency regarding the information required to make public accountability effective.

2.d. Diverse Providers Policy: Aims and Rationales

Taken together the above policies involve a set of aims and rationales for diverse provision. Since diverse provider policy is politically controversial we here limit ourselves to summarising the aims and rationales which governments (as opposed to their critics or opponents) and official bodies have stated explicitly (as opposed to conjectural aims). Three policy aims to which provider diversification is particularly relevant, and which we consider in this study, are cost control, which requires efficiency-raising innovations; the bedpan doctrine, which among other things requires provider responsiveness to commissioners; and improved experiences of care for patients.

2.d.i. *Innovation*

Regarding innovation, diverse provision has a dual rationale: that non-NHS providers will introduce innovations that NHS providers did not; and that their example will provoke NHS providers to devise innovations of their own²⁷, whether through competition, institutional mimesis²⁸ or both. The Gershon report²⁹ cited the specific example of how NHS use of Independent Sector Treatment Centres (ISTC) forced down spot prices from private healthcare providers by 40 to 45 percent. For the public sector generally, policy-makers have assumed that including non-publicly owned providers will increase value for money by raising service quality and reducing costs (e.g. by ‘process reform’ and increasing staff productivity).²⁹ Some pro-privatisation think-tanks³⁰ also argue private providers are likely to be more efficient, productive and innovative than publicly-owned ones.

Not only technical emulation is involved. The ‘New Public Management’ tends to assume that public organisations can and should so far as possible imitate corporate organisational structures and managerial practices (e.g. strategic management³¹), often copied from outside the health sector. Then, publicly-owned providers develop into ‘quasi-firms’ with:

‘assertive senior management, importing personnel from the private sector; a smaller and more strategic board with empowered non-executives, often with a business background; and aligning managerial and professional domains through [...] professionals with part-time managerial roles’³² p.3.

From the same sources has come a ‘market logic’ (sometimes³³ equated with ‘competition’). UK policy-makers also encourage these organisations to obtain income from non-public sources, and to make subcontracts and undertake joint ventures with corporations. This is thought to promote

efficiency through innovation. As health policy changed in these directions (and not only in the UK), health managers regardless of who owns their employer have tended to legitimate their work by enacting these norms.³⁴

2.d.ii. Responsiveness to Commissioners

For diverse provision to have its intended effects, providers must be responsive to their local NHS commissioners. That is also a central means for maintaining the public accountability of NHS-funded services, as the bed-pan doctrine requires. For all three quasi-market structures (see above) the overall coordination and commissioning role will increasingly be taken by STPs. But whoever is commissioner, ensuring that NHS-funded providers are responsive to national policy imperatives and local healthcare needs requires that commissioners have sufficient information about provider activity to verify those points; and strong enough media of control over providers to remedy any shortfalls.

Both the Commons Public Accounts Committee and the Audit Commission have considered whether more diverse provision may weaken provider accountability to (NHS) commissioners.^{35,36} Commissioners' control over all types of provider is weakened by information asymmetry in the providers' favour, and commissioners' lack of managerial capacity.^{37,38} Early critics³⁹ of diverse provision argued that this information asymmetry was greater in the case of non-NHS than NHS-owned providers. Freedom of Information requests largely do not apply to non-public providers.⁴⁰ Moreover, it can be argued that the profit-maximising motive of privately owned providers also increases the incentive for them to act opportunistically by taking advantage of these informational asymmetries.⁴¹ To ameliorate this problem the Private Healthcare Information Network (PHIN) was in 2014 given a legal mandate to collect and make available data from all private healthcare facilities on all patients, whether privately or NHS-funded⁴² and make these data publicly available (which began in May 2017). The House of Commons Select Committee on Health and, retrospectively, the Audit Commission have powers to obtain evidence from providers, but these are inherently exceptional methods. All healthcare providers, irrespective of ownership or their sources of funding, come under the CQC quality and finance inspection regime.

Commissioners have various 'media of power' by which to influence providers: commissioners' managerial, above all monitoring, activity; creating a 'negotiated order' with providers; discursive control (persuasion appealing to common cultures and to evidence-bases); material and financial incentives; and juridical control.³⁸ Regarding the latter, the NHS standard contract used by all providers includes dispute clauses avoiding the courts and using what is known as alternative

dispute resolution processes. Although current policy aims to provide equal treatment for providers of different ownership (see below), some exceptions remain. The first (but not subsequent) round of contracts gave ISTCs guaranteed (block) payments not the HRG payments normal for NHS acute care.⁴³

2.d.iii. Outcomes for Patients: Patient Experience and Choice

Recent UK health policy defines quality of care as comprising clinical outcomes, safety, and patient experience.¹³ In these terms, two somewhat opposite policy justifications have been offered for provider diversification.

The first is that non-NHS providers will behave differently to NHS ones, bringing innovation and greater responsiveness to users, service quality and efficiency⁴⁴:

‘This diversity gives people more choice over where they get treated, it introduces a wider range of expertise into the health service, and the competition it generates incentivises all providers to offer the best service to patients.’⁴⁵ p.13.

An alternative rationale (sometimes⁴⁶ argued more coherently outside than by government) argues that no harm will be done by introducing non-NHS providers because differences of ownership and the managerial consequences are (so to speak) behind-the-scenes back-office matters that are invisible and indifferent for patients; indeed non-NHS providers are currently encouraged to use the NHS logo in order to blur the difference.⁴⁷ Another variant plays down the importance of provider ownership compared with ‘how the NHS is organised and the ability of its leaders to deal with rapidly growing financial and service pressures’⁴⁸ p.22), or with ‘a mix of complex policies ... mediated by other environmental factors’⁴⁹, p.58), or compared with NHS healthcare remaining free at the point of use.¹³

Either way, current NHS policy¹³ conceptualises quality of care as concerning outcomes (positive effects on patient functioning and pain), safety (lack of negative effects) and patient satisfaction (emotional and attitudinal effects). The latter assumptions draw upon (among other sources) ‘consumerist’ ideas about patient choice being both valuable in itself and as a competitive mechanism through which, as explained above, diverse provision will result in innovations that raise service quality. Thus non-NHS provision is thought also to make services more responsive to users’ demands.^{19,50,51}

2.e. Concomitants

Provider diversification involves various concomitant policies (which may also, even mainly, be adopted for other reasons too).

2.e.i. *Regulation*

When the Health and Social Care Act (HSCA, 2012) took effect in April 2013 it explicitly applied competition law to the NHS quasi-market, with a presumption in favour of competitive procurement of NHS-funded services.⁵² Monitor, the new economic regulator for the whole NHS, (since renamed ‘NHS Improvement’ along with other arms-length bodies such as the Trust Development Authority), acquired some functions of the former Co-operation and Competition Panel and, along with the national competition authorities (since April 2014 the Competition and Markets Authority (CMA)), powers to enforce competition law to prevent anti-competitive behaviour and to produce a ‘level playing field’ which places neither public nor private providers at any substantial advantage in competing for NHS-funded contracts. *The NHS Procurement, Choice and Competition Regulations No.2 2013* (PRCC) make NHS procurement guidelines matters for statutory regulation. In their discussion of recent regulatory decisions Sanderson et al.⁵³ demonstrate that regulatory practice has not changed substantially since the H&SC Act came into force, despite the best known decision of the new authorities which was to prevent the proposed merger of three NHS foundation trusts in Dorset in 2013.

This regulatory regime covers all healthcare providers, whether NHS-funded or not.¹³ Simon Stevens remarked that

‘Although external inspection and regulation of providers began as a tool of centralization, it has turned out to be a precondition for a more plural ownership structure’.¹

For inspection and regulation are ownership-neutral⁵⁴ methods of provider monitoring, not reliant on NHSE having hierarchical or quasi-hierarchical control over service managers. NHS Improvement and the CQC jointly license all providers and inspect their quality. NHS Improvement have the somewhat ambivalent role of promoting both competition – which as noted policy-makers often confuse with provider diversity – and continuity of ‘key services’, for which it can authorise special funding arrangements should the service not otherwise be financially viable, and risk-pooling.¹³ Section 75 of the H&SC Act required NHS commissioners to undertake open competitive tendering for the provision of NHS-funded services. Later guidance appeared somewhat to relax this requirement, although not clarify it completely.⁴⁸ NHS England has warned NHS commissioners that a single tender is open to challenge, and such calls should still be publicly

advertised to ensure that there really is only one capable provider.^{51,55} The NHS Standard Contract is as the name suggests designed for use with all NHS-funded providers irrespective of ownership.

Updated EU procurement regulations introduced in 2015 (taking effect for the NHS in 2016) require NHS commissioners to hold a public competition for all contracts worth more than €750,000, reducing the scope for commissioners to use single-tender bidding where only one ‘most capable provider’ exists⁵⁶ (a practice which Monitor had tolerated⁵⁷), although it has been suggested (reportedly⁵⁸ by Simon Stevens) that single-tender bidding remains of value for CHS tendering. Ambiguous guidance⁵⁹ has been issued by NHS England about how to comply with these regulations, which appears to allow commissioners to avoid competitive tendering in a broader range of circumstances. Brexit may of course eventually change or remove these regulations.

2.e.ii. ‘Pro-Competition’ Policies.

Nevertheless the regulation of competition has remained largely an internal matter for the NHS despite the increasing emphasis on competition law and external regulators.⁵³ Further policies have also been used to promote competition.

Any Qualified Provider: The Any Qualified Provider (AQP) policy stated that any licensed provider (‘meeting rigorous quality requirements’⁵¹) which could provide services at NHS prices under the NHS Standard Contract was permitted to provide them. Commissioners were free to purchase services from any qualified provider, but each PCT was required to make at least three AQP contracts in 2012⁶⁰ and more subsequently.

Primary Medical Care: When the GPs' contract with the NHS was revised in 1990, general practices could instead of doing their own out-of-hours (OOH) work arrange, or pay, for other doctors to do so. Corporate deputising services and (still more) GP cooperatives consequently developed.⁶¹ By allowing general practices to opt out of OOH provision, however, the 2004 GMS contract was a death-blow to many cooperatives. The 1997 Personal Medical Services (PMS) scheme opened up primary medical care to nurse-led providers, corporate and proprietary provision. The Alternative Provider Medical Services (APMS) scheme permitted companies, social enterprises, mutuals, ‘groups of existing GPs’⁶² and combinations of these organisations to bid to operate general practices.

Social Enterprises: After 2011 a small number of NHS community health services trusts were ‘spun out’ as the Social Enterprises described below. The government gave NHS staff the ‘right to request’ such a conversion. However NHS pensions, pay and conditions were more generous than those of

most non-NHS providers, making NHS staff reluctant to exercise their new 'right' and few did.^{61,63} To remove that 'barrier'¹³ NHS pensions rules were revised. TUPE arrangements guaranteed NHS pay and conditions for existing NHS staff who transferred to a provider under different ownership, but not for any new staff recruited by the new provider. Since 2004 governments also tried to make it easier for 'third sector' organisations (voluntary associations) to bid for health and social care contracts, for instance by allowing NHS organisations and local authorities to offer them larger, longer-term (more stable) contracts.⁶⁴

Treatment Centres: Independent sector treatment centres (ISTC) were set up (one per Primary Care Trust (PCT)) specifically to carry out elective outpatient, day-patient and low-complexity in-patient surgery on NHS patients.⁶⁵ ISTCs were initially contracted at national level with, in effect, block contracts but patient numbers afterwards declined.⁶⁰ After the initial round of contracting some (but not all) ISTCs were subcontracted to their local NHS trust. Some were taken over by the NHS.

Fair Playing Field review: The Fair Playing Field review⁴⁰ identified measures to prevent quasi-market 'distortions', i.e. the following types of barrier to more diverse providers entering the NHS quasi-market:

1. 'Participation' barriers unrelated to provider efficiency or quality
2. Some (implicitly, non-NHS) providers facing external costs or financial rules which others do not (e.g. taxes, VAT rebates, more expensive capital).
3. External factors (e.g. commissioners' demands, public policy) preventing providers adapting their services.

To reduce these barriers, NHS commissioners should (the review argued) be given more stable, longer-term funding settlements; be allowed flexibility to let contracts of more than one year's duration; and publish their intention to let new contracts. NHS cost data, quality metrics and 'standard currencies' should be improved. The levels of working capital and reserves required of social enterprises and charities should be defined. NHS pension provisions, clinical indemnity arrangements, freedom of information arrangements and capital costs (but not taxes) should be equalised across provider types.

2.f. Varieties of Provider Ownership

Occasionally policy-makers themselves distinguish the different kinds of 'private' provision, if only to advocate one kind of private provider by appeal to another ('GPs are private providers so what is

wrong with corporations providing hospital services to the NHS?'). Usually, though, UK policy debates about diverse providers are framed as a contrast between 'public' and 'private' ownership. That is simplistic. Like other developed health systems, the UK one contains at least the following different types of provider ownership, mostly 'private'.

1. Corporations, shareholder-owned and for-profit in the sense of distributing profits as dividends to their owners. (In this report we use the term 'corporate' only in this specific sense.)
2. Proprietary, i.e. owner-managed, small firms such as single-handed GPs and the small private hospitals that were more prevalent before 1990.^{4,66}
3. Partnerships, owned and controlled by a group of individuals, often from one particular profession e.g. medicine (hence, 'professional partnership'). Decisions are made by the partners (but not usually their employees) on a more-or-less democratic basis. The organisation is owned by the partners severally. (STPs and similar inter-organisational networks are not 'partnerships' in this sense.)
4. Cooperatives, which are collectively owned and democratically controlled by their working members, who produce and sell goods or services for their own benefit⁶¹ (hence, 'producer co-operative'). Each member has a vote. Usually she has no 'share' that she can sell or transfer upon leaving, although there are exceptions.
 - (a) Consumer (as opposed to producer) cooperatives seek to obtain for their subscribers goods or services on advantageous terms.⁶⁷ We know of only one healthcare consumer cooperative in England although Group Health and others play a large role in the USA, as does social health insurance (SHI) in mainland Europe. Some employ their own healthcare staff. Insofar as they are purely buyers and providers of healthcare, consumer cooperatives are outside our present remit.
5. Not-for-profit providers, owned and controlled by their members or subscribers through a self-governing body (e.g. trust) specially constituted for that purpose. They are therefore 'mission-driven', the mission reflecting their members' interests, usually in providing some particular service. They are 'not-for-profit' in that they do not distribute profits as dividends although some do try to make a surplus to finance service developments. Others aim only to break even. Some recruit volunteer labour.⁶⁴ In the UK this wide category includes unincorporated organisations (membership organisations such as clubs), Community Interest Companies, and Industrial and Provident Societies.⁶⁸ Their scale and managerial style ranges from small local bodies to large chains with a similar management style to some

corporations. Not-for-profit organisations also include most charities although in the UK being a charity is a legal status not a type of ownership; as is limited liability status.⁶⁸

6. Public firms, publicly owned but allowed a certain autonomy from central government. For NHS Foundation Trusts an increase in formal autonomy is conditional upon high levels of compliance with certain key, nationally uniform managerial performance targets.⁶⁹ They compete for income (above all from ‘commissioners’, in the NHS) and have leeway to innovate. To a varying extent they tend to adopt new public management (NPM) ideas and practices, and be organisationally structured in imitation of corporations but without external shareholders or equity.
 - (a) What in the UK (but not elsewhere) are called ‘social enterprises’ are so to speak ‘semi-public-firms’ with elected (resident, worker, user) representatives on their boards, and for governance but not ownership purposes a separate legal personality. Community Interest Companies (CIC) were an organisational form invented for these purposes. Although sometimes⁷⁰ mis-described as ‘employee-owned’, the state in fact still owns these providers’ assets. Former NHS Trust social enterprises may within limits carry any operating surplus forward to the next financial year, but can also go bankrupt.
 - (b) NHS Foundation Trusts are permitted to operate wholly-owned for-profit subsidiaries, providing privately-funded healthcare, but whose profits return to the NHS Trust. These subsidiaries may also enter into joint enterprises with non-NHS organisations.

Organisations’ names and self-descriptions, even their legal personality, are sometimes misleading as to who really owns and controls them, hence which of the above categories they really belong to. Thus many OOH ‘cooperatives’ had essentially the same structure as a professional partnership general practice and kept it when converting themselves to (nominally) ‘social enterprise’ or ‘not for profit’ status. Outside the UK, ‘Social Enterprise’ usually means ‘producer and/or consumer co-operative’.

There are also hybrids.⁷¹ Under ‘functional privatisation’ a hospital or clinic remains publicly owned but it is partly or fully managed by a non-public organisation under contract to the state⁴², in contrast to ‘formal privatisation’ when public hospitals are sold off. Examples of functional privatisation include

1. ‘Administrative concession’ under which publicly-owned hospitals managed under contract by a private management firm, as were Hinchbrook hospital during 2012 to 2016, Amadora Sintra Hospital, Portugal or the Alzira project in Spain.⁷²

2. Turn-key contracts (private suppliers design and at least partly operate publicly-funded hospitals), such as the Private Finance Initiative (PFI: LIFT was the primary care equivalent⁷³). NHS trusts contracted with consortia of corporations and private equity firms to plan, finance, and build hospitals, provide the ancillary services, on-site shops and car parking. The trust paid the consortia for these but retained clinical budgets, income and management. The 1996 NHS (Residual Liabilities) Act made the Secretary of State for Health guarantor of PFI schemes in the NHS.⁷⁴

Lastly, there are coalitions or provider networks (e.g. public-private ‘partnerships’⁷⁵) containing two or more the above kinds of organisation e.g. joint bids by general practices and proprietary firms to provide OOH services.

Current policy assumes that provider diversification will have its intended effects through the following sequence:

1. Commissioners commissioning providers with a wider range of ownership than formerly.
2. New patterns of management, new working practices and innovation, and greater efficiency develop among the more diverse providers ...
3. ... which makes providers become more responsive to commissioners and improves patients’ experience of NHS-funded services.

As shown above, the policy documents contain in addition numerous more specific assertions which elaborate and specify these three points more fully. Together this complex set of policy assumptions constitutes a set of casual assumptions about how the policy will work⁷⁶. Causal assumptions are empirically testable hypotheses, which raises the question of what existing research already suggests about the validity of these assumptions about diverse healthcare provision. We address that question next.

Chapter 3. Research Background: Provider Ownership and its Implications

3.a. Organisational environment, structures, work-processes and outcomes

As our analytic framework we develop an explanatory model⁷⁷ which elaborates Donabedian's⁷⁸ account of how the relationships between organisational structures, process and outcomes differ between organisations under different ownership. Its main elements are:

1. An organisation's *environment*, i.e. the external resources on which the organisation depends, the policy and legal framework, its market and social context, which all constrain its owners' activities.
2. An organisation's *structure* embodies its ownership. Through it, the owners define that organisation's aims and implement the work processes required to achieve specific objectives that realise these aims. Within a formal governance structure there may co-exist network-like elements of 'informal organisation' and market-like elements (an 'internal market' in the strict sense).
3. The owners' aims are realised through work *processes* (in healthcare, the care process) chosen for that purpose and successively modified by innovations intended to meet their aims more fully.
4. The work-processes produce *outcomes*; the extent to which the organisation satisfies its owners' objectives and aims, but also third parties' demands (e.g. patients' experiences^{79,80} and choice, responsiveness to commissioners).

In quasi-markets the providers' effects upon patients are mediated through and constrained by commissioners. For application to quasi-markets one must therefore adapt Donabedian's model to show how the production process impacts immediately upon commissioners, and through them upon patients, dividing point 4 above into outcomes for commissioners and outcomes for patients.

The above model implies that the substantive outcomes that an organisation produces, and therefore the *content* of all these relationships, may differ by organisational ownership. Therefore it is necessary to differentiate types of ownership clearly, which empirical studies often do not. Many confuse privatisation with competition, and both with contestability.⁸¹ Some studies associate 'possibility of competition' with higher efficiency⁸² and quality,⁸³⁻⁸⁶ and others^{43,87,88} the opposite, but often neither side clearly differentiates ownership types.

3.b. Environment

State-owned organisations' critical environment is the 'outer' (regional and national) policy-making domain in which its governmental 'owners' formulate their policies for publicly owned organisations.

3.c. *'Outer' environment: national and regional*

All providers have the same legal and regulatory environment. Many organisations (especially large ones) try to influence it through policy communities⁸⁹, lobbying, sponsorship, creating pressure and interest groups, influencing the mass media, and direct coercion (e.g. a 'run on the pound', strikes). Often policy makers try to design these environments so as to channel provider competition into specific loci (e.g. to promote quality competition) and out of others (e.g. price competition through reducing quality or safety standards). Such regulation will tend to produce convergence among providers irrespective of ownership.

State-owned bodies such as NHS Foundation Trusts⁴⁴ are embedded in 'quasi-hierarchical'⁹⁰ relationships of authority, monitoring, accountability and sanctions that obtain between whole separate public organisations.⁹¹ Other organisations become incorporated into this quasi-hierarchy to the extent that they are commissioned by public bodies. Then, the final link in the accountability chain⁹² (the link between provider and commissioner) is contractual rather than quasi-hierarchical. Providers appear to vary, by ownership, in how willing they are to do so. In the USA, publicly owned and private not-for-profit substance abuse treatment providers were more likely than for-profit organizations to make contracts with an accountable care organisation (ACO), or plan or be negotiating to do so.⁹³

3.d. *'Inner' environment*

No less important for public organisations, and still more for a corporation, proprietary firm, social enterprise, professional partnership, cooperative or voluntary association, is the 'inner environment' of its local health economy. Various studies suggest that the market or quasi-market environment constraints on healthcare providers depend on how competitive that market is. Indeed there is some evidence that competitiveness rather than ownership drives market behaviour. A paradox of competition⁹⁴ is that it produces both provider-side concentration ('consolidation') of ownership (which is occurring in England⁴⁶) and a convergence of work-processes, service patterns, performance. It has been suggested⁹⁵ that the differences, by hospital ownership, in outcomes for

renal patients were lower in the USA when for-profit hospitals faced competition. In Germany, differently-owned healthcare provider types converged in terms how they used of mergers.⁹⁶ DRG payment led to convergence in average length of stay (ALoS) across all types of hospital.⁹⁷ After the introduction of DRGs there was no significant difference between costs or technical efficiency between German for-profit and public hospitals.⁹⁸ In Italy too DRG-based payments seemed to make for-profit⁹⁹, not-for-profit¹⁰⁰ and public hospitals converge in terms of technical efficiency. Providers with large market shares tend to set pricing and quality patterns across the health system¹⁰¹, so the behaviour of different types of provider may depend partly on the overall mix¹⁰² and converge over time. Corporations, public organisations³⁴ and partnerships also try to limit the effects of competition by merging³⁴ or by creating 'alliances' (cartels). Non-publicly owned organisations face the possibility of merger or takeover, especially if their shares are publicly traded. Corporate, proprietary, cooperative, not-for-profit and partnerships may also be exposed to competition outside of the quasi-market, indeed often originate outside it. Then they face dual competitive pressures, both for public contracts and for privately-paid sales. For them an important environmental consideration is then whether the two income streams are purely additive or whether pursuing one might compromise ('cannibalise'¹⁰³) the other. Geographical (e.g. urban vs. rural) and demographic characteristics also constrain how competitive a local market¹⁰⁴ or quasi-market is.

How tightly the commissioners can constrain providers of any ownership depends on three factors: the commissioners' choice of service specification; their bargaining power with providers; and how far commissioners can ensure provider compliance with the agreed specification. A first stage in a commissioning cycle is for the commissioner to specify what service and/or price it wants.³⁸ In theory, the commissioners then structure competitive bidding process, or the ways in which patients or GPs choose providers, so as the make providers compete to meet these specifications. How far providers accept the commissioner's specification depends in practice on their relative bargaining power. In quasi-markets the availability of alternate providers (see below) may make a provider contestable⁸¹, but conversely when the provider faces multiple public commissioners and/or private payers (private health insurers, patients with health insurance, employers, patients who can pay out-of-pocket) the commissioner becomes contestable from the provider's standpoint, with an increase in the provider's bargaining power. Depending on the balance of negotiating power the commissioner can become either a service and/or price 'maker' (setting a service specification then seeking suppliers for it), or a service and/or price 'taker' (choosing from what providers offer).¹⁰⁵ Competitive-bidding structures assume that commissioners are 'makers', patient choice structures more that commissioners (and patients and GPs) are 'takers'. How far the commissioner can ensure provider compliance with whatever service specifications the commissioner and provider have agreed then depends on how the commissioner uses the media of power³⁸ mentioned in Chapter 2

(commissioners' planning and monitoring capacity; a 'negotiated order' with the provider; persuasive appeal to EBM, managerial ideology or public policy; providers' resource dependency on the commissioners: provider competition or contestability (again); and juridical contract-enforcement and regulatory controls available in the 'outer' environment (see above)).

As noted, the NHS combines three different designs of quasi-market²⁰: competitive bidding; patient choice-based; and primary care doctor based. Because the three differ in how much power over providers they give to commissioners, and to which commissioners,¹⁰⁶ the policy outcomes resulting from diverse provider ownership might therefore also be expected to vary in each.

3.e. Constraining away the differences

Whatever the internal organisational pressures for each type of provider to develop in specific ways, strong regulatory, quasi-hierarchical¹⁰⁷ or contractual control providers may in practice reduce, even negate, any differentiation in the work processes, hence the 'real-side' outcomes of, differently-owned healthcare providers. Evidence based medicine has increasingly standardised clinical work processes^{108,109} which in turn reflect clinical techniques and human biology, neither determined by organisational ownership. Professional bodies' disciplinary influence is indifferent to provider ownership.¹¹⁰ Professional cultures are similar across providers.^{111,112} Budget constraints can also mean that providers 'sometimes collaborated with their competitors and competed with their collaborators' irrespective of ownership ⁴⁴ pp.9-10).

Organisational cultures can also promote convergence. When corporate models of organisation and management are ideologically dominant,¹¹³ managers, irrespective of who owns their organisation, often imitate what they take (or mistake) for corporate practice, e.g. management fads such as mergers.³⁴ Assuming the same 'isomorphic' mechanisms operate in the NHS as elsewhere,²⁸ one would then expect NHS quasi-market structures, organisational structures, institutional logics and managerial practice to converge upon corporate norms; and similarly in local government, not-for-profit organisations and the professions.¹¹⁴ Managerial cultures at times also clash with not-for-profit providers' original 'mission'.¹¹⁵ Managers in NHS trusts may believe that, for political reasons, their organisation is 'too big to fail'³⁸ but in 2008 that belief was also current in large financial corporations.

There are also practical reasons for convergent managerial practices. The practical difference between non-corporate providers aiming to attract income to develop their activity and corporations seeking income for shareholders may also be slight for employees and middle managers, as opposed to top managers and shareholders. When their sheer expansion necessitates a more elaborate

structure, professional partnerships evolve into ‘managed professional firms’ with a hierarchy of senior and junior partners.¹¹⁶

3.f. Organisational structure

3.g. *Owners’ aims*

We define ownership as beneficial ownership i.e. who in practice ultimately controls and benefits (and is ultimate recipient of surpluses or debts) from a given organisation. Diversity of ownership implies diversity of aims.

Usually researchers take maximising^{117,118} the owners’ monetary profits (‘return on investment’) as corporations’ prime aim. Indeed in the UK it is their managers’ and directors’ main statutory responsibility. Simon¹¹⁹ argued rather that corporations ‘satisfice’ their profits. Either way, the main structural consequence is that corporations require organisational structures for maintaining shareholder control and returning income to them, often achieved by developing separate specialised structures for coordinating production (line management, project teams etc.) and for financial purposes (holding companies, corporate governance structures, audit etc.).¹²⁰

As creatures of policy, public firms’ main aims are typically policy implementation, sustaining the legitimisation of government, of local MPs⁴⁰ and indeed the political regime as a whole.¹¹³ For NHS Foundation Trusts an increase in formal autonomy is conditional upon high levels of compliance with certain key, and nationally uniform, managerial performance targets.⁶⁹

Partnerships’ and cooperatives’¹²¹ aims typically centre upon satisficing the members’ (or partners’) personal income and maintaining their control over working life, including doing what they regard as worthwhile, high-quality work befitting their expertise and status.⁶¹

Small proprietary providers such as nursing homes also seek profits¹²² but here ‘profit’ represents the owner’s personal income, not external dividends or other rentier payments.

Not-for-profit, and especially voluntary, organisations are ‘mission driven’: their primary goal is to deliver a particular service.⁴⁰ UK policy-makers have therefore often seen these organisations as being particularly motivated and capable at tackling the most ‘wicked’ social, environmental and health problems.⁶⁴ Like cooperatives, not-for-profit organisations must raise enough income to cover their costs, but doing so may lead them to acquire the secondary objective of income growth¹¹⁵, sometimes inaccurately described as their ‘commercialisation’.

Irrespective of ownership, disputes among the owners, and between the owners and others, may in practice compel the owners to moderate or qualify their original aims or to accommodate also others' (possibly incompatible) aims. In this kind of 'negotiated order'¹²³ one observes only comprised, even obfuscated, forms of the respective aims, which empirically may be formulated as 'performance', 'targets', 'impacts', 'goals', 'mission', 'objectives' etc. as the case may be.

3.h. Hierarchy and democracy

Organisational research literature differentiates two main types of organisational structure, according to whether the actual producers also own and control the organisation. Corporations, public firms and (some) social enterprises are not generally producer-controlled. They therefore differ less in their internal structures, that of bureaucratic hierarchy¹²⁴ ('machine bureaucracy'¹²⁵), than in their external accountabilities and what substantive imperatives are transmitted through the hierarchy, the corresponding organisational cultures, the scope for functional differentiation and autonomy in their subordinate divisions or units, and senior managers' decision-making methods.⁷⁷ Marketing and financial structures are generally more salient and developed in corporations and not-for-profit organisations than in public firms, cooperatives or partnerships.

Because its formation as a profession preceded that of the centralised state, the British medical profession's self-image of their status and role retained much of the self-image of the individual 'free' professional, proprietor or partner.¹¹⁴ Subsequent hierarchies who needed their skills therefore faced the problem of how to incorporate this independent, non-hierarchical occupation:

1. NHS hospitals ('public firms') have traditionally had parallel uniprofessional 'silos'¹²⁶ with, at the top, a stratum of 'hybrid' medical managers linking non-medical managers with medical non-managers^{127,128}; and analogously in the other clinical professions. Care is coordinated across silos through 'matrix management'¹²⁹ and project teams.¹³⁰
2. Corporate and not-for-profit hospitals sometimes have the above structure. Managerial control over doctors, including willingness to dismiss doctors, is reportedly more overt and directive in ISTCs than NHS Trusts.²⁷ However the smaller corporate and not-for-profit hospitals may instead have an 'admitting rights' structure which more sharply separates general and medical management. The hospital owners can grant or withdraw individual doctors' admitting rights, but since they depend on doctors for patient admissions they are usually more concerned to attract than control doctors.

As public firms, NHS Foundation Trusts were designed to imitate aspects of not-for-profit organisations and of corporations whilst remaining publicly-owned. Unlike earlier NHS trusts, they have a dual governance structure comprising a Board of Governors which may include members of staff, local residents, the local municipal authority and NHS commissioners). They appoint the chair and non-executive director members of a board of directors, which also includes the chief executive and a small number of other executive directors.⁶⁸

Professional partnerships have a dual structure: an essentially democratic structure among the partners and, managed by them, a subtended hierarchy of other staff as employees. The medical partners may be occasionally supplemented with members of other clinical professions and/or managers. Salaried doctors and other staff representatives may occasionally be included as honorary partners for decision-making (although not necessary equity ownership) purposes.⁶¹ UK out of hours cooperatives are modelled on general practices but the democratic layer is proportionately larger.

Not-for-profit organisations, especially large ones, often have a subtended hierarchy of employed staff, even managers. A not-for-profit organisation's external accountability is typically to its external members, subscribers or donors. An important component of voluntary organisations' structures are therefore structures for obtaining donations and for recruiting volunteers, hence for propagating the organisation's aims and a corresponding internal ethos. In smaller, more 'voluntary' not-for-profit organisations much of the work (including management) is done by volunteers, who may themselves elect some of their managers or directors.

The term 'Social Enterprise' is ill-defined. Outside the UK it usually refers to democratic organisations such as co-operatives or mutuals which are neither publicly owned nor for-profit¹³¹. In the NHS 'social enterprise' often (but not always) refers to a spun-off but still publicly-owned organisation. In both settings the term can also refer to the organisations making up the non-statutory 'social economy'.¹³²

3.i. *Coordinating and controlling work processes*

An organisational structure is also the means through which its owners coordinate, motivate and control the people ('producers') who actually undertake operate the production process so as to realise the owners' aims. Through that structure the owners therefore:

1. Obtain whatever external resources the work process requires
2. Direct and control the actual producers' activities so as to execute the work process, which above all involves coordination (division of labour; task sequencing; transmitting work-in-progress from one producer to another; information-transmission; bringing the product or service to its users or vice-versa).
3. Observe the producers, work process and products to check the accomplishment of the owners' intentions, diagnosing and remedying any shortfalls.
4. Regularise, formalise and legitimate the above activities, hence maintain the required communication channels.

If one would expect these activities to be most intense and systematic in respect of the aims that are most important to the owners, the observed patterns of 'tight-loose' control¹³³ including the criteria by which managerial performance is assessed and which goals preoccupy managers in practice, would be evidence of what aims the owners prioritise. Similarly, the most confidential or secret matters might also be assumed important to the owners' aims.

Corresponding to their different, if sometimes compromised, aims organisations under different ownership have correspondingly distinct institutional logics,¹¹⁴ internal managerial regimes,^{37,134–138} skills, 'ethos'¹³⁹ and 'cultures'.^{140,141} 'Culture' is the 'taken-for-granted, shared, tacit ways of thinking, perceiving and reacting', above all its members' normative¹⁴⁰ representation of how the organisation ought to work in respect of (e.g.) working practices, behaviour (e.g. initiative, integrity, flexibility), and relationships specifically with patients. Different cultures at times understand the same term differently. For corporations, 'environment' means above all 'market', and they can take having wide financial and managerial discretion for granted.³² For public firms, the opposite often applies.³⁴

Culture and logics differ within as well as between organisations.^{33,140} In healthcare, tensions persist between 'sedimented'¹⁴² managerial (sometimes³³ confusingly called 'corporate') and professional cultures.¹³⁷ Divergent cultures limit how far an organization's managers can, as often assumed,^{143,144} manage its culture to taste. The mutual accommodation of conflicting interests may compromise an its managerial culture as well as its owners' aims. Rival cultures are accommodated and preserve

their identities through such localized means as ‘special case’ decision-making, informal consultation, jointly resisting common adversaries (e.g. government policy), shared short-term innovative projects¹³⁷ and ‘ceremonial’ but incomplete implementation of what each culture demands.³⁴ In contrast, an organisation’s members also experience and understand how the organisation works in reality; its *climate*. For instance a proclaimed culture of ‘psychological safety’¹⁴⁵ may contrast with a climate in which ‘whistle-blowers’ are punished.

3.j. Process

3.k. *Selection of core process: institutional logic and technology*

To achieve their aims an organisation’s owners establish a labour (e.g. a care) *process*,^{146,147} coordinated through their organisational structure and which they expect to realise those outcomes. Selecting a core process is implicitly the adoption of a logic model⁷⁶ and institutional logic.¹¹⁴ A core process is defined by its aim(s) rather than technologically since the same technology can serve different institutional logics. An organisation might use physical exercise, say, just for the immediate physical effects (e.g. club members’ pleasure); or embed it within a financial process (e.g. a commercial gym); or to pursue a policy ‘mission’ (e.g. reducing healthcare demand).

3.l. *Care process and care groups*

Differently-owned providers tend to prefer to offer different kinds of services,¹⁴⁸ at different locations and for different patient groups.^{101,149,150} Corporations especially are often accused of ‘cream-skimming’ the most profitable care groups and ‘dumping’ the rest. Corporations locate services where paying customers are likely to be found, for instance in Bath because of its socio-economic profile, in the case of Circle.¹⁵¹ Corporations can always ‘dump’ unprofitable contracts, and have done so (e.g. for NHS community health services, the ‘functional privatisation’ of Hinchingsbrooke hospital^{6,152}). So can social enterprises (e.g. mental health services in Cornwall). In Germany, privatisation of small rural hospitals led to closure of labour-intensive, hence costly, services (A&E, paediatrics).⁴² However, accusations that ISTCs ‘cherry-pick’ patients compared with NHS services for the same patient groups appear unsubstantiated¹⁵³, even though ISTCs were designed to treat only the care groups profitable to corporations.²⁷

3.m. *Care process and innovation*

When a work-process fails to meet their aims, its owners' usual recourse is, if they can, to innovate with (in healthcare) new clinical techniques or models of care (e.g. to reduce side-effects¹⁵⁴), whether locally invented or copied (as ISTCs copied NHS use of chair-based post-operative recovery and discharge lounges⁴²). Organisations are most 'receptive' to,^{2,155,156} i.e. select, innovations which are compatible with their:

1. 'Values', i.e. the owners' aims.
2. Working practices (including technical compatibility)
3. Existing organisational structures, control and ownership.

Hence different ownership implies different selections of innovations^{155–158} and technologies.⁷⁸ Observed care processes are a sedimentation of such innovations, plus any unofficial work-arounds added by workers themselves.^{27,159,160}

3.n. *Expansionary development*

In quasi-markets where cash follows individual patients, and commissioners must pay for all treatments actually given, all providers have an incentive to attract patient referrals (supplier-induced demand¹⁶¹). To expand profits, corporations naturally seek (circumstances permitting) to expand their activities, even by replication without increasing technical efficiency. That is, to expand services which in marketing terms are either 'cash cows' or 'stars'.¹⁶²

1. 'Cash cows' in healthcare typically are commodified services for frequently-occurring conditions¹⁶¹ with controllable, predictable costs because they have standardised, discrete treatments. Corporations then extract profits by offering these services at high volume and with low unit cost.²⁵ In the UK and elsewhere corporate hospitals focus on less complex, younger patients and with better mental health status and higher income^{163–165}. In England, planned acute hospital treatment in gynaecology, ophthalmology, orthopaedics and plastic surgery⁸⁸ best satisfy these criteria; in England and Australia, elective surgery generally.¹⁶⁶ Further income can be gained by offering the patient or commissioner supplementary technical elaborations (e.g. screening, post-discharge domiciliary care) or upgraded 'hotel' services. Until the introduction of DRG payments, German private hospitals would increase lengths of stay to raise revenue.¹⁶⁷

2. 'Star' services which the corporation has a unique advantage in providing and high profit margins e.g. because of fee-for-service (i.e. cost-plus) payment.

Expansionary profit seeking also motivates corporations also to innovate in pricing, e.g. by dividing episodes of care up into discrete chargeable items¹⁶⁸:

'In Ireland, patients in that have complications after care in private hospital often need to go back to the GP and get a referral, which leads to affordability issues.'⁴²

It also motivates marketing to patients and gatekeepers, reporting or comparing the corporation's clinical outcomes, quality of clinicians, facilities, patient satisfaction and waiting times.

In many countries, public firms' policy mandates include guaranteeing access to treatment for the full range of conditions and (especially for university hospitals) developing new clinical interventions and models of care.³⁴ Pharmaceuticals apart, university (i.e. public) hospitals are the traditional source of 'technology push' in healthcare¹¹⁵, concomitantly developing a wide-spectrum service profile and technical innovations, even for small care groups and patients with ambulatory care sensitive conditions.¹⁶⁹ Because of their political salience public hospitals may also face pressure to adopt *ad hoc* symbolic innovations to show that 'something has been done' to remedy some policy problem or exposed service deficiency.

Partnerships, cooperatives and (early in their development) proprietaries develop to pursue the interests of their working owners. Hence they innovate so as to:

1. Raise the owners' working conditions, income and status, hence:
 - (a) Delegate other work from the partners to employees, e.g. for medical partners to focus on acute clinical¹⁷⁰ work.
 - (b) Maintain partners' autonomy in how they work. Hospital- or HMO-employed doctors in the USA were more likely than independent ones to use electronic records¹⁷¹ and evidence-based care management processes.
2. Minimise external 'stakeholders'' influence, hence favouring internally-funded innovation which for all but the largest co-operatives implies labour- rather than capital-intense innovation.

3. Pursue the organisation's (non-financial) 'mission', which in healthcare implies selecting innovations for on the basis of evidence about their technical effectiveness.
4. Increase the equity value of the infrastructure, insofar as partners can withdraw their share on leaving the enterprise.

The above contrasts might explain two empirical findings. Since incremental innovation results more from 'market pull', it is likelier to appear in corporations, partnerships and proprietaries; and since radical innovation results more from 'technology push', it is more likely to originate in university (i.e. public) providers.¹⁵⁴ Interpreting 'divergent' innovation as including changes to existing professional jurisdiction, the above contrasts also explain the slight evidence, from the USA, that for-profit hospitals there are more likely to make 'divergent' (radical) innovations than public and non-profit hospitals.¹⁰⁴

Expansionary corporations might appear more likely than other providers to achieve economies of scale. But in practice public hospitals in the NHS (and most health systems) are usually larger to start with. These contrasting factors may explain why the evidence about the relationship between ownership and economies of scale is complex. Large (> 1000 bed) German for-profit hospitals operated more efficiently than their public counterparts,¹⁷² suggesting that the former more fully exploited economies of scale, but when taking the quality of care into account the efficiency differences were less.

3.o. Cost reduction

Transaction cost theory asserts¹⁷³ that those who own and control an organisation will seek to reduce costs in ways that so far as possible conserve their own income and power, which implies that differences in ownership will produce different cost reduction foci.

Hierarchically-structured corporate, proprietary and publicly owned hospitals face similar cost-reducing innovation options:

1. Reducing expensive, i.e. clinicians', labour since about two-thirds of healthcare costs are for labour through:

- (a) Low staffing levels, of which Serco's out-of-hours service in Cornwall was a publicised example.¹⁷⁴ Facing the same cost patterns, however, NHS services are also understaffed at times (Mid Stafford Hospital being the notorious example¹⁷⁵).
- (b) Reducing developmental or training 'overhead'.²⁷
- (c) Substituting cheaper (e.g. nursing, therapists or even unskilled) labour for expensive clinicians' labour.
- (d) Shift employers' costs elsewhere by using an admitting rights model for doctors mainly employed by public hospitals.

2. Replace inpatient with outpatient and/or primary care.

However corporations would appear to have less scope than publicly-owned hospitals for saving 'hotel' costs, since that would remove a selling point to private patients. Against this, by concentrating on 'commodified' treatments corporate hospitals may through standardisation¹⁷⁶ be able to increase their technical efficiency more than the wider case-mix lets public hospitals do. Specialised public treatment centres had 18%, and private treatment centres 40%, shorter ALoS than NHS hospitals even after controlling for differences in age, gender, number and type of diagnoses, deprivation and regional variation, suggesting that these differences reflected efficiencies not 'skimming'.¹⁷⁷

For public hospitals, past austerity policies have stimulated informal innovations for tacitly 'rationing' access through increasing waiting times, more stringent gate-keeping, higher referral thresholds.^{178,179}

Cooperatives, social enterprises, professional partnerships, proprietary and not-for-profit providers face the weaker financial imperative to cover, not minimise, their costs.^{180,181} In them, Niskanen's theory implies¹⁷³, cost reduction will only as a last resort be achieved by reducing partners', cooperators' or proprietors' income.

Some methods of cost reduction appear ownership-neutral:

- 1. Reducing 'industrial' and consumables, e.g. pharmaceuticals, costs.¹⁸²
- 2. Cost-shifting to other providers, commissioners, patients, informal carers or volunteers. For example Irish private hospitals require patients to make their own post-discharge arrangements before starting treatments, so as to avoid bed-blocking.⁴²

The multiple combinations of cost reduction methods available, some of them not ownership-specific, may partly explain the mixed evidence about differences in production costs between providers under different ownership.¹⁸³ German private hospitals were on average less technically efficient than public hospitals until DRG payments were introduced.¹⁶⁷ Even then, public hospitals remained more efficient than for-profit hospitals.^{172,184,185} Not-for-Profit hospitals were less efficient than either public or for-profit hospitals.^{172,184} Indeed converting German public hospitals into public firms increased their efficiency to the extent of creating 'likely an effective alternative to privatization'.¹⁸⁶ Italian for-profit hospitals were less technically efficient than public and not-for-profit hospitals, possibly because the private hospitals faced regulations that set an unstable limit to their admissions.¹⁷⁶ (However, unstable admission levels are normal for public hospitals in most health systems.) The quality improvements for hip fracture patients following the introduction of a revised DRG system which incentivised prompt treatment were greater in private (albeit from a lower starting-point) than in public hospitals.¹⁸⁷

3.p. Commissioners as intermediaries

The care processes from which commissioners choose might therefore vary to begin with on account of providers' diverse ownership. Because a commissioner in a quasi-market selects which care processes and service specifications to purchase for its population, it mediates the ways in which the providers' care processes produce outcomes for patients. Commissioners make this selection in light of the commissioners' own and, ultimately, the government's priorities; and patients' preferences and interests (expressed through e.g. patient participation or involvement, consumer research, patients' complaints about providers).

3.q. *Monitoring compliance: provider transparency*

Transparency of provider information about services is a precondition for providers' public accountability. It is also a precondition for commissioners being able to influence how providers respond to them, but information asymmetry compromises commissioners' capacity to do so.¹⁸⁸ Information publication reduces this asymmetry (and that between providers and patients¹⁷²). One would expect least transparency where there was a history of disputes ('low trust') or infrequent or interrupted contact between provider and commissioner (e.g. due to commissioner re-organisation and staff turnover). Provider transparency also however seems partly to depend upon provider ownership.

Secrecy ('commercial in confidence' rules, non-disclosure agreements, 'intellectual property' rights) prevents public access to information that would weaken one provider's business models and/or bargaining position by helping another provider to make commissioners a better offer. Empirically, corporations seem especially prone to secrecy. A recent Europe-wide study found that:

'Obtaining data about any dimension of quality from private hospitals was difficult in all the countries included in the case studies. Data is usually provided by private hospitals on the areas of quality where they excel ... this data is considered to be commercially sensitive and private hospitals are wary of quality indicators being misrepresented by the media. Problems with care may only be ... uncovered by the media or if patients are referred to public hospitals'⁴², p.66).

Initially the publicly available (Hospital Episode Statistics (HES)) data about private treatment centres under contract to the NHS were initially too incomplete to enable comparisons between public and corporate providers,¹⁸⁹ although they have subsequently become less so. At the time of writing (July 2017), the publicly available data on the Private Healthcare Information Network were entirely inadequate for that purpose. Whilst corporate providers are used to providing activity data promptly to non-NHS payers (some of whom will not pay them otherwise), sharp practice has occasionally occurred in providing such data to NHS commissioners.¹⁷⁴ The lack of transparent monitoring data about corporate contractors' performance is also reported more widely.¹⁹⁰ Up-coding to increase providers' reimbursement appears to be more characteristic of corporate than other hospitals¹⁹¹⁻¹⁹⁴ (and possibly also not-for-profit hospitals in Germany¹⁹⁵).

In *Public Firms* a residual public service ethos favours public accountability but in practice it does not so readily extend to policy failures, influence or patronage that policy-makers would rather not publicise,¹⁹⁶ nor to what whistle-blowers sometimes reveal.¹⁹⁷ Bidding to commissioners can motivate public firms to exaggerate their costs, hence inflate prices.⁴⁴ Information asymmetries that impede informed consumer choice are also likely to be lower in *social enterprises* and *voluntary organisations*, especially if they are client-controlled⁶⁸; and in *co-operatives*, especially consumer cooperatives such as Group Health which employ their own health-workers.⁶⁷

3.r. Costs and responsiveness to commissioners

Among the aims which commissioners pursue in mediating the relationship between provider and patient are health policy implementation, containing the costs of healthcare for the state, and adjusting providers' care processes as the local 'inner' environment changes. Many studies report associations between organisational type and provider behaviour regarding prices,^{101,198-201}

contractual flexibility (corporations and proprietaries being less flexible),^{38,202} and responsiveness to financial incentives.^{188,203}

Where DRGs (in England, HRGs) are used and commissioners have little discretion in whether or what to pay for work already done, providers of any ownership often just do the work and bill the commissioner irrespective of the commissioner's wishes.^{44,204} Then, corporate marketing characteristically addresses patients or GPs directly, by-passing the commissioner. In response, some publicly-owned hospitals (at least, in England, Germany and parts of Italy³⁸) agree with their commissioners an expected volume and mix of cases, with full DRG payment for the cases within that 'corridor', and decreasing (eventually zero) incremental payments for cases above or below those limits.

Any large provider with spare capacity can exploit economies of scale by offering commissioners services that it already provides in other market segments, in doing so spreading their fixed costs. Among for-profit providers, competition may even facilitate price-raising¹⁶⁸ (cp. also US study of dialysis (Cutler, private correspondence)). Some writers^{205,206} argue that organisations (corporations, proprietaries) which distribute profits to their owners therefore face stronger incentives than public sector organisations to reduce costs. However, if providers insist on their contract the gains from increased technical efficiency accrue to top managers and shareholders, not to commissioners as price reductions. NHS foundation trusts, however, have not done this, instead usually negotiating 'local variations' and other non-contractual payment adjustments at the end of each financial year.¹⁷⁹ In cooperatives and partnerships, it is the cooperators or partners who benefit from increases in technical efficiencies, insofar as the efficiencies are neither a cause nor consequence of price or output changes that reduce the co-operative's income.

3.s. Outcomes for patients: experience and choice

Healthcare quality can be conceptualised, in terms of patients' rather than providers' needs²⁰⁷, as comprising outcomes (positive effects on functioning and pain), safety (no avoidable negative effects) and satisfaction (emotional and attitudinal effects). Patient choice of services is an aspect of the latter, insofar as it enables the patient to obtain the services best fitted to her preferences about what ends clinical care serves and the impacts of care upon her daily life. Providers under different ownership differ in their use of 'exit' rather than 'voice'²⁰⁸ mechanisms for discovering and responding to patients' demands, but to complicate matters commissioning through competitive tendering relies upon 'voice', commissioning through a patient choice system more upon 'exit'.

3.t. *Quality and safety*

The effect of profit-seeking on aspects of service quality that are not contracted for, or invisible to external monitoring, may also be adverse.²⁰⁵ North American studies report associations between organisational type (hence ownership) and provider behaviour regarding some clinical outcomes (small differences²⁰⁹, sometimes none²¹⁰), and quality.^{101,211} Garg²¹² found that patients treated in American not-for-profit hospitals were more likely to receive transplantation, and their mortality rate was lower, than in for-profit hospitals. French for-profit hospitals were less likely to have someone on the pre-emptive registration list for renal transplantation than (public) university hospitals were, although pre-emptive transplantation is associated with a longer survival.²¹³ In France the risk associated with re-vascularisation (a standardised uncomplicated treatment) is higher in for-profit than public hospitals.²¹⁴ Publicly owned and not-for-profit substance abuse treatment organizations provided a richer array of services for their (US) patients, including HIV testing and other medical care, than for-profit ones.^{215–217} Despite serving often sicker, poorer populations US community health centres perform as well or better than private practice primary care on ambulatory care measures.^{218–220}

3.u. *Experience of care*

NHS patients rated some non-clinical aspects of care quality higher in ISTCs than in NHS hospitals, others lower (mostly small differences).³⁷ Similar total scores for quality across different provider types masked differences in which aspects of quality each type of provider managed better.²²¹ Outcomes for cataract extraction, inguinal hernia repair, hip replacement, knee replacement and varicose vein surgery appear similar in Treatment Centres and NHS hospitals.^{153,222} German patients perceived non-profit hospitals as more trustworthy but less competent than for-profits.²²³ In primary medical care, providers holding APMS contracts performed significantly worse than PMS/GMS practices on 13 of 17 quality indicators (including all measures of clinical quality) during 2008-13, and worse on two additional quality indicators in at least three of those five years; but better than other practices in terms of percentage of patients satisfied with opening hours and the percentage who were prescribed low-cost statins.²²⁴ This pattern was found among newly-entered providers (likelier to be proprietary or corporate) not among existing providers (likely to be professional partnerships) which had changed to an APMS contract.²²⁴ Treating patients with multiple chronic conditions effectively often requires combining the work of different providers into a coherent ‘integrated’ sequence. In practice, corporate providers appear less prone to cooperate across organisational boundaries than do other types of provider.^{27,225} Patients’ referrals even between NHS providers are often problematic, and those between providers under different ownership likely to be more so.⁵⁰

3.v. Choice

‘Consumerist’ policies require that patients choose their healthcare providers on instrumental grounds (access, waiting times, location, quality, provider's reputation etc.). Corporations and proprietary providers are accustomed and adapted to this standard market mechanism. However consumerist assumptions face two main empirical challenges. The affective aspects of choice (e.g. relational continuity with a preferred individual professional) co-exist with, indeed often outweigh, instrumental choice.²²⁶ Also the standard micro-economic view of instrumental choice has itself been criticised as empirically unrealistic because it assumes impossible cognitive skills²²⁷ or impossibly perfect information.²²⁸

3.w. Voice

‘Voice’ methods²²⁹ make user representation in decision-making or advisory bodies providers’ mechanism for discovering and responding to users' demands, especially in public providers, social enterprises, voluntary organisations, complex care pathways involving multiple organisations, and professional partnerships. These organisations have relied upon:

1. Patient and public involvement (PPI) in decision-making bodies. In NHS Foundation Trusts, those local residents who volunteer to be public members elect governors, who then elect the majority of the trust board. Nevertheless, getting uniform patient participation in the governance and in making the FT accountable to them has proved difficult in practice.²³⁰
2. Representation of user’ views through consumer research, typically routine surveys. Such surveys often tend to focus on non-clinical aspects of quality (e.g. food, room, waiting times, staff behaviour)⁴², and patient satisfaction, although PROMs are an exception.
3. Subscriber (i.e. patients) elect the governing body members of social health insurers (as in Germany) consumer cooperatives, some of which (e.g. Group Health in the USA²³¹) own and directly manage the healthcare providers which their patients use.

Chapter 4. Methods

4.a. Design

Since policy interventions are beyond researchers' control an observational study was the strongest feasible research design for answering the research questions in Chapter 1. To understand how the different managerial regimes inside the 'black box' of the private or public provider influence organisations' behaviour required theory-driven qualitative methods.²³² The theories we used were the organisational theory and transaction cost economics^{233,234} mentioned in Chapter 3. To assess how generalisable the findings were required more quantitative methods. We therefore used a mixed methods comparison of different organisational types of providers combining:

1. Systematic comparison of organisational case studies describing how providers under different ownership managed innovation and responded to NHS commissioners, and (Work Package 1).
2. Comparative qualitative study of patient experiences and choice (Work Package 2).
3. Contextualising quantitative analysis of routine administrative data and of geographical data, to assess how typical, of their kind the case-study organisations were (Work Package 3).

Table 1 shows how each method contributed to answering each research question.

Table 1: Research questions, methods, data, analyses

Research Question		Method	Data Sources	Analysis
How do differently owned providers of NHS-funded services vary in respect of their responses to:	Innovation and use of freedoms to innovate (RQ1)?	Organisational case studies	Interviews: managerial and policy documents; media rapportage; <i>ad hoc</i> supplementary enquiries; published studies.	Systematic comparison through framework analysis; induction; test and revise initial explanatory framework (Chapter 3).
	NHS commissioners, regarding service design, foci of interactions, changed requirements, national policies, transparency and information (RQ2)?		Interviews: observation of commissioning meetings; managerial and policy documents; <i>ad hoc</i> supplementary enquiries; published studies.	
	Patients' experience of services, choice of provider (RQ3)?	Qualitative analysis of patients' reported experience	Focus groups, interviews.	
What implications for commissioning and managerial practice (RQ4)?		Deduction and inference from answers to RQs 1-3.	Findings for RQs 1-3.	Logical analysis.

Our underlying methodology was realist.²³⁵ We regarded different forms of provider ownership as being alternative mechanisms for promoting the types of innovations and responsiveness to NHS commissioners and patients mentioned in Chapter 1. In Chapter 3 we formulated initial theories about these mechanisms. The findings chapters below then compared these theories with our new evidence, revising and refining the theory as the evidence dictated. This falsificationist^{236,237} approach built reflexivity into the study by making us look for errors in the theories which we initially brought to our new data. In that way we could arrive at a more strongly evidence-based account of how and why differences in provider ownership produced differences in the policy outcomes of interest.

4.b. Systematic comparison of organisational case studies

To reveal and explain any connections between provider ownership and differences in the relevant policy outcomes (innovation, responsiveness to commissioners, patient experience), we systematically compared case studies of differently-owned providers in terms of the theories in Chapter 3. Each 'case' (unit of analysis) was one type of provider, by ownership, for a given care group (CHS, OOH or hospital, as explained below).

4.b.i. *Sampling*

To compare the different types of provider ownership, we assembled a qualitative sample of case-study sites, each of which instantiated at least one type of ownership. In the English NHS different types of provider ownership are concentrated in specific services and therefore care groups. Chapter 5 gives fuller details but in summary the patterns during the study period were:

1. Corporate: planned hospital care, especially orthopaedics, ophthalmology, gynaecology, cosmetic surgery, treatment centres, community health services.
2. Proprietary: small, often consultant-owned, private hospitals; single-handed general practices.
3. Partnership: general medical and dental practices; some OOH services.
4. Co-operative (producer co-operative): OOH services

5. Not-For-Profit providers focused on similar care groups to the corporations. Charitable voluntary providers focused more on specialised community services, mental health services.
6. Public firms (NHS trusts): CHS; large, acute general hospitals; ambulance. UK-style social enterprises (variant): CHS.

We decided not to include hybrid organisations but concentrate on ‘purer’ forms of ownership.

Coverage of the range of provider types therefore required a sample crossing the above range of services and care groups, but to enhance comparability containing as few different care groups as possible. As focal services we therefore selected:

1. Community health services
2. Out-of-hours primary care.
3. A secondary care speciality. Orthopaedics was the obvious choice but since it had already been studied we added ophthalmology.

The sample was qualitatively representative in that taken together, the study sites instantiated all main forms of provider ownership found in the English NHS. Because these services have high proportions of older patients with complex or multiple health conditions, we made that our focal care group.

For each focal service we made a purposive sample of CCGs that jointly yielded a maximum-variety sample of provider types by ownership. Where possible we selected from those CCGs ones where we could co-locate more than one case study, i.e. having more than one type of provider for a given service, so as to help us abstract from differences between local health system contexts when it came to comparing providers. Since NHS providers were found everywhere, we initially selected study sites by the availability of non-NHS providers beginning with the least common types. A first step was therefore to find which non-NHS providers existed and where. As official data were scarce at the time, we used two methods:

1. We extended and updated our existing (2013) database³⁸ on NHS commissioning, from which we selected CCGs having low supply side concentration and high spending on private providers.
2. To identify NHS-funded but non NHS-owned providers we manually searched:

- (a) The NHS Choices list of NHS providers at <http://www.nhs.uk/service directories/pages/caretrustlisting.aspx#TrD> However at the time we sampled (February 2015) this list did not include the many mental health or acute trusts which (also) provided community health services.
- (b) The NHS Partners' Network (NHSPN)
- (c) Urgent Health UK
- (d) The National Audit Office (2014) report Out of Hours GP Services in England
- (e) Our contacts with national organisations (e.g. NHS Confederation) and providers.
- (f) Rapportage in the national media (BBC, Times, Guardian, Economist) and professional press (Health Services Journal, Pulse etc.)

From these sources we assembled one spreadsheet each for hospitals, CHS and OOH services, listing all the NHS-funded but not NHS-owned providers that we found. We categorised each such provider into one of the ownership categories listed in Chapter 2 and identified which CCG(s) they provided services for. When there was a choice we selected larger rather than smaller non-NHS providers in order to study those making the largest contributions to their local health economy. That method yielded the following sampling frames for non-NHS providers.

For planned ophthalmic services we ranked UK private hospitals by the number of NHS-funded in-patient cases in 2011-12 (the latest data then available). Ten private hospitals had over 1000 such cases. To select the currently largest providers we combined the totals for hospitals which at the time of sampling, i.e. early 2015, were under the same ownership (though not necessarily so in 2011-12). Applying the same method to orthopaedics yielded a list of 38 private hospitals with at least 1000 NHS-funded cases. Ramsay, Spire and Care UK also owned treatment centres, as did seven other smaller corporations. We found no proprietary acute hospitals working under NHS contract (as opposed to taking privately-funded patients), nor any hospitals operated by cooperatives, partnerships or social enterprises.

Community health service case numbers were not available so as an indicator of provider size we instead used the number of sites (CCGs) in which they held NHS contracts. On that basis there were, early in 2015, four corporate providers with multiple NHS contracts, a number of (then) single-site CHS providers (e.g. Serco, Nestor) and what appeared to be AQP contract holders for services such as diagnostics and certain therapies (e.g. Connect Physiotherapy, In-health). We found 13 social enterprises (all community interest companies) providing CHS. All but one, a referral

screening centre which we excluded from the sample, were former NHS Trusts and therefore similar in scope and size. There were then four CHS providers owned either by a general practice, a group of general practices, or a group of individual GPs. Although there were many voluntary providers of community health services working without NHS contracts and many voluntary organisations providing NHS mental health services under contract, we could find no voluntary organisation which at that time held an NHS contract for CHS.

Social enterprise, NHS and general practice OOH services were all widely distributed, so again we first selected a corporate study site then added providers under other forms of ownership, using so far as possible the same criteria and methods as above. Approximately ten percent of general practices reportedly still remained responsible for their out-of-hours services (<http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/priorities/out-of-hours-care/background>) but these typically discharged the responsibility by sub-contracting another provider (e.g. deputising service or one of the large OOH providers). Despite CQC's assistance in searching for one, we therefore found no partnership general practices that provided their own OOH services independently. The lack of a central database made local networks were the only way of identifying general practices that did so, a method that was not practicable for us to extent beyond our main case-study areas. Although they had changed their legal status, some former cooperatives retained their original ownership and structure after becoming nominally 'social enterprises' or 'not-for-profit' organisations. Lastly we selected where possible the main NHS trust providing the same services for the same CCG as the non-NHS provider(s).

4.b.ii. The resulting sample

Negotiating research access was the most constraining, slow and laborious stage of sample selection, especially for NHS hospital trusts but also because of the constant flux of non-NHS providers moving in and out of markets, and changing ownership. During these negotiations one sampled provider lost its NHS contract and another failed to win won the one that it had been confident of gaining. Another selected provider lost part of its NHS contract. A by-product of these sampling methods was a profile of the diversity of provision of NHS funded services in February-March 2015 (Chapter 5).

Table 2 shows the eventually resulting sample of sites from which we were able to obtain data.

Table 2: Study sites sample with case study (CS) numbers.

	Hospital Orthopaedics	Hospital Ophthalmology	Community Health Services	GP Out-of-Hours
Corporate	CS1: Corporation A, (ISTC)	CS2: Corporation A, (ISTC)	CS3: Corporation B	CS4: Corporation A
Proprietary	[One hospital, no access]		X	CS8: Proprietary D*
Public	CS13: Foundation Trust E		CS15: Foundation Trust F	CS16: Ambulance Foundation Trust G:
Co-operative	X	X	X	CS20: Co-operative H*
Social Enterprise	X	X	CS23: Social Enterprise I	CS24: Social Enterprise J
Not-for-profit	CS 9	CS 10	X	X
	Not-for-profit chain C			
	CS25: Voluntary hospital K	X		
Professional Partnership	X	X	CS31: Partnership L	X

* Changed ownership type during study period: see text.

In theory the presence of eight forms of ownership and four focal services implied 32 (= 4x8) possible combinations of service * ownership, hence 32 case studies if we studied each one separately. However not all 32 combinations existed in England. (This incidentally shows the value of consulting also the secondary research on other health systems, some of which reports the characteristics of service * ownership combinations which do not at present exist in England.) Grey cells marked 'X' in table 2 indicate those that did not. Also, some of the existing ownership-service combinations were rare. We could find only one proprietary hospital providing NHS-funded

ophthalmic and orthopaedic services and it did not have the capacity to grant us research access. The free-standing voluntary hospital provided mainly orthopaedics services, adding ophthalmology only late in the fieldwork period. One of the not-for-profit chain hospitals also provided only orthopaedics services. Much NHS-funded secondary care supplied by non-NHS providers is given at ISTCs, which we therefore counted as ‘hospital’ care even though it is given on a day-case basis (which however NHS trust hospitals also do). Our intended proprietary case-study OOH provider converted to corporate ownership before fieldwork started. We nevertheless still included it because it had changed from co-operative to proprietary to corporate ownership under the same CEO, giving interesting contrasts of ownership whilst holding constant the setting, main activities and some of its senior managers. These changes were recent enough for informants to describe the organisation under its previous ownerships. Similarly, the OOH cooperative to which we had access had converted to a limited liability, not-for-profit company before fieldwork started. However its board was still elected by its GP subscribers who were also the majority of its working members, so despite changing its legal personality it remained essentially a cooperative. The social enterprise OOH provider had retained cooperative ownership and structure despite changing its legal personality. In studying these cases we focused on the form, hence period, of ownership required to give range required for our sample. Our sample thus covered all the forms of provider ownership then contracted to NHS commissioners, and all the relevant service * ownership combinations except for a proprietary hospital.

4.b.iii. Cases and sites

Sampling where differently-owned providers which served the same local health economies (LHE) gave us fewer study sites than case studies (Table 3).

Table 3: Case studies and Local Health Economies

Case Study	Local Health Economy
Corporate Hospital Orthopaedics & Ophthalmology (CS1)	LHE A
Corporate Hospital Orthopaedics & Ophthalmology (CS2)	
Public Firm Hospital Orthopaedics & Ophthalmology (CS13)	
Public Firm Community Health Services (CS15)	

Social Enterprise GP out-of-hours (CS24)	
Not-for-profit Hospital Orthopaedics (CS9)	LHE B
Partnership Community Health Services (CS31)	
Social Enterprise Community Health Services (CS23)	
Voluntary Hospital Orthopaedics (CS25)	LHE C
Corporate Community Health Services (CS3)	
Corporate GP Out-of-Hours (CS4)	
Not-for-profit Hospital Orthopaedics & Ophthalmology (CS10)	LHE D
Public Firm GP Out-of-Hours (CS16)	LHE E
Co-operative GP Out-of-hours (CS20)	LHE F
Ex-Proprietary GP Out-of-hours (CS8)	LHE G

4.b.iv. Data collection

For each case-study organisation we identified informants by snowballing from a key informant. The choice of informants reflected the study design, discussions with the key informant, and practical considerations such as availability for interview. Our managerial respondents typically included (variously named) hospital directors or chief executives, medical directors, operations managers, finance managers, quality and performance managers, service managers and business development or marketing managers together with clinical leads in our tracer services, lead nurses or matrons and contract managers. Certain further informants had organisation-specific roles such as directors of transformation or integrated care, or patient engagement manager. Our commissioning respondents varied from senior commissioning or programme officers to contract managers, and included a GP clinical lead, finance manager and director of quality and safety. Most were CCG officers but some were from a CSU.

For the qualitative parts of the research we assembled the data summarised in *Table 4*. We used a semi-structured interview schedule (Appendix 1) as an omnibus questionnaire, selecting at interview any points that we particularly wanted to probe in light of what data we already had, any ambiguities or contradictions in our data so far, and where possible to check for (hence correct) any justification bias when informants described another (e.g. competing) organisation. Guarding against that, we included informants' accounts of how other organisations worked provided that the informant was speaking from recent first-hand clinical, managerial or patient experience, and not otherwise. Taking the key informants' advice as to which managerial documents were seminal to our research questions, we obtained those documents and content-analysed them. We observed provider-commissioner meetings.

Table 4: Data collected

	Interviews	Other material
Organisational case studies	83	212 documents, 226 media reports
Commissioning meetings		15 Observations (27 hours)
Patients	89	5 focus groups (38 participants), 5 individual patients/representatives (one further LHE)
Contextualisation data	N/A	HES, OPCS
Secondary data	N/A	283 published papers, 34 research reports

The meetings included contract review meetings, clinical quality review meetings and combined quality and performance meetings (sometimes more than one per provider). In two cases (one CCG) no meetings were observed but a senior contract manager was interviewed instead. With the interviewees' consent, interviews were audio-recorded and transcribed. We pseudonymised the data throughout.

4.b.v. Analysis

As noted, each 'case' (unit of analysis) was one type of provider (by ownership) for a given service (CHS, OOH or hospital speciality). We collated and triangulated all the data obtained from the

sources listed in table 4 into a case-study for each organisation. These studies were used, firstly, to populate a framework analysis^{238,239} whose categories reflected our initial analytic framework (hence previous research: Chapter 3) and our research questions (Chapter 1). The framework analysis was conceptually equivalent to a tabulation in which each row was a type of provider ownership and each column one of these categories. This method exposed where data were missing, ambiguous or seemingly contradictory, prompting further data collection and exposed any disconfirming evidence and counter-explanations for the theories in Chapter 3. It enabled us to incorporate multiple perspectives²⁴⁰ and corroborate assertions, a necessary precaution with such politically-contested subject-matter. When different pieces of evidence appeared contradictory, we sought further evidence or interpretation from our informants to resolve the contradiction.

Soon after data collection began, pairs of the researchers separately coded the same data to check whether our coding frames were usable and comprehensive. The researchers reconciled initial coding differences by the standard method of making explicit their respective different rationales for their initial coding, and then formulating supplementary coding criteria to remove the initial ambiguities. These discussions most often concerned the types of ownership and governance structure. The initial divergences largely reflected the team members' different disciplines, hence different conceptual repertoires and vocabularies. These discussions had two main outcomes. In some cases the researchers decided upon explicit definitions (see Chapter 3) of terms such as 'corporate' to make explicit what this report does, and does not, mean by them. Other discussions yielded a more refined understanding of the data, for instance about the distinctions between legal personality and ownership, and between nominal and beneficial ownership.

Data which did not fit into the framework were coded and separately analysed inductively to expose themes relevant to our research questions but which the researchers had not foreseen. Such data from our first fieldwork LHE were trial coded transcripts, coding criteria agreed where the coders had initially coded differently, then summarised code by code into new themes which we used, where necessary, to supplement, refine and re-define our original analytic framework. Thus extended, the framework analysis showed the extent and loci of variation in provider behaviour in practice, and the constraints upon that variation and became raw material for the final, synthetic stage of analysis (see below).

4.c. Studies of patient experience

Molineuvo et al.⁴² report the difficulty (across countries) in obtaining internal administrative data about quality from private hospitals. Not expecting to be able to obtain on request any such data which were commercially confidential or sensitive for other reasons, we therefore collected data on

patient experiences directly from patients themselves and secondarily from published sources. We interviewed, and ran focus groups of, patients who within the last three months (to reduce recall bias) had used the focal services. This work thus included patient and public involvement as a research method (involving patients in refining research questions, providing data, advising the researchers) and a policy outcome (whether commissioning decisions have become more democratically accountable). Because we wanted to trace the effect of ownership, hence organisational structure, upon management, working practices and innovation, and then upon patients themselves, we conducted this work in the same LHEs, and with the same providers and services as the organisational case studies. We also used the same methods as for the organisational case studies except for the following details.

4.c.i. Sampling

Formal sampling calculations are not relevant to this type of qualitative research. Rather, we interviewed patients until data saturation. Ideally we would have identified patients by file-sampling providers' patient lists but few providers could accommodate that and so as a fall-back we asked each case-study provider to approach 30 patients who had all the following characteristics:

1. Had used our tracer service within the last three months;
2. Aged 65 or over;
3. Not receiving terminal care;
4. Not cognitively impaired;
5. Located within a defined geographical area (to be agreed with the organisation).

We aimed at a sample of 5-10 patients per case-study LHE. Patients' response rates to requests for interview were generally low. It was harder to recruit patients who had used OOH services than those who had used, say, hospital orthopaedics because of the limited contact and anonymity that typifies OOH services, and because these services are more marginal to most patients' experience. We collected patient data in all the organisational case-study organisations but two. One not-for-profit hospital and the professional partnership that provided CHS said they were also willing to draw a patient sample for us and received the study documentation, but after more than six months of chasing up and with the end of the study approaching we had still not received any responses from their patients and had to abandon collecting patient data there.

4.c.ii. *Data Collection*

Within each case-study LHE we used two methods to obtain data on patients' qualitative experiences of differently-owned healthcare providers.

4.c.iii. *Focus Groups*

To identify which aspects of choice are important to patients and any sensitivities likely to arise in researching them, we first held focus groups of patients and representatives of patient organisations, exploring through them which aspects of service provision patients would like to have choices about; whether they actually had those choices; and how different organisations consulted and/or involved patient organisations in decision-making. Because of the ways in which CCGs and other organisations tend to organise their PPI and similar activities we conducted focus groups by LHE (rather than by provider). The means of accessing users and their organisations, varied by LHE.

1. For our largest study LHE (LHE A) comprised two STPs. In one we consulted the county and two city Health Watch organisations, speaking variously to their volunteer officer, community development officer, community engagement officer and diverse communities' officer. Together these informants covered the two (corporate) treatment centres, two NHS trusts (one hospital, one CHS), and a social enterprise providing OOH primary medical services. In the second STP, the location of our NHS Trust OOH case study, we conducted a patient focus group. This group was organised by the Chair of the county 50+ group and drew on members from a number of local forums, including many with formal representational links to health providers or local government.
2. In our other main study LHE (LHE B) our access was facilitated by the U3A.
3. At LHE G, location of the ex-proprietary OOH provider, we arranged access to patients via one of the local senior councils. This focus group was held in a local sheltered housing complex. It also included people with local, regional and national representative roles.

Elsewhere, coverage was not universal but:

4. In LHE C the group was hosted by a village information centre and social action project (which supported people on a short term basis by e.g. driving for health appointments and hospital visiting) and who recruited participants from amongst their volunteers and users.

5. In LHE D the community engagement/volunteer coordinator from the city's Healthwatch recruited participants (including some pensioner's champions) and attended herself.

With participants' consent we audio-recorded and transcribed the focus group meetings.

Where possible we also attended meetings of the patient forums set up by the providers where we conducted organisational fieldwork: specifically, an expert patient's group chaired by the Hospital Director at one of the corporate hospitals, an established service user and carer strategic forum run by a social enterprise CHS provider in LHE B, and a patient, carer and voluntary sector forum run by the former proprietary OOH provider in LHE G. Since patient forums are not focus groups we had to attend as observers. The forums did however provide an alternative view of patients' preferences with patients acting as advocates, raising issues that mattered to them rather than ones suggested by us. Patients did however raise issues about choice spontaneously in the forum meetings. Accessing these bodies was one way of reducing the constraint of research participation fatigue on the part of patient organisations, which often seemed to be short-staffed and inundated with consultation requests.

In the event our sample contained 89 individual patients interviews and 6 focus groups. The patients' mean age was 74, 90% were white British and 61% female. The youngest group was those receiving elective hospital orthopaedics and ophthalmology, the oldest those receiving community health services. All patients interviewed from the not-for profit providers received elective treatment as inpatients (mostly knee and hip replacements), that at two corporate ISTCs as elective outpatients. In contrast many patients interviewed from the NHS Trust had either entered it as urgent or emergency cases (e.g. following a fall or fracture) or for planned specialist treatment (e.g. corneal graft). An additional advantage of concentrating the research in two main areas was that patients were often able to reflect on choice and experience associated with other case-study organisations locally too.

4.c.iv. Patient Interviews

Patient interviews also used a semi-structured schedule (Appendix 2) which in part reformulated relevant parts of the WHO World Health Survey 2002 rotation B – Individual Questionnaire (<http://www.who.int/healthinfo/survey/instruments/en/>), [whslongindividuals.pdf](#)), Q7100 as open questions. Like other studies²⁴¹ we found that patients' recall was often partial. Patients often called upon partners, and paper records if available, to substantiate their experience. Many interviews for this study were conducted with a partner not only present but actively aiding recall. Their help was an important factor shaping these patients' navigation of the health system.

4.c.v. Initial Analysis

We analysed focus participants' responses by induction from focus group transcripts, pooling data across focus groups on the assumption that patients' preferences about choice in a given service are independent of provider ownership. We summarised the contents of each transcript as a list of themes about what choices patients said they were offered, about which aspects of care, their experiences of choice-making, its consequences and their preferences. We then combined these lists of themes into a single summary for each case study. As with the organisational case studies, we carried direct quotations forward (increasingly selectively) at each step.

To combine these patient data and compare them systematically across provider types, we extended the framework analysis used to analyse the organisational data and reported above. To it we added further (virtual) columns, each corresponding to a theme derived from the focus groups and patient interviews. As for the organisation study, we collated into this framework what data we could, this time using the thematic summaries described above. As before, data which did not fit into it were coded and separately analysed inductively to summarise the response-patterns not foreseen by the researchers. Again, these methods enabled us to incorporate multiple perspectives²⁴⁰ but since patients' experiences, attitudes and preferences may be expected to differ, we did not treat such differences as contradictions somehow to be resolved, but simply noted and reported any that did occur.

4.d. Contextualising the case studies

4.d.i. Design

The contextualisation work-package (WP3) aimed to assess whether the case-study LHEs had any particular characteristics which might prevent generalisation from findings about them, i.e. any environmental factors likely to moderate in atypical ways the structure-process-outcome relationships described in Chapter 3.

An important environmental characteristic was provider competition, whose character differed in competitive-bidding and in patient-choice structures. The case-study CHS and OHS providers operated in a competitive-bidding environment, where competitive pressures exist only at the time of bidding or re-bidding. For providers in patient choice structures, the geographical dispersion of providers, might through its implications for travel times confound the extent to which choice of provider is practicable for patients.

Our focal secondary care services operated within patient-choice structures. We therefore report first the contextualising factors that applied to all three focal services (CHS, OOH, hospitals), then additional contextual factors that applied only to the hospitals. We compared each case-study LHE with others in England in terms of:

1. Population size. This constrains the scope for provider development, cost containment, innovation, and for the presence of diverse providers themselves.
2. Population Deprivation. Local differences in population age-sex mix, in particular deprivation²⁴² may give rise to differences in population healthcare burden on providers. To measure deprivation latter we used the mean Index of Multiple Deprivation (IMD) score for 2014/15 for the population served (CCG populations for the non-hospital services, population within 30 minutes drive time for secondary care services).
3. As a proxy for organisational complexity, understood in terms of the extent of the referral networks²⁴³ and inter-organisational care coordination that a provider is involved with, we compared the number of CCGs (for hospitals) or general practices (for CHS and OOH providers) that each provider was involved with.

Appendix 3 gives fuller details.

For the case-study hospitals, a patient-choice quasi-market, additional possible moderating (confounding) factors were:

1. Whether other hospitals (of any ownership) exist in the locality, hence the possibility of contestation or competition (see above) between, say, publicly-owned hospitals. We therefore compared our case-study hospitals in terms of their local (30-minute drive-time) market share, number of other non-NHS providers for the same care group, and Hirschman-Herfindahl Index (HHI)²⁴⁴, a standard measure of market concentration.
2. As a proxy for the likely presence of private payers we again used IMD scores, on the assumption that the less deprived a population is, the greater the proportion of it that has health insurance or can pay out-of-pocket.
3. How geographically dispersed their patients were, measured by drive time, which might constrain a hospital's scope for innovation (e.g. use of day-case treatments).

4. How likely individual patients were to be able to travel to an alternative (competing) hospital.
5. Mean age of patients, on the assumption that older patients tend to require more intensive treatment which again might constrain a hospital's scope for adopting such innovations as day-case treatment.

Again, appendix 3 gives fuller details.

4.d.ii. Data collection

For hospital services we obtained the latest HES data available (i.e. 2014-15) for the HRG, ICD10 and OPCS Classification of Interventions and Procedures (OPCS-4) categories corresponding to our focus on orthopaedics and ophthalmology. Our orthopaedic record-level dataset comprised elective admissions (admmeth=11,12 or 13) for any provider with an ICD10 diagnosis code M00-M99 or Q65-Q79 or a OPCS-4 procedure code O06-10, O17-O19, O21-O27, O29, O32, V01-V68, W01-W99 or X19-X27. We extracted subset datasets relating to hip and knee arthroplasties (replacements) with OPCS-4 codes as defined by the *National Joint Registry* (OPCS Codes relevant to procedures recorded on the NJR, Version 4, November 2016, <http://bit.ly/2tfHwlo>). Our ophthalmic record-level dataset comprised elective admissions for any provider with an ICD10 diagnosis code H00-H59 or Q10-Q15 or a OPCS-4 procedure code C00-C90. We extracted a subset dataset for cataract operations with OPCS-4 codes C71-75 or C77. HES data include information on the Lower Super Output Area (LSOA) of patients' residence, allowing us to calculate individual patient travel times, using OpenStreetMap routing data (Project OSRM; <https://github.com/Project-OSRM>). The OpenStreetMap data also allowed us to define catchment areas in terms of a 30-minute travel time to each provider. Linking LSOA data to IMD2015 and 2011 census data then allowed us to profile the characteristics of the patients attending each provider and the characteristics of each provider's local catchment population.

Announcements in 2014 notwithstanding, equivalent data were not available for CHS and OOH providers. The monitoring of OOH service provision seemed somewhat haphazard during the study period, having apparently been tendered out in 2006 and OOH providers are not obliged to report to the organisation that let the tender. For OOH and CHS providers, therefore, we could not detail the characteristics of the recipients of services, but their effective catchment areas could be defined in terms of CCGs, Local Authorities (LAs), Middle Layer Super Output Areas (MSOAs), LSOAs and, for OOH providers in particular, their constituent General Practices. Linking the geographic data to IMD2015 and 2011 census data allowed us to describe the characteristics of each provider's

catchment area, whilst linking GPs with Quality and Outcomes Framework (QOF) data allowed us to describe the health status of each provider's catchment population in terms of the prevalence of Coronary Heart Disease (CHD), hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and cancer.

4.d.iii. Data analysis

We therefore made a cross-sectional comparison describing a range of 2011 Census characteristics (demography, National Statistics Socio-economic Classification (NS-SeC), general health status, ethnicity and tenure) and the IMD2015 profile (and population-weighted mean) for each provider catchment population and, for HO&O providers only, characteristics of each provider's patient cohort for

1. all elective orthopaedic procedures,
2. all elective ophthalmic procedures,
3. elective hip arthroplasties (using National Joint Registry OPCS Codes relevant to primary hip procedures; <http://bit.ly/2tfHwlo>),
4. elective knee arthroplasties (using National Joint Registry OPCS Codes relevant to primary knee procedures; <http://bit.ly/2tfHwlo>), and
5. elective cataract operations (OPCS-4: C71-75 & C77).

The 2011 Census and IMD2015 characteristics of provider populations are compared to national averages, and those of the orthopaedics and ophthalmic patient cohorts with those for all providers of the relevant procedures. In addition we compared the QOF prevalence of a range of conditions (CHD, hypertension, diabetes, COPD and cancer) for GPs served by the case-study OOH and CHS providers against prevalence rates for all GPs in England. We also compared the number of CCGs commissioning each case-study hospital, and its case mix in terms of social deprivation, showing whether that provided served a greater proportion of residents from the less-deprived localities surrounding than other nearby providers did, or than the averages for England as a whole. Once again appendix 3 gives fuller details.

4.e. Synthesising the findings

4.e.i. *Provider ownership profiles*

By collating findings from the organisational and patient experience work-packages we assembled a behavioural profile for each provider type i.e. an empirical summary of what behaviours appeared characteristic, according to our data, of foundation trusts, of corporate providers, social enterprises etc. Comparing these profiles shows the loci of variation in provider behaviour regarding the policy outcomes on which our research questions (Chapter 1) and initial explanatory schema (Chapter 3) focussed. Using the quantitative findings we considered the ways in which these profiles might reflect local contexts rather than provider ownership, so that if necessary we could qualify our findings accordingly. Within the limitations of the data available to us, these methods yielded an empirical ‘ideal type’, representing the typical characteristics²⁴⁵ and consequences of each type of provider ownership.

In presenting our findings (Chapters 5-10) we combine the (largely similar) findings for planned orthopaedics and planned ophthalmic services in each case-study organisation. We also combined our own fieldwork with secondary research findings.

4.e.ii. *Generalisability*

The methods reported above allow two ways of evaluating whether the case-study findings are generalisable. Qualitative generalisation assumes that the same kinds of organisational structures (ownership, management) and productive processes will, in similar settings, produce similar effects. In collecting and analysing the case-study data we therefore made a point of seeking any evidence that the study organisations were atypical:

1. Of organisations under that kind of ownership (i.e. was this particular corporation in any important ways atypical of other corporations?; and so on);
2. In their care processes (‘technologies’);
3. In their ‘inner’ local environment (e.g. any unusual characteristics of the local population or the set of providers serving it).

Following realist practice, we deliberately looked for any factors that might confound the relationships between ownership, management, care process, and policy outcomes for commissioners and patients, to take these into account when trying to form from our case studies an ideal-type profile of a corporate (or public, or cooperative ...etc.) provider. The more similar to the

rest of England were our study LHE environments and, for each case-study organisation, organisations under that kind of ownership, the more confident can we be that the study findings generalise across England.

The contextualisation study provided evaluated whether our study LHEs were atypical in quantifiable ways (e.g. size, case-mix, location, socio-economic setting) that might confound the relationships between ownership, management, care process, and policy outcomes for commissioners and patients.

4.f. Deriving practical implications

Findings from realist research standardly take the form of statements that doing X (for example commissioning voluntary organisations to provide services) under circumstances C (continuing the example, the voluntary organisations can recruit volunteers, patients are willing to use them etc.) will probably produce outcome Y (for the same example, introducing (say) new forms of hospice care). Without any loss or addition of content, such findings are easily reformulated as hypothetical imperatives: in this case, ‘If you wish to introduce (say) new forms of hospice care, then in settings which have sufficient volunteers and suitable patients, commissioning the relevant voluntary providers is likely to achieve that aim’. The imperative is ‘hypothetical’ because it applies *only if* one chooses the corresponding policy outcome. Whilst it states that the intervention in question (say, commissioning voluntary providers) is probably sufficient to achieve that outcome, it does not imply that the proposed intervention is the only, still less the best, way to do so. An evidence-based hypothetical imperative is also always corrigible by new evidence. With those provisos, the realist methodology used in this study can yield evidence-based practical implications.

4.g. Research governance

4.g.i. *Patient and public involvement*

Patient and public involvement in this study was relatively limited, focusing upon patients’ roles as key informants rather than as participants in the managements of the study. Within those limits, patient and public involvement in the research was achieved by three complementary means.

As explained above, we arranged focus groups to discover patient and carer views about: which aspects of service provision people would like to have choice about; whether they actually had those choices; how different organisations consulted or involved patient organisations in decision-

making; and whether there were any aspects of patient choice that they thought patients might be sensitive about discussing with the researchers. In this way patient and public involvement was used as: a research method (involving patients and their representatives in refining research questions, providing data and advising the researchers); as a source of research findings (about how choice operates and whether commissioning decisions have become more transparent and accountable) and as guide to analysis (informing our analytic framework).

In some of our case-study organisations we observed patient forums. This offered us the opportunity directly to observe patient-provider interaction, including some providers' responses to patients' concerns. It also gave patients (as with the focus groups) an opportunity to question us directly about the research.

As already described, we interviewed patient in the same LHEs, providers and services as the organisational case studies. This enabled us to trace the effects working practices and innovation, hence those of ownership, organisational structure, and management, upon patients themselves. We again focused on patients aged 65 and over who had recently used the particular tracer service under study in each provider. Once the case-study organisation had sent details of our research to patients who met our study criteria, interested patients dealt with us directly, with no further provider involvement. These interviews helped populate our analytic framework and suggested new emergent themes to supplement, refine and re-define our initial (Chapter 3) theories.

Throughout we met the participants' costs of participation (e.g. travel costs etc.) and paid them an honorarium. Focus group participants and interviewees were both concerned to contribute to policy relevant research (hoping their experience could be useful) and keen to hear of our findings.

4.g.ii. Equality and diversity

One aspect of the research was to examine whether different providers of different ownership tend to gravitate towards different kinds of population catchment areas. Specifically, we were interested in whether corporate and not-for-profit providers tended to concentrate near wealthier populations, hence whether the supposed benefits (if in fact found) for NHS patients of using these providers were more accessible to those than to other populations. We also compared the CCGs commissioning each case-study organisation in terms of social deprivation, showing whether that provider served a greater proportion of residents from the less-deprived localities surrounding than other nearby providers did, or than the averages for England as a whole. Results of this work are in Chapter 11 section (a)iii and Appendix 3.

4.g.iii. Ethics

The NHS REC system approved the study (reference 10/H0206/71), subject to informant anonymity and obtaining research governance approval from each NHS organisation involved, which we did. University of Plymouth ethical approval was obtained for non-NHS sites. In compliance with the ethical approvals all informants and study sites are pseudonymised in the following Chapters, including (for consistency) those who waived their right to anonymity. We obtained permission (reference DARS-NIC-15504-X5K0H) to access the relevant HES admissions and case-mix data for our case-study organisations.

Chapter 5. ‘Outer’ environment: the diverse provider landscape

- An increasing share of NHS spending has been on non-NHS providers
- The largest increase has been in community health services, partly due to NHS trusts converting to social enterprises
- The non-NHS provider side of the quasi-market has been very unstable with many entrants, exits, mergers and take-overs
- There has been a trend towards more corporate and financialised ownership

Policy-makers have wished to see competition between more diverse providers in the NHS quasi-market (Chapter 2). An important feature of each provider’s environment was therefore which other providers existed or were likely to enter or leave it. We therefore used the methods reported in Chapter 4 to find which non-NHS providers existed and where. Because of the confidentiality which sometimes surrounds the ownership of non-NHS providers and changes in it, because not all such changes are publicly reported, and because those which are reported are not always easy to find, this chapter probably errs towards under-reporting such matters.

Overall some £10 billion of the total NHS budget of £113 billion was spent on non-NHS providers in 2013-14.⁴⁸ During and immediately before the study period the population of non-NHS owned organisations, other than professional partnership general practices, providing NHS-funded services was complex and constantly changing. For our focal services the main patterns were as follows.

5.a. The scale and nature of diverse provision

5.a.i. *Hospitals*

Non-NHS hospitals continue (as since the 1990s) to concentrate on planned acute treatments in a few specialities (orthopaedics, ophthalmology, gynaecology, general surgery⁸⁸; cosmetic surgery, termination of pregnancy). Private (mostly corporate) hospitals now do some 20% of NHS-funded hip and knee replacements.²⁴⁶ NHS commissioners also contract private providers *ad hoc*, often for rather marginal services.⁴⁴ Proprietary hospitals play a trifling role compared with the corporate chains (not the case in the 1980s). Against this, some, but not all, former ISTCs have closed or been absorbed into the NHS, at least two for quality and safety reasons.^{83,247} We found only one voluntary hospital of comparable size to a corporate hospital, and no hospitals owned by social enterprises, cooperatives or professional partnerships.

For orthopaedics we found in early 2015 that 38 private hospitals had taken at least 1000 NHS-funded cases in 2011-21 (the latest data then available). Grouped by owner and in descending order of caseload they were:

1. Care UK: 8 hospitals, 25466 cases.
2. Ramsay: 14 hospitals, 25072 cases.
3. Spire: 4 hospitals, 6203 cases.
4. BMI: 4 hospitals, 4711 cases.
5. Horder Healthcare: 1 hospital, 4613 cases.
6. Nuffield: 3 hospitals, 4515 cases.
7. Nations Healthcare: 1 hospital, 2091 cases.
8. Circle: 1 hospital, 1391 cases.
9. Aspen: 1 hospital, 1097 cases.
10. Spencer Private Hospitals, 1007 cases.

Similarly for ophthalmology in early 2015, nine corporate hospitals had over 1000 NHS-funded in-patient cases. Again grouped by owner they were:

1. Care UK (including UK Specialist Hospitals, which Care UK took over in 2013): 6 hospitals, 10,221 cases.
2. Ramsay: 2 hospitals, 2617 cases.
3. One Nuffield Health hospital had 1105 cases.

NHS commissioners also contracted private providers *ad hoc*, often for rather marginal services.⁴⁴ Nuffield's not-for-profit hospitals – that largest group of that kind - had an annual turnover of £767 million in 2015²⁴⁸ compared with £117,229 million for the English NHS.²⁴⁹

Conversely, in 2014-15 NHS trusts obtained a mean of 1.2% of their income from private patients (mostly small private patients units) but around ten tertiary care trusts, mostly in London,

considerably more²⁵⁰, the highest being 22% (<https://nhsprivate.wordpress.com/>, 19th January 2016). Some NHS Trusts have created a charity to own and operate services for private patients, others a separate company limited by guarantee. Either way, one reported effect (<https://nhsprivate.wordpress.com/> 19th January 2016) was to circumvent the requirements for reporting in the Trust's 'Section 44 Declaration' and therefore the limit on, non-NHS income. The largest took 2230 NHS-funded in-patient orthopaedic cases in 2011-12, making it the third-largest commercial provider of such work. Pressure on NHS funding apparently made such activity more financially attractive to NHS Trusts. Collaborations between NHS trusts and corporations have also been established, a recent (early 2017) example being for the Hospital Corporation of America (HCA) to lease four floors of a new cancer unit at Guy's and St Thomas' Foundation Trust.²⁵¹ The Christie Hospital in Manchester also has a joint venture with HCA.

5.a.ii. Community health services

Community health services have recently had the fastest increase and widest variety of non-NHS providers. An estimated 31% of the £9.7bn NHS funding of CHS in England in 2012-13 was paid to non-NHS providers²⁵² although much of this went to former NHS trusts that had converted to social enterprises.⁴⁸ By 2016, 47% of contracts by value went to non-NHS providers, i.e. 'private firms' (a category which in that study²⁵³ lumps together several different, but not all, types of 'private' ownership), general practices, not-for-profit organisations, voluntary organisations ('charities') and 'others' (in that study an enormous category containing local authorities, social enterprises and other community interest companies).²⁵³ However the 'private providers' mostly had small contracts: a 39% share by number but only 5% of the total by value.²⁵³ Re-ablement services continued to be obtained mostly from non-NHS providers, as did around 20% of mental health services.⁷⁰ Local authorities provided around 5% of NHS-funded mental health services. The main corporate providers were Care UK, Primecare (Nestor), Nationwide, BUPA and especially Virgin, which during the study period gained a number of multi-million pound contracts. We also found four CHS providers, besides our CS31, whose owners included GPs. Nevertheless there remained activities with almost no corporate or proprietary providers, in particular the Vanguard projects. (An American ACO is involved in one vanguard scheme, a high-street pharmacy in one other.²⁵⁴)

5.a.iii. Our-of-hours primary medical care

Since 2004 many OOH cooperatives have converted to social enterprises (e.g. Community Interest Company) which, Urgent Health UK claims, now deliver care to nearly 50 per cent of the

population, although as shown below this change is often more one of legal status than a substantive change in organisational structure, *de facto* ownership and control. In particular, some pre-2004 cooperatives remain operational, having changed in legal personality but not in ownership or control. Others have de-mutualised and become larger as a result of competitive tendering pressures.⁶¹ About 48% of OOH care is provided by ‘commercial’ (i.e. neither NHS nor social enterprise) providers²⁵⁵, above all Care UK and Virgin. The NHS Direct helpline is being outsourced to private bidders.³⁰ There remain a few large and growing proprietary primary care providers (e.g. AT Medics²⁵⁶), and Virgin has also been taking over general practices.²⁵⁷ Nearly all the ‘limited companies’ providing primary care have APMS contracts, and in 2012 they represented about 45% of APMS contractors.²⁵⁸ A counter-tendency has been an increasing proportion (over 24%) of GPs leaving partnership status in favour of employment by foundation trusts (e.g. through a subsidiary²⁵⁹), GP federations or the new models of care noted in Chapter 2.

5.b. Patterns and trends

5.b.i. *Entrants*

The foregoing suggests three main patterns of entrant to the NHS quasi-market:

1. Marginal-income-seekers, established healthcare providers already privately financed (e.g. by insurers, out-of-pocket payers, donors) but wishing to supplement their income with NHS contracts.
2. Incoming bidders from outside the health sector who saw opportunities for diversification as NHS contracting was opened up. These included non-health corporations such as Virgin and bidders from overseas health systems as United Health Group (which later renamed its European operations ‘United Health Europe’). Across England, general practice support services were outsourced to Capita in 2015.
3. Policy-inspired independent providers of NHS-funded services, whether created from scratch (e.g. the Independent Sector Treatment Centres, later renamed just as ‘Treatment Centres’) or NHS trusts ‘spun off’ as ‘social enterprises’.

Correspondingly the contribution which NHS funding made to these providers’ income varied widely from almost 100% (ISTCs, competitively-tendered services such as Virgin CHS) to a small marginal contribution.

Many voluntary providers were serving CHS care groups (Dementia, Alzheimers, Autism, in past years HIV-AIDS, hospices) who in the voluntary providers' view the NHS had either under-served or offered unsuitable services. Most media mentions of charitable providers were related to specific projects rather than broad-spectrum service provision. They were usually very local and often initiative-specific. Age UK was widely active e.g. in Northampton and Brighton, in Cornwall is part of the Integrated Care Pioneer, and as a joint-bidder in Vanguard projects.²⁵⁴

5.b.ii. Exits

In 2014 Serco announced its withdrawal from the NHS contracts after making multimillion pound losses. Peninsula CIC (a social enterprise) withdrew from CHS because it could not provide the demanded services within the price offered. Similarly, corporate primary care providers such as The Practice and Vida have handed back unprofitable contracts.^{260,261} Circle relinquished its management-only contract for Hinchbrook Hospital in 2015 because it had been unable to make the savings promised.²⁶² Southern Cross went out of business in 2011, due to having sold the leases on its care homes to external landlords. NHS Direct collapsed in at least three counties. Some corporations withdrew from CHS bids once the financial or other implications became apparent. BUPA did not take up an musculoskeletal services (MSK) contract it won in West Sussex because 'we cannot deliver the model we proposed without either compromising on the quality of care or destabilising other services' (referring to the local NHS hospital trust).²⁶³ Capita and Circle among others initially expressed an interest in bidding for CHS services in Cambridgeshire and Peterborough but withdrew because of 'the steep financial efficiencies required'. For reasons which they have not stated publicly Ramsay withdrew from building a private hospital jointly with an NHS trust in Cambridge.²⁶⁴

CCGs' use of Any Qualified Provider contracts also appears to have stagnated since 2013 at about 130 registered providers, usually small to medium sized firms and proprietors.²⁶⁵ Median contract size was £318,000, and contracts were predominantly for 'marginal' services such as audiology, non-obstetric ultrasound, podiatry, MRI scans, eye care, and back and neck pain. By 2014 only a minority of CCGs appeared to have any plans to extend the scheme.²⁶⁶

5.b.iii. Market behaviour

Chapter 3 cited studies (mostly American) examining whether corporations are liable to 'skim' and 'dump' patients in order to have a profitable case-mix. We found only a few such reports about UK

hospitals. In an earlier period, BUPA was alleged²⁶⁷ to have offered some categories of cancer, cardiology and gynaecology patients a cash payment to seek treatment at NHS rather than BUPA hospitals. At the time of writing (early 2017) the Competition Commission was seeking fresh evidence and submissions for a report which described benefits and incentive schemes which private hospital operators allegedly provided to referring clinicians. There has also been a growth of private screening services, with the apparent effect of raising demand for NHS general practice services²⁶⁸, and reportedly²⁶⁹ of small private hospitals registering patients with GPs rather than using consultants.

Occasional instances of 'hard-ball' competitive behaviour have been reported. Both corporate providers and NHS trusts initiated court cases respectively to compel²⁷⁰ or forbid²⁷¹ CCGs to consider bids from corporate providers. In primary medical care 'bad behaviour' could happen between competitors

'especially where they were based in the same building. In Site 1 there were allegations by APPCs that other practices had removed signage and misdirected patients. In Site 2 there were suggestions that staff at a minor injuries service which shared premises with an APPC practice had deliberately misdirected patients away from the APPC.' (62, p.6).

Doctors' everyday work-practices within the APMS contractors did not appear to differ much from those in traditional professional-partnerships in terms of the division of clinical labour and focus on meeting QOF targets.⁶² Since about two-thirds of the cost of healthcare is labour, reducing the use of expensive labour i.e. that of clinicians, especially doctors, is therefore the remaining way of reducing costs (hence extracting profits) once the price of a contract is determined. This may explain the pattern of low staffing levels in some corporate and proprietary providers, of which Serco's out-of-hours service in Cornwall was the most publicised example.^{118,174} Similar accusations have been made about Capita²⁷² (but also about some NHS providers).

5.b.iv. Financialisation

Non-NHS hospitals had two main forms of ownership. Equity partnerships ('venture capitalists') own at least the majority of Circle, Aspen, Care UK (c.20% of which is owned by 'managers and staff', but mostly by three managers), Allied Health Care (owned by Acromas, which in turn is co-owned by private equity firms Charterhouse, CVC and Permira) and Spire (owned by Cinven). Private equity firms also have (together) a large minority (49.9%) shareholding in the General Healthcare Group (GHG: owners of BMI). Stock market listed providers include Care UK, BMI (originally part of American Medical International but now owned by GHG, itself majority owned

by Netcare RSA), HCA (UK branch of Hospital Corporation of America), Ramsay Healthcare (UK branch of Australian Ramsay Health Care Australia), Serco PLC (1987 management buyout from Radio Corporation of America) and Clinicentre Ltd. (owned by Carillion). HCA is a private company (owned neither by an equity company nor with publicly traded shares).

We found a tendency for corporate providers to divide themselves into an operating and a property company. In 2013 Cinven sold then leased back Spire's hospitals. Circle and BMI are both so divided. BMI consists of BMI OpCo and GHG PropCo. GHG Propco then consists of GHG Propco 1 and GHG Propco 2. Circle consists of two companies: Circle Partnership as operating company and Circle Holdings as a financial company, to which Circle Partnership pays 7% interest on loans for capital, including working capital. Health Properties, a Jersey company, finances further hospital acquisitions. Circle and BMI take high-interest loans from companies owned by their parent companies. Insofar as interest on these loans pushes the provider company into a nett loss, it can receive tax credits on account of that loss. Debts are also secured against the property companies. Southern Cross had also in effect separated its property holdings from its remaining role as essentially an operating company. These arrangements have been conceptualised^{120,273} as 'financialised' organisational structures.

5.b.v. Churn and concentration

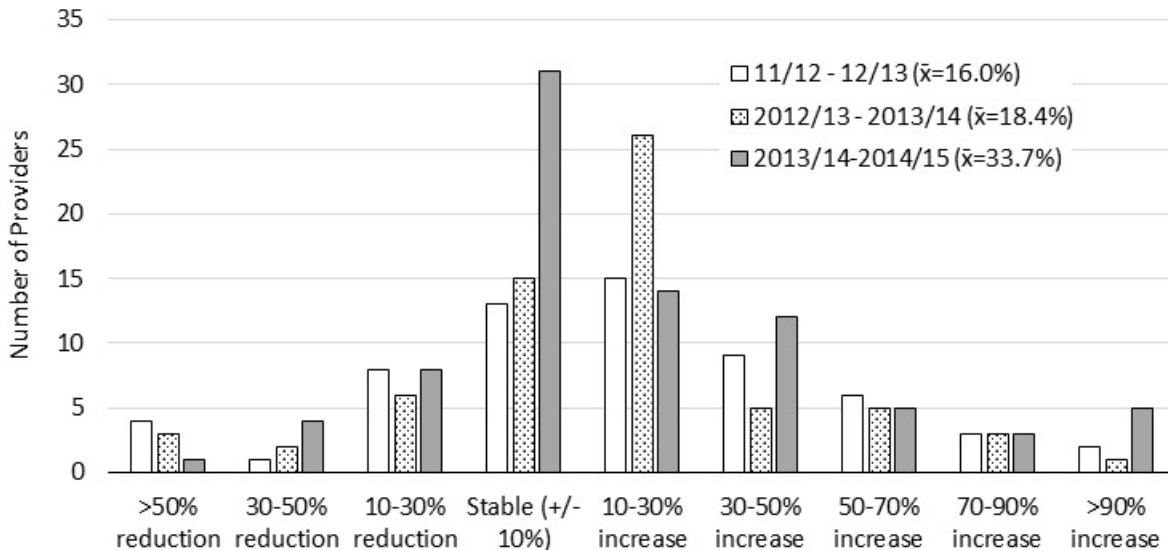
In combination, cost containment, provider exits and mergers had four effects: 'churn' in non-NHS provision; concentration of ownership; de-concentration of hospital services; and corporatisation.

In the hospital sector, provider 'churn' had two main elements:

1. Instability in what non-NHS provision NHS commissioners purchased;
- and
2. Reduction of the range of hospital ownership.

The first was numerically more important. Changes at the volume of NHS-funded work at particular hospitals had larger consequences for the overall number of NHS-funded episodes at independent hospitals than changes in ownership did. Overall, the number of NHS episodes being undertaken by independent providers rose sharply: 16.0% year-on-year between 2011/12 and 2012/13, 18.4% between 2012/13 and 2013/14, and a still more spectacular 33.7% between 2013/14 and 2014/15. But not all providers increased their NHS-funded caseload. Many were either stable or declined, as figure 1 illustrates.

Figure 1: Instability of NHS-funded case-load for non-NHS secondary care providers



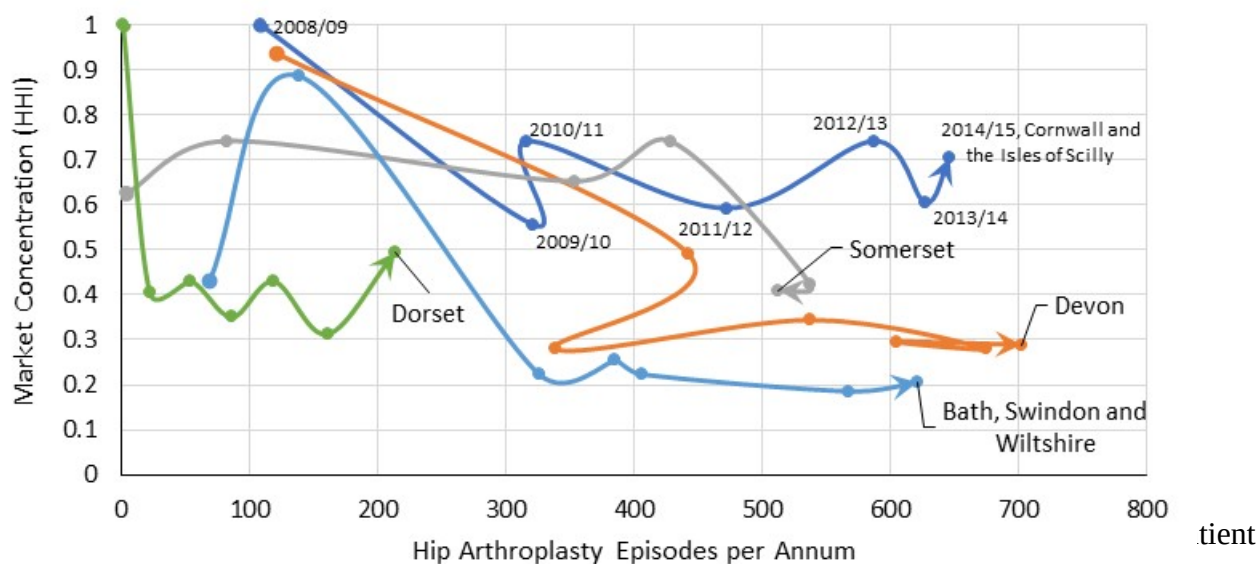
‘Churn’ in non-NHS provider ownership continued before and during the study period. Care UK formed in 1982 (under another name), acquiring between then and 2015 at least six other service providers before being bought by a private equity group. Aspen Healthcare was a management buyout from Paracelsus Kliniken Deutschland GmbH, then merged with Welsh, Carson, Anderson and Stowe, a venture capital firm. BMI acquired three Abbey Hospitals in 2010. Ramsay acquired Capio UK and its hospitals, day surgery providers and two neurological rehabilitation homes (2007). Cinven acquired BUPA Hospitals (2007), and subsequently others, to form Spire. Care UK subsequently bought out LiveHealthcare, a South African company running treatment centres, and the Mercury Health ISTCs. to form Spire. Outside our focal care groups, though still relevant to OOH services, and as further evidence of ownership ‘churn’, The Practice took GP surgeries from Chilvers McCrea and United Health Europe. Virgin acquired and re-named Assura Medical 2010, Care UK acquired Harmoni 2012 and a large number of care homes. Small numbers of professional partnership general practices have been taken over by NHS trusts, in effect nationalised. Besides the exits from the NHS quasi-market reported above, The Practice and Vida withdrew from a number of general practices. Circle relinquished its management-only contract for Hinchingsbroke Hospital in 2014. Southern Cross went out of business in 2011, due to having sold the leases on its care homes

to external landlords. NHS Direct collapsed in at least three counties. All four cases about NHS procurement and conduct that reached the Cooperation and Competition Panel during 2009-13 came from non-NHS organisations, as was one of the two complaints to Monitor about NHS commissioning during 2013-15.⁵³ Nuffield Health acquired 35 Virgin Active clubs in 2016. ‘Following Brait’s [an investment company] acquisition of a majority stake in the company, Virgin Active’s strategy has been built around a focus on operating and developing prime sites in metropolitan hubs in its key geographies.’ (<https://www.virginactive.com/latest-news/virgin-active-today-announces-the-sale-of-35-uk-clubs>, accessed 23rd April 2017). BUPA acquired the Oasis dental chain in 2016. Against the trend, small but growing numbers of professional partnership general practices have been taken over by NHS trusts, in effect nationalised.

The nett effect has been to concentrate ownership among non-NHS providers, of whom seven now take 88% of NHS-funding of non-NHS providers’ inpatient work.⁴⁶ Gershlick and Firth²⁵³ suggest that in 2016 there was little concentration among ‘private’ CHS providers (whom they define as excluding local authorities, social enterprises and general practices) because the former had (their figures imply) a mean of 2.6 contracts each. However the same data also suggest a strongly bi-modal distribution. Just 8% of ‘private’ CHS providers had NHS contracts worth over £1 million (compared with 32% of NHS providers) whilst 59% of private providers held NHS contracts whose combined worth for each of them was below £100,000, implying that the value of the biggest 8% exceeded that of the smallest 59%.

Whilst this concentration of ownership reduced NHS-funded patients’ choice of *supplier*, it did not in the hospital sector necessarily reduce their choice of *place of treatment*. In local health economies there was, over time, an increased number of provider sites, hence less geographical concentration of activity. A case in point (and a pattern replicated across the country) is in the south west where, using STP areas as proxy ‘health economy areas’, there was a notable reduction in market concentration scores (HHI) between 2008/09 and 2014/15 (at least with respect to hip arthroplasties). There were different – sometimes even erratic - patterns in different STP areas (as figure 2 illustrates) but the overall collapse in HHI scores is evident.

Figure 2: Non-NHS provision of NHS-funded hip arthroplasties in the South West, 2008
– 15: Scale and Market Concentration



5.b.vi. Corporatisation

There has been a limited corporatisation of non-corporate providers, but not the reverse. As the more expansive GP-owned companies (e.g. Chilvers McCrea Healthcare, DMC Healthcare, Medvivo) began winning NHS contracts outside their local area they became large – perhaps too large - for a proprietary structure. Medvivo was bought by a venture capital firm. GP support services (e.g. medical record transfers) were outsourced to Capita. Acromas, co-owned by private equity firms Charterhouse, CVC and Permira, took over Allied Healthcare, which itself took over the Sue Ryder charity's and Nestor Primecare's domiciliary care. Thamesdoc, originally a co-operative, was acquired by Harmoni, then Harmoni by Care UK. Once on the stock market, Care UK was acquired by Bridgepoint, a private equity group. With the concentration of ownership described above, these findings suggest a trend towards large, more 'financialised'¹²⁰ corporations absorbing, or through competitive bidding supplanting, providers under other forms of ownership. In 2014, corporations made up 59% of the private providers contracted to CCGs, and of those, 58% were backed or owned by a private equity firm.³⁹

5.c. Summary

The share of NHS spending on non-NHS providers grew consistently over the last five years. However, market entry by non-NHS providers has mainly been for services with low entry costs (day surgery, CHS and OOH) rather than complex in-patient care. Partly this change represents the conversion of some NHS trusts to social enterprises. There was considerable ‘churn’ among non-NHS providers, with two main elements:

1. In the hospital sector, unstable volumes and case-mix of non-NHS funded workloads.
2. In all sectors, a constant ‘churn’ of entries, exits, mergers, acquisitions and re-acquisitions among the non-NHS providers.

In CHS especially, a polarised market structure emerged with many small and a few large, dominant non-NHS suppliers. These findings suggest an empirical pattern that in an environment with mixed public and private payers, non-NHS providers tend to converge upon having larger, fewer, more predominantly corporate and financialised structures. Paradoxically, concentration (i.e. less diversity) of ownership occurred alongside de-concentration of local NHS quasi-markets for secondary care, in the sense of more non-NHS hospitals becoming available to NHS-funded patients. In themselves however those trends imply neither convergence nor divergence of working practices between non-NHS and NHS-owned providers.

Chapter 6. 'Inner' environments - constraining diversity away?

- Regulations and quality standards tended to encourage broadly convergent behaviour among differently-owned providers.
- NHS budget restriction limited the diversification of provider ownership, especially the expansion of corporate provision.
- Some but not all providers had substantial private besides NHS income.
- The same providers would often simultaneously collaborate in some respects and compete in others ('co-opetition').

An organisation's environment influences that organisation's behaviour, but the organisation's ownership determines which aspects of its 'environment' do so the most, as Chapter 3 discussed. Even when provider ownership is diverse, these environmental constraints may however so constrain diverse healthcare providers' behaviour as to produce convergent patterns of innovation, responsiveness to commissioners and patient experience. Conversely, diverse providers' behaviour may diverge partly because, in effect, they work within different quasi-market environments. We therefore start our findings by reporting on these points, for our case-study organisations.

Here and in subsequent chapters we present our findings thematically, combining the (in the event largely similar) findings for planned orthopaedics and planned ophthalmic services in each hospital. In labelling the direct quotes from informants, we use the first number to identify the case-study (CS), hence provider type - see Table 2, Chapter 4; the next letter identifies the type of informant (**M**anager, **C**ommissioner, **P**atient, **FP** Focus Groups Participant) and the following number the individual respondent.

6.a. Cost control and STPs

Restrictions on CCG budgets and falling HRG tariffs affected all the case-study organisations. The largest hospital in this study (NHS trust, CS13) had to deliver a £33 million 'Cost Improvement Programme':

'a very big drive ... through next year to break even, to get the extra cash that you need from the government.' (CS13/M47).

Similarly for HRG tariffs;

‘they introduced an over performance rate at 70%, so basically we’ve got to pay for everything at 70% over a [pre-defined] level [of activity]. Well, that level wasn’t the year before’s outturn, it was the year before’s plan.’ (CS13/M44).

The CHS Trust (CS15) had already seen its income reduced by 10% over the preceding five years. It had been predicted (National Health Executive 16th December 2015) that HRG tariff reductions would reduce the income of the (mainly corporate) private providers of orthopaedics services by 7% in 2016-17.

6.a.i. Cost control

Consequently the innovations that CCGs would fund tended to focus cost containment rather than expansion (see Chapter 8), tending to reduce differences in innovation between differently-owned providers. At one of the corporate hospitals (CS1) the introduction of a list of procedures of limited clinical value (PLCV, e.g. certain cataract extractions, certain physiotherapy, cosmetic surgery) reduced the range of activities. The partnership community health services (CHS) provider (CS31) said that financial difficulties made the CCG risk-averse and

‘not that outward looking’ (CS31/M55)

which restricted the commissioning of new kinds of services. Conversely, the commissioner for the NHS trust out-of-hours (OOH) service (CS16) was under less financial pressure than many others in its region which made a

‘big difference’ (CS16/M03),

allowing commissioners to look at things differently: moving beyond the commissioning of individual services to engaging with providers, partners and patients and trying to shape national policy. Rising indemnity costs hindered greater GP involvement in OOH services. However the OOH co-operative had during our fieldwork assumed responsibility for its members’ indemnity insurance. The ex-proprietary and corporate OOH providers were also exploring this option but so far offered it to their directly employed nurse practitioners and their one directly employed doctor, who explained

‘The big bonus for me is [corporation] do reimburse my indemnity, which is massive, it’s pretty much 20 grand a year that’s why a lot of doctors won’t do out of hours, it’s too expensive.’ (CS4/M60).

Cost control also reduced the scope for provider diversity. Lower profit opportunities drove away some corporate providers. The social enterprise (CS23) reported that the CCG had found that many providers which might have tendered for its CHS contract found the work unaffordable. Tight NHS budgets also limited this social enterprise's opportunities to collaborate with for-profit providers:

'when we talk to the private sector ... they come up with profit – it's not good enough to have a 10% profit. So that conversation soon stops and we talk to local Trusts and it's a bit like you [the trust] just want to run the services. So that conversation soon stops as well and it's a bit like tell us why, why would it improve the service?' (CS23/M35).

In two of our study LHEs, referral screening systems meant (CS9,25) that

'GPs can't refer directly in to see an orthopaedic surgeon, they refer directly into what's known as the MSK, musculoskeletal service, where there's a big physio and MDT input' (CS2/M19).

This filtering device delayed patients' access to secondary care generally, undermining the faster access to care which was traditionally corporate hospitals' main selling point in England.^{4,88}

6.a.ii. Sustainability and Transformation Partnerships

STPs aimed to address the quality and financial sustainability of general practice, NHS workforce, workload and hospital infrastructure. Their purpose was to find ways to reconfigure services using the new models of care and meet the cost-reduction 'challenges' mentioned in Chapter 2. NHS and non-NHS providers seemed to have different opportunities to participate in this type of inter-organisation planning.

Most of the STPs for our study LHEs listed their collaborating organisations, which were primarily NHS acute, CHS, mental health and ambulance trusts, CCGs and local authorities, including health and well-being boards. They also listed the organisations falling within the STP footprint and/or involved in delivering the STP. Only one of the non-NHS organisations we studied (the corporate CHS (CS3)) was listed as a collaborator, and only one (the social enterprise CHS (CS23)) as falling within the STP footprint. The latter STP had included some other non-NHS providers in its footprint but certainly not all since it omitted another of our study organisations (an NFP hospital (CS9)).

It appeared that NHS organisations mostly saw STPs as matter for NHS, not non-NHS, providers. In LHE1 the STP catalysed joint working among the larger providers i.e. NHS Trusts, but had tended to focus only on them:

‘What we need to do is make sure that the treatment centre is included in part of that [STP], which is probably something that we haven’t done to date’ (CS1/C10).

Elsewhere, the voluntary hospital’s operations director made contact with its local STP

‘but I think...the feedback I got was that they weren’t ready for us at this stage [laughs]’ (CS25/M53).

One of the corporate hospitals (CS2) saw in the STP an emerging alliance between two of the acute trusts and the two CHS providers (also NHS trusts) but suggested that all providers were needed at the table. Managers from the corporate CHS were also engaged with STPs but found it

‘really difficult going through a re-procurement process and [trying] to engage constructively in the STP’ (CS10/M39)

since for STP purposes they had to sit around the table with competitors with whom they didn’t want to share ideas. The corporate OOH provider also found participation difficult, but more because there were several CCGs whose boundaries did not coincide with this provider’s catchment area, which had different working practices, and seemed to desire both economies of scale and service localisation. However the recently ex-NHS social enterprises might be included:

‘So [provider] are interesting because they can’t, because they’re a community interest company, they cannot be part of the financial arrangements but they are very much around the table with everything else. But in [area] you’ve got [corporation] running children’s service and they’re outside. And then what do you do with all the little providers?’ (CS13/).

If diverse providers’ responses to STPs differed, that was at least partly because NHS commissioners themselves treated them differently. Non-NHS providers were sometimes willing to contribute to the local STP but neither they nor NHS commissioners clearly foresaw yet what non-NHS providers’ role, if any, was and the same applied to the proposed ‘accountable care’ organisations.

6.b. Quality and safety

6.b.i. *Common standards*

Common minimum service standards might be expected to make provider behaviour convergent, unless differently owned-providers attached different weights to these standards compared with other institutional logics.²⁷⁴

Minimum standards for entering the NHS quasi-market tended to reduce divergence between providers' service standards and reporting requirements. In order to join the extended choice network (c. 2007) the voluntary hospital had to

'get our computerised patient administration system to a level that it was acceptable to the NHS, so we could do choose and book' (CS25/M50),

which involved ISO 27001 (information security standard) certification and adopting the NHS information governance toolkit. This requirement applied to all hospitals. At the time of our fieldwork the new 2016/17 NHS Standard Contract was being introduced, but it was a framework contract that allowed some local discretion. One not-for-profit hospital (CS10) at least was re-negotiating the detailed terms with its local CCG. The new contract was for two years not one. It stipulated indicative caseload volumes (reducing flexibility) but also decreased the time spent on contract development.

Once a provider entered the NHS quasi-market, common standards also tend to reduce divergence by requiring certain common working practices irrespective of ownership. Together, informants at all our case studies confirmed that they were subject to at least the following standards, the exact selection varying by focal care group.

1. NICE guidelines e.g. on venous thromboembolism or pre-operative blood pressure. The case-study organisations, their parent organisations and sometimes also a cross-organisational task group altered managers to relevant guidelines. This codification reduced differences between case-study organisations. We found no evidence of differential prioritisation or trade-offs against other priorities. The voluntary hospital (CS25) informants said that its clinical governance policies and procedures were constantly adapting according to 'best practice' and NICE guidelines. In the corporate CHS each business unit's clinical lead (CS3/M43) ensured they adhered to NICE guidance.
2. Many managerial key performance indicators (KPI). Thus the social enterprise CHS (CS23) found itself having to generate demand for Improving Access to Psychological Therapies (IAPT) service in order to meet the uptake targets for that nationally-prioritised service

development. The social enterprise (CS24) and co-operative (CS20) OOH providers had, like all others, to report their National Quality Requirements (NQR: 'Carson standards') performance on triage time and appropriateness, although the introduction of NHS111 had made some of these standards in need of re-interpretation, if not redundant. All providers of NHS-funded joint replacements sent outcome data to the National Joint Registry. The focus for clinical governance in the voluntary hospital (CS25) was quite closely prescribed as it followed the National Patient Safety Agency (NPSA) templates, which NHS acute trusts also followed.

3. Documentation of certain managerial decisions was required in non-NHS as in NHS hospitals. In a not-for-profit hospital

'I think we've got in to, from a regulatory point of view, now everything has to be down, documented or they say it's never happened. So we're in that mode of where, you know, we have our own board meeting and we document and agree exactly what we want to be working on.' (CS10/M29).

4. CQC inspections reportedly played a significant part in governance for all providers. The OOH social enterprise (CS24) described CQC as its '*main regulator*'. CQC inspection methods for independent hospitals were still being finalised when we did our fieldwork. This had posed problems for our multi-site NFP provider (CS9) which, despite being involved in developing the guidance and inspection process, felt their inspection had been conducted within a framework that was still evolving. The same attention to the five key CQC questions was reported in both the for-profit (CS4) and not-for-profit (CS9) corporations. The largest NHS trust in this study (CS13) saw CQC inspections as burdensome and quite adversarial, and meant the Trust had thus often to respond to priorities set externally rather than their own strategic plans. This was felt to reduce their autonomy (despite being a Foundation Trust).
5. Health and Safety Executive reviews.
6. QOF requirements partly applied to all OOH providers (case studies 4,8,16,24).
7. In the corporate OOH provider (CS4) doctors' written work (referrals, prescribing) and calls were audited by clinical staff (based on Royal College of General Practitioners (RCGP) guidance) and the medical director and clinical leads checked whether the doctor's response had been appropriate;

‘there are clear guidelines on what a competent medical consultation entails, and so it’s very specified’ (CS4/M60).

Audits for the same purpose were also routine in the ex-proprietary, cooperative and social enterprise OOH services (case studies **8,20,24**).

A few outcomes standards were being applied to the not-for-profit and corporate providers as well as the NHS, above all PROMs, safety incident reporting, patient satisfaction data and the friends and family test. The national patient satisfaction standards were checked at all the OOH providers.

6.b.ii. Ownership-specific standards

Other policies and standards, however, applied differently to diverse providers:

1. The Safe Staffing requirements²⁷⁵ (introduced in the NHS response²⁷⁶ to the Francis²⁷⁷ report and requiring hospitals to publish staffing levels monthly) applied only to NHS providers. Both the corporate and the social enterprise CHS providers (case-studies **3,23**) had however also implemented these requirements locally and voluntarily as good practice.

2. NHS Providers reported their reference costs and surplus or loss to NHS Digital, non-NHS providers report profit or loss to Companies House. Social enterprises were subject to:

‘a community interest company regulator who’s very light touch and really I can’t imagine what you’d have to do to deserve their ire’ (CS23/M35).

3. Non-NHS providers, including social enterprises, were not accountable to NHS Improvement or NHSE. The NHS Mandate formally applied only to NHS-owned organisations:

‘we have to cope with what primarily is a statutory driven [...] sector – and so a lot of things that people have, don’t apply to us [social enterprise]’ (CS15/M35).

4. Data returns from NHS providers went to NHSE and NHS Digital, although some NHS providers were sceptical of their value:

‘NHSE give us all templates of what reports we should create [...] They’re not massively useful and the amount of reports and paperwork we create on a monthly basis is just

ridiculous and one of the things that we're all very keen on is as we move to an integrated hub that we have integrated reports. Why do we have three quality reports or three performance reports?' (CS16/M04).

Corporate hospitals and the Voluntary Hospital (CS25) returned data to PHIN. The CMA had told non-NHS providers that greater information should be made available to patients; a regulatory intervention tending to produce convergence in this respect.

5. CQUINs targets were applied, and incentivised for NHS trusts. National CQUINs for our tracer services included: improving staff health and well-being; reducing the impact of serious infection; supporting pro-active and safe discharge, personalised care and support planning, ambulance conveyance and NHS111 referrals. Compliance earned up to 2.5% of contract value. For the NHS hospital trust:

'A lot of our focus is largely trying to deliver the CQUINy bits, making sure we get paid properly for the performance' (13/M44).

Some of these national indicators were however barely applicable to some providers (typically smaller, non-NHS organisations). Instead the 2.5% was available for local CQUINs (<https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf>). For the voluntary hospital, for instance, the quality CQUINs had been suspended because the requirements of the Default Tariff Roll-over (DTR) tariff made CQUINs difficult to achieve and 'financially inexpedient' in the independent sector. Our voluntary hospital informants saw CQUINs' effect as minimal:

'one would think that CQUIN could have had a fantastic impact on outcomes, but I don't think they did really' (CS25/M49)

because (in their view) CQUIN was set as a lowest common denominator standard, not used to drive innovation. Those adopted by the corporate ISTCs were locally agreed and thus varied between LHEs.

6. NHS Providers were not liable for VAT on non-clinical services or corporation tax. Companies usually were, but some non-profit and voluntary providers registered as charities were exempt from corporation tax.

Some care standards were discretionary. The OOH social enterprise (CS24) for example had an additional suite of locally agreed KPIs, introduced with new contracts in 2013 and covering various measures concerning outcomes, referrals, unfilled shifts and frequent callers. Similarly, the ex-

proprietary provider had a suite of local KPIs, many about end-of-life care. They were hoping to extend these KPIs to include OOH services for children. As noted, the corporate and social enterprise CHS providers implemented the Safe Staffing requirements voluntarily.

Standard-setting thus presented a mixed picture, but despite instances of discretionary and of systematically different constraints for NHS and non-NHS owned providers, the stronger tendency appeared to be towards convergence.

6.c. Commissioning environment: implications for provider responsiveness

Chapter 9 reports how differently-owned providers responded to their NHS commissioners' demands. Here we focus on what external configurations of NHS commissioners and non-NHS payers the case-study providers faced, which had implication for their bargaining power and (as Chapter 6 explains) their patterns of innovation.

6.c.i. *Public commissioners*

For our case-study organisations two main characteristics of their commissioning environment were its heterogeneity and its instability.

Both the corporate hospitals were ISTC s, hence served NHS patients only. They were now paid by NHS tariff. The local CCGs commissioned the ones that we studied, although some elsewhere had entered the NHS quasi-market through the Any Qualified Provider (AQP) scheme. Unlike many of the other ISTCs, including the other one in this study, the case-study 1 ISTC received few referrals via choose and book: one informant said less than 15%, another 5%. The OOH cooperative (CS20) obtained roughly equal income from members' subscriptions and CCG contracts. Winter pressure monies supplemented that.

The entry and exit of non-NHS providers made the commissioning environment somewhat unstable and unpredictable for the remaining providers. When recently-entered providers (often corporate: see Chapter 5) relinquished an NHS contract, CCGs re-let these contracts requiring *ad-hoc* responses from the remaining providers (often NHS Trusts). Insofar as corporate providers, especially ISTCs (CS1,2) or the not-for-profit corporation (CS9) relied on providing a narrow range of operations, they were especially at risk from changes to national tariffs and the appearance of lists of PLCVs. Against this, competitive tendering involved periodic risks of losing contracts.

Both the corporate hospitals (case-studies 1,2) and the voluntary hospital did some capacity-relieving work for local NHS hospitals. At case-study 2 this had been done under the old contract by means of a ‘partial pathway transfers’ but that had ceased and the CSU were pushing for a sub-contract (which the NHS hospital trust (CS13) was resisting). In the voluntary hospital, its local NHS hospital trust referred NHS-funded patients to them, paid for that work at NHS tariff rates, then claimed the tariff payment from the relevant CCG(s).

‘So they are the trust’s patients, the trust outsource them to us, we invoice the trust, the trust pays us. But they then will invoice the CCG for that.’ (CS25/M53).

During the study period the introduction of the Better Care Funds introduced an element of joint commissioning between local authorities and CCGs. It was particularly mature in one of the cities in LHE A, where one of our NHS hospital trust informants attended Better Care Fund meetings as part of their responsibility for collaborative working. This was also an area where integrated commissioning existed more generally. None of this, however, had much impact on the corporate ISTC, suggesting again that they were rather marginal to NHS local health economy. It was however an income source for the ex-proprietary OOH provider (CS8) which was also undertaking much activity around the integration agenda.

6.c.ii. Private payers

To the extent that they depend on external financing, providers behave so as to meet their payers’ demands.²⁷⁸ Insofar as they all pursue the same sources of income, diverse providers’ behaviour towards commissioners might therefore be expected to converge. However a provider’s aims, hence its ownership, may instead lead it to prefer specific sources of income. Then, the more the balance of public and private income varies between providers under different ownership, the more divergent their behaviour will be. Among our hospital case-study organisations the balance between public and private income did indeed differ.

Both ISTCs (CS1,2) did all, and the voluntary hospital (CS25) did nearly all, their work for the NHS. At one not-for-profit hospital (CS9) orthopaedics and general surgery were the main components of its NHS-funded work. It had planned to obtain 21% of its income from the NHS., but when we did our fieldwork the actual proportion was about a third and it had recently been

‘much greater than it is now’ (CS9/M26)

At that higher level it had sometimes proved difficult for consultants to get a bed for their private patients, which our informants said damaged the hospital's reputation. At another hospital under the same ownership (CS10) about 20% of ophthalmic activity was NHS-funded, and even more orthopaedics was (no figure given). These were its two main areas of NHS work. To spread its risks in face of competition, the voluntary hospital (CS25) acquired a plastic surgery centre with entirely private patients.

The NFP hospitals (as opposed to treatment centres) therefore depended much more on private payers than NHS income. Managers at both emphasised they were independent providers and the NHS tariff did not pay well:

'You know, at the end of the day we are a private provider, we do want to ensure that we've got our PMI and we're capturing the bulk of the insured patients locally. We've also got a self-pay market that we want to ensure that we see growth there. So for us NHS is another, just as important, form of our activity, but we wouldn't want to see the hospital taken over with NHS patients because the margin is so tight.' (CS10/M29)

'we're not an NHS hospital, we offer it as an option and we have to be sensible with the fact that we've got private patients here as well' (CS9/M27).

Possibly the hospital would offer less capacity to the NHS, for

'then there's an opportunity to increase our private work which gives us a better margin, let's be honest about this' (CS9/M26).

One not-for-profit hospital (CS9) also offered private patients only clinical (ophthalmic) services (cataracts, laser eye surgery, cysts etc.) which were no longer available at this hospital on the NHS, and an enhanced recovery pathway (at no extra cost) using the provider's health gym.

Differently owned providers therefore displayed divergent behaviour when differences in ownership were reflected in a different balance between NHS and private payers. Where only NHS funding was available provider behaviour was more convergent. This finding suggests that the more a non-NHS provider depends on NHS income, the more its behaviour will converge upon that of NHS trusts ('public firms'); and that the more a public firm relies on private payers, the more its behaviour will converge on that of non-NHS providers; an implication relevant to some NHS trusts.

6.d. Co-opetition

In a given locality the same providers would often simultaneously collaborate in some respects and compete in others; so-called 'co-opetition'.²⁷⁹ The Social Enterprise CHS (CS23) for example saw the voluntary sector as affording both possible competitors and partners. GPs were also seen to be emerging as potential competitors as well as collaborators. Some NHS informants interpreted (or misinterpreted) the Five Year Forward View as implying a shift towards 'cooperation' and 'collaboration' and away from provider 'competition', equating the latter with more diverse ownership. Many however also perceived NHS Improvement (formerly Monitor) as taking a more pro-competitive view.

6.d.i. *Provider competition*

Our secondary care case-study organisations mainly competed *in* the patient choice part of the NHS quasi-market. Through tendering, the CHS and OOH providers competed *for* markets.

The NHS trust hospital (CS13) managers suggested that they were seen by some competitors as

'being fairly, you know, cut throat, carnivorous, if you like, wanting to grab everything to ourselves here' (CS13/M45).

They said this competitive culture was present at both commissioning (contracting) and clinical level, and in regard to private practice. In that city, we were told, all the local NHS hospital trusts, BMI, Care UK, Circle, Ramsey and Virgin had all bid when the planned orthopaedics work was re-tendered. In another city, the not-for-profit hospital (CS10) told us that the competitors for their work were independent providers such as BMI, Nuffield, Spire, and Ramsey

'And the NHS actually, we usually find that the NHS usually win the tenders' (CS10/M29).

The voluntary hospital (CS25) said that a bid for MSK contracts was

'the one and only time we've entered into anything jointly [with the local NHST]' (CS25/M50).

Previously they had sought orthopaedic work through the Any Willing Provider scheme. Local private hospitals such as Spire and Nuffield were considered competitors to a degree, and

'yeah we keep an eye on well is the NHS Trust sending NHS patients more there than they're sending here under 18 weeks' (CS25/M50).

Whilst both the NHS Trust (CS15) and the social enterprise CHS (CS23) thought that no local competitors could completely replace them (see below), matters were different for particular component services of theirs. The NHS Trust (CS15) knew that nearby ISTCs provided hospital-at-home services for surgical patients. Informants at the social enterprise CHS (CS23) saw scope for competition for specific pathways such as frail elder care, minor injury units or urgent care. The main potential competitors were two neighbouring NHS mental health trusts, the NHS hospital for some care pathways (e.g. acute stroke care, stroke rehabilitation) and a corporation for children's services. The corporate CHS (CS3) saw nearby NHS providers as its competitors:

'all of the acutes, for example, our neighbouring community providers, bordering community providers, any number, any number'(CS3/M39).

Even the voluntary sector were seen as potential competitors insofar as their care coordinator role at the emergent integrated care hub might lead them to find substitutes for clinicians (CS3/M40).

Both the ex-proprietary (CS8) and social enterprise (CS24) OOH providers saw corporations as their main competitors, competing largely on price. One corporation had won a tender by bidding £7.87 per call as against £7.90 for an allegedly higher quality service, but

'a lot of those organisations have withdrawn from the market now because there's not a profit to be made' (CS24/M01).

For some of the case-study organisations, both prospective competition and longer-standing local rivalries inhibited collaboration. Social enterprise CHS (CS23) informants perceived a risk that that other providers would suggest mental health services and probably children's services should be contracted to a specialist provider, a risk inhibiting collaboration. The OOH co-operative (CS20) was about to relinquish a contract for OOH services to a 'private competitor' (partly owned by GP members of the cooperative) because:

'we use that exact word, [Town's] GP practices are subsidising [Firm] and they won't like it if we announce that to them, which we haven't done. But we have a meeting with them on Monday, to see the CCG.' (CS20/M56).

6.d.ii. *Collaborating providers*

For some case-study organisations, provider competition was practically absent. Moreover they often positively collaborated with other providers, whether by establishing a division of labour between them, by one subcontracting the other, or in less formal ‘relational’ ways.

The CHS trust (CS15) had not had to tender to one CCG for a long while, and another CCG had expressly decided not to seek tenders

‘because they do not believe it adds significant value’ (CS15/M23)

By implication, the CCG did not think any gains were worth the transaction costs. They only let competitive tenders if providers were unable or unwilling to negotiate satisfactory arrangements with them. Both the physical and mental health contracts with the social enterprise CHS (CS23) had gone to tender rather than the preferred provider route. One respondent commented on the fact that CCG staff made threats such as

‘that service, we may put that out to tender, unless performance improves’

but this view was largely attributed to unhelpful individuals rather than the CCG officially.

‘We’re sensible enough to think well if there’s someone better to provide it then why are we doing it?’ (CS23/M35)

and

‘there are very few people able to compete with us because of the scope of what we do and how embedded we are locally, and with our social care colleagues’ (CS23/M34).

The social enterprise CHS (CS23) was trying to link their services (e.g. contraceptive and sexual health services) with those (respectively, genito-urinary medicine) in the NHS hospital trust, which meant entering

‘any sort of competitive tender together’ (CS23/M33).

NHS Trust OOH service (CS16) informants felt they had few if any local competitors

‘because we’re embedded because we have 111 and out of hours and the single point of access, I think it would be perceived as quite difficult to move us off’ (CS16/M04).

The OOH Co-operative (CS20) thought they were

‘in a much safer position than other out of hours organisations because we’re actually owned by our member practices’ (CS20/M56),

which removed the need to tender to a CCG every three or five years. The NHS trust’s OOH service (CS16) had not been re-tendered since 2004 with KPIs and other matters being re-negotiated annually, although recently the CCG made a contract variation to synchronise the NHS111 and OOH contracts so that both services could go out to one tender.

One study LHE (a city) lacked private hospital competition. The two private hospitals nearest to one of the not-for-profit hospitals (CS9) were over 50km away, and one of them belonged to the same organisation. The local NHS hospital had closed its private patient unit. Voluntary hospital (CS25) informants explained that for MSKP and the orthopaedic services

‘they [NHS trust] can do certain things that we can’t necessarily’ (CS25/M53:161),

Therefore,

‘We’re not aggressive with each other, we’re not actively you know, poaching each other’s customers in effect and in fact at times it’s the complete opposite. If a local trust is struggling to meet their 18 week target then they will contract with us to help them deliver it and so on those kind of things that is a collaborative arrangement’ (CS25/M50).

Both corporate ISTCs had minor illness units which helped support their respective NHS hospitals trusts’ A&E departments. Informants at that NHS trust (CS13) recognised but downplayed the contribution:

‘Early days I think it was very fraught, now I think it, sort of, works. If we take a trust view, I think, or more of a clinical trust view, is that they do all the simple stuff, all the difficult gets deferred to us and we’re still the dumping ground, which I think is true. And [I] think their threshold for more complex is fairly low’ (CS13/M45).

Their local ISTC (CS2) broadly endorsed this; it focused on providing ‘bread and butter elective care’ for relatively fit and well people. Consequently,

‘I [corporate hospital manager] don’t feel competitive in nature towards any of the other providers locally. I think we’re providing a slightly different service’ (CS2/M19).

As reported above, non-NHS providers were sometimes subcontracted to NHS Trusts and *vice-versa*, removing competition between them those services. At CS2 a remaining tension with the NHS trust was over how tariffs were decided and paid between them rather than about who provided what treatments, with the corporate hospital informants feeling that the NHS Trust should be rewarded for the complexity of its surgery. A GP-owned company had previously provided OOH services for most of the county where our social enterprise OOH provider (CS4) subsequently operated, but the GP-owned firm had done so by subcontracting the work to a large corporation. The latter then withdrew, reportedly

‘on the basis you couldn’t make a profit, or a big enough profit’ (CS24/M01).

The same corporation had also provided NHS111 services under sub-contract both to an NHS Trust, and OOH services to care homes under sub-contract to another corporation. According to its annual report the Social Enterprise OOH service (CS24) had also had until 2013 a

‘long and successful sub-contracting relationship’

with an NHS ambulance trust for call-handling services.

As for positive collaboration, not just non-competition, the CHS trust (CS15) was collaborating with a bordering corporate CHS provider whose treatment centre (for diagnostics services) was not being fully utilised, and still more with voluntary providers (Community Voluntary Services, Voluntary Action Group, Community First). A number of private partners from consulting firms, information and IT providers, and ‘private’ healthcare providers had also approached them to collaborate regarding the STP. Both the not-for-profit (CS9) and the corporate (CS1,2) hospitals saw themselves as taking pressure off the local NHS trust. These collaborations were at times informal, *ad hoc* and practical:

‘You have to be able to ring them [corporate provider] up and say, “Actually, the radiology system has gone off, and we’re desperate and you’ve got to do something.” And they’re going to go, “We’ll going to get out of bed and we’re going to sort it for you”’ (CS13/M46).

These relationships extended to pharmaceutical companies and a private company running the hospital at home service:

‘And actually it took us [NHS hospital] a while, I think, to realise, it took me a while (...), that actually even the people who ran those private sector services were good people. They were normally ex-NHS people who wanted to do partnership and integration.’ (CS13/M46).

Although this NHS trust’s (CS13) local environment was described as fraught by ‘history’ and ‘politics’ it still collaborated with another NHS hospital trust to provide a more stable service, and with the community trust (CS15) to support, for example, the frail elderly pathway.

The voluntary hospital also saw its not-for-profit charitable status as promoting a symbiotic relationship with local NHS trusts. The Corporate CHS (CS3) took a similar view for slightly different reasons, offering spare capacity to a nearby NHS hospital to alleviate escalating pressures there because

‘it’s about doing the right thing, it’s about being a good citizen within the health economy, doing the right thing for patients, but it’s also about reputation and being seen as an organisation that can do. Because that will always help us win the contract back’ (CS3/M39).

The voluntary hospital (CS25) knew that many NHS hospitals were struggling with their elective orthopaedics, which limited scope to train junior doctors, and so the voluntary provider offered to provide this training opportunity, which would also increase their operating theatre efficiency.

‘So from that perspective I see them as partners because, you know, we have to support each other to be able to deliver the service across the economy’ (CS25/M53).

6.e. Diverse providers and their environments

Stringent restrictions on NHS budgets tended to encourage broadly convergent behaviour regarding innovation. They also tended to limit ownership diversification among providers of NHS-funded services, especially the expansion of corporate provision. Insofar as safety, quality and reporting standards were common across diversely-owned providers they tended to produce convergent behaviour but this effect was mitigated insofar as not all standards were the same for diverse providers. Other conditions tending to produce convergent behaviour were the scale and composition of care groups for competitively tendered services (OOH, CHS).

Case-mix differences tended to produce divergent service development between NHS trusts and other hospitals, their selections of services and care groups reflecting the providers' aims and therefore ownership. To a limited extent, the emergence of STPs seemed to at least initially to expose (not 'cause') divergences between providers within and without the 'NHS family'. These differences reflected provider histories of inexperience at participation in NHS-style planning at health economy level, but that may in turn reflect different ownership insofar as such participation is barely relevant to the aims of the owners of corporations. Providers which relied on both privately- and NHS-funded patients diverged in behaviour from those which, irrespective of ownership, relied solely on NHS-funded payment because the former needed to preserve their income from, and therefore differentiate, their services for privately-funded patients.

That two providers operated in the same place did not necessarily mean that they faced the same environment in terms of case mix, care group size, substitute or competing providers. Providers were not just constrained by their environment, in particular their competitive environment, but also tried to re-shape it. This brings us to our findings about how these environment conditions related to diverse providers' organisational structures and work processes.

Chapter 7. Diverse structures

- Differently-owned providers had different top-level organisational structures and accountability chains.
- At workplace level the structures for coordinating everyday work were essentially similar (bureaucratic hierarchy) irrespective of ownership.
- A partial exception was that in doctor-owned organisations, the doctors self-organised their work in more-or-less democratic ways.
- Marketing was more developed in non-NHS providers.

Next we report how organisational structures differed by ownership. Because the same corporation owned case-study providers 1,2 and 4 we have combined our data about them to describe a single organisational structure. This also applies to case-study hospitals 9 and 10, both owned by the same not-for-profit organisation. In the event we found few structural differences between the ophthalmology and orthopaedics hospital services when they were in the same hospital, so we have also grouped our data about them together.

7.a. Ownership and aims

All the case-study organisations irrespective of ownership had a set of broad aims stating how their activity benefited patients and their staff. Additionally they had more specific objectives, stated by a variety of sources: by managers themselves, in managerial documents (e.g. annual reports), on websites and in other publicity materials. Where the case-study organisations differed by type of ownership was in what objectives they had, what these objectives covered, and the balance of emphasis between objectives.

7.a.i. *Common aims*

No healthcare provider is likely to deny that they aim to provide the best possible care for their patients. Every study organisation had somewhat rhetorical strategic ‘mission’ or ‘vision’ statements. The formulations differed slightly by focal service but were nevertheless similar irrespective of ownership. High quality, patient-focused care was one:

'Everything we do is about putting people first - whether that be delivering exceptional care and support for our clients, or providing growth and development opportunities for our teams' (corporate website, CS4)

The OOH social enterprise aimed to

'provide high quality, patient-focused service for the patients' (CS24) .

NHS hospital trust informants said for example that it aimed to

'work with our partners at the leading edge of healthcare' (CS13).

The 'partners' explicitly included patients. Besides helping maintain patient independence, the CHS trust stated it aimed to

'play a lead role in the development of an integrated health and social care system in [county]'(CS15).

Its detailed aims, as outlined in its Annual Plan, included the delivery of:

1. Safe Services
2. Improved clinical outcomes
3. Improved patient experience

Another permutation was for 'people to stay safe, well and at home', this example reflecting national imperatives in the 'vision' of the CHS social enterprise (CS23). The free-standing voluntary hospital had aims based on:

'clinical outcomes, our clinical experience and clinical excellence; patient advocacy, because patients like us and they want to come back.... So those are three pillars, if you like' (CS25/M53).

and the not-for-profit chain was (an informant said):

'a very, very people based organisation and it wants to do the right thing in the right way ... it's patient first, which is, yeah, things like the health MOT, the health recovery plus stuff is all added value bits because we care about the patient.' (CS9/M32).

7.a.ii. *Ownership-related objectives*

What differed was what further objectives were stated and where the emphasis lay. Evidence about the latter includes the patterns of ‘tight-loose’ control¹³³, that is which aspects of managerial performance were closely monitored, heavily incentivised and preoccupied managers in practice; and what was left to local discretion.

The corporation owning case-study organisations 1,2 and 4 described itself as a major international private equity group focused on investing in market-leading businesses, to realise ‘value’ in its portfolio companies. Each hospital director had a monthly business review by telephone with her line manager, covering:

‘quality, patient outcomes, patient experience, so you get the usual stuff around complaints and VTE, audits and all stuff, and watching outcomes on your orthopaedic, result scores on the national grids, and all of that stuff comes into it. And of course the numbers comes into it as well.’ (CS2/M18)

‘It’s very well policed, I can assure you’ (CS1/M06).

A hospital operations manager suggested that as long as financial targets were met there

‘was quite a lot of autonomy on sites to make investment’ (CS1/M07).

During re-tendering the finances were reviewed centrally to ensure the ISTC returned a profit, with a risk assessment in advance. In the corporate OOH services the service manager had set the budget himself with approval from the central finance team but also

‘we have shareholders and we need to make a profit, our service is scrutinised’ (CS4/M58)

There was no critical threshold and he had never been criticised for overspending provided it could be justified by patient care and appropriate staff deployment.

In the corporate CHS, its ex-NHS managers and staff described budget management as being more rigorous than in the NHS. The Head of Intermediate Care and Community Hospitals was accountable for delivering the required services within budget. The corporation had a clinical governance scorecard which went to the board (reporting for example infection control, serious incidents, safety and supervision). There was also a finance dashboard for each business unit.

'So I know I'm paying my staff, I'm buying equipment, I'm paying, you know, even down to my water coolers, you know, I'm maintaining and servicing my hoists and paying my estates, and everything is coming out of my budget. So I see the whole picture, if that makes sense' (CS3/M43).

Thus

'they are obsessed with budgets. They are obsessed with targets. And to be fair, they're also obsessed with client satisfaction' (CS3/M43).

Community hospital inpatient care was not expected to come in under budget but if surpluses were generated elsewhere they were to be reinvested in the service.

Since its proprietary days the objectives of the ex-proprietary OOH provider expressly included financial growth. Then, it had tried to win more contracts partly as a

'potentially commercial opportunity ... but also the ability to step outside, in those days, some of the red tape associated with the NHS' (CS8/M09).

They therefore diversified into telehealth and acquired a housing association careline. They also bid jointly, although unsuccessfully, with other companies and NHS trusts for additional service contracts. These expansionary efforts attracted an offer of buy-out from an American finance company. An informant thought that

'for a commercial organisation, we are not financially driven' (CS8/M10)

but was more sceptical about other 'independent' providers:

'having worked in the independent sector a lot say they are [patient-focussed], but in the basements of their buildings ... conversations I've had could lead you to conclude differently' (CS8/M10).

Being state-owned, NHS trusts' (CS13,15,16) overall objectives derived of course from the health policies outlined in Chapter 2. Accountability for pursuing them carried through to senior and middle managers there, with a high degree of central control, above all through commissioners (see Chapter 9). Far from financial expansion, the NHS trusts had objectives for financial contraction. Reducing spending was a – if not the – major, clearly-incentivised objective, especially in the hospital trust which faced a £33 million 'Cost Improvement Programme':

'there's clearly a very big drive, and I understand it, on saving money in terms of coming through next year to break even, to get the extra cash that you need from the government. You know, there's obviously the CQC priorities, and the front door work really, the capacity challenges, you're constantly on black and red alert, and the four hour waits and the [winter] pressures' (CS13/M47).

The hospital trust's objective was minimising losses rather than making a surplus (in any event unrealistic for most services in the circumstances):

'I'm not too concerned about profit necessarily [...] But as long as the organisation doesn't lose money, and we're providing a better service or an improved service, then that's got to be what we try and aim at' (CS13/M045).

For the NHS trust providing OOH services, the most recent financial reports (2014/15) showed an operating surplus of £0.2 million, less than projected. The CHS Trust (CS15) had to remedy the previous year's overspend of about £1.9 million. After the three quoted above, the remaining two aims in its Strategic Plan were:

4. Improve value for money, reduce costs
5. Establish new service models for sustainable health and social care

Its income had already been reduced by 10% over five years, but since demand for its services were meantime rising it still faced severe cost control pressures. Re-designing of services here had one extreme implication. Interviewees there expected the CHS Trust not to continue in its current 'monolithic' mode but to move towards:

'a sort of network of arm's length business units that sit within a wider structure'
(CS15/M23)

'our organisation won't exist, and our board is absolutely clear [FT name] will not exist in a two to three year timescale because there will be a new entity that delivers an integrated primary care offer' (CS15/M25).

Self-dismemberment was quite opposite to the non-NHS case-study organisations' objectives.

The not-for-profit hospital chain (CS9,10) was owned by its membership (company limited by guarantee, maximum liability £1 per member). Annual General Meetings of members elected the Board, whilst the Board decided who may become a member. Its aims were to promote and provide

healthcare ‘for the public benefit’. Yet it also explicitly aimed to make a profit each year, not for distribution as dividend for investors but to develop its services. Each hospital had a profit target and related targets such as one for revenue generated from enquiries (i.e. conversion of enquiries into sales). Hence

‘the need to keep the money rolling in’ (CS10/M06)

was a recurrent managerial issue. In CS9 this was behind, for instance, efforts to increase their High Dependency Unit’s activity as a way of increasing private general surgery work, bringing diagnostics in-house and offering IVF. The monthly monitoring phone-call to the national headquarters had traditionally been very finance-led. Hospital managers’ financial authority was very circumscribed. For the respondent who had previously worked in the NHS, this NFP organisation seemed to have more focus on and awareness of costs. Nevertheless:

‘it’s not a mercenary money before everything else, ... And I think it would be a real mistake to move off that patient first bit and that people relationship bit, because that’s the bit that counts’ (CS9/M32).

Case mix and service viability were considered matters for local decision by the senior management team, influenced in part by consultant availability and fees.

The CHS social enterprise (CS23) Board members were state-appointed but also included elected resident, staff and patient representatives. Clarity about its objectives was achieved through discussions at workshops that engaged 40 or 50 people, not just the directors. As ‘*an independent company*’ this social enterprise could take up issues that emerged locally, which our informants thought made the organisation ‘ethical’. The enterprise wanted to transform services transferred with it out of the NHS. It set itself additional targets to those in its contract as a way of expressing ‘*local commitment*’. One was to apply NHS waiting times standards voluntarily:

‘there are national waiting times for non-acute services and health other services. From day one that’s something we set ourselves to say we will aim to achieve 18 weeks’ (CS23/M37).

Some of its objectives were role-specific and others, which we take as the ‘tighter’ targets, organisation-wide. The latter covered waiting times, length of stay, financial indicators, ability to recruit staff, team development, the introduction of additional services, patient experience and the performance of specific projects. As a CIC it could neither trade at a deficit nor make more than a 1% surplus on turnover. It had been able to seek ways to address the gap between income and rising expenditure which in the NHS:

'well, we could have done but we wouldn't have been motivated to do so, such as things that aren't tied to our main terms and conditions' (CS23/M33).

When it had been an NHS trust its surplus was given to the acute sector. Now,

'So our commitment to, as a social enterprise and as a community interest company, is that whatever surplus we make a percentage of that will be returned back in to the communities, either through our services or by payment or links with other services' (CS23/M37).

Our informants contrasted these aims with NHS trusts' centrally-imposed objectives.

The free-standing voluntary hospital was a charity whose aim was patient well-being and the advancement of health rather than competitive advantage. In 2011 it adopted a five-year strategy of expanding and diversifying the hospital's case mix, changing the hospital's charitable objectives away from a focus specifically on muscular skeletal services towards more generic objectives.

'to advance health; that's one of the 13 auspices of being a charity, advancing health and saving lives. Obviously it's the advancing health element of it that we focus on. And we've just built on our heritage originally of providing MSK' (CS25/49).

Its strategic objectives rather vaguely required the hospital to make a 'reasonable' profit. Its business plan was not disclosed to us but we were told that it included a 'social return on investment analysis' of the charity's impact and its opportunities to improve and develop.

Again, few organisations would deny that they wanted to advance the welfare of their staff. But GPs' interests - developing what they regarded as good practice, being of practical and financial assistance to their general practice(s) and retaining their own independent control of the organisation – predominated in the cooperative (CS20), OOH social enterprise (CS24) and the partnership which provided CHS (CS31). Like other OOH providers the social enterprise OOH services originated from earlier cooperatives. Its aims were locality-based, i.e. to:

'provide high quality, patient-focused service for the patients of North [County], North East [county], [district 1] and [district 2] Clinical Commissioning Groups (CCGs) in the [hospital 1] and [hospital 2] hospitals' catchment areas' (CS24, business plan).

It also had the objective of growing its ‘core business’ and therefore tried to make a surplus. By its own rules any surplus should be paid back into the local health economy but it was not obvious how:

‘[O]bviously you can’t start up a new service off your own back; all those things have to be commissioned and also the money is not necessarily recurring money. So it is quite a difficult challenge really, knowing how to use any surpluses that we have, so as far as possible we just try and invest the money back into the business’ (CS24/M01).

The OOH co-operative expressed essentially similar aims:

‘[O]ur only concern is that patients are getting the best possible treatment, and if we can keep the cost to our GP members to a minimum, then all well and good’ (CS20/M55).

Income had to exceed expenditure, but there were no shareholders or overseeing body determining financial targets. Last year a surplus was returned to member practices:

‘The member practices are happy as long as we have, you know, what they pay us pays for it and we make a little bit extra that pays for cars and new equipment’ (CS20/M55).

Rather than formal objectives, at the partnership CHS provider

‘[w]e have more of an ethos about how we want to practise medicine, and we would want partners to join us who share that ethos and then, sort of, help them to continue doing what we do’ (CS31/M55).

Their knowledge of the local health system motivated them to develop an MSK pathway because many GP referrals to secondary care needed physio, an x-ray, or a steroid injection rather than full access to a treatment centre, yet there was no financial incentive to manage such patients through general practice.

‘So [GP] and I looked at it, we know we can do so much better’ (CS31/M55).

Our informants saw their four merged general practices (see below) as a platform for working collaboratively and sharing information, hence for introducing an MSK pathway where referral decisions can easily be reviewed or endorsed. They also emphasised patient-centred care, integrating teams and ensuring that patient saw the right person.

7.b. Organisation aims and structure

Top-level organisational structures and the accountability chains from staff to manager to owner clearly diverged by organisational ownership and aims among the case-study organisations.

7.b.i. *Financialised structures*

For our three corporate case-study organisations, their own documents and Companies House records showed that one for-profit corporation (CS1,2,4) was mainly owned by a pan-European private equity group, another (CS3) was wholly owned by an offshore holding company, and the once-proprietary OOH provider (CS8) was almost 90% owned by an American finance company, with four individuals owning the rest. All had a ‘financialised’¹²⁰ structure designed to transfer payments arising from property-rights in money (‘capital’, ‘investment’), land or intellectual property, or other transfer-payments from an operating company into a separate holding (owning) company. (Chapter 5 showed that in this structure is widespread among corporations in UK healthcare.) Our questions elicited the response that there was no direct interaction between the managers at provider (hospital, clinic, call centre etc.) level and the owning company, which in all cases was rather distant from actual service providers’ day-to-day practical managerial activity.

7.b.ii. *Politicised structures*

Our case-study NHS foundation trusts (CS13,15,16) were, like all such, one end of an accountability chain⁹² running upwards to commissioners (CCG for most services, local authorities for a few contracts), NHS England, the Department of Health, health ministers and ultimately Parliament. Like all the case-study organisations they were to varying extents regulated, scrutinised and guided by a cluster of national organisations (described in Chapter 6) at arms-length from government. Although formally separate organisations, these case-study NHS foundation trusts were embedded in a network of vertical ‘quasi-hierarchical’^{90,107} accountability chains converging upon government, supplemented with a contractual accountability to the local CCG(s), local authorities and (for any specialist services) NHS England. Informants in the CHS social enterprise, until recently an NHS trust, described how they were not now

‘required to report every nut and bolt back through an accounting chain and back through the performance management chain’ (CS23/M37)

7.b.iii. Mission-based structures

The free-standing voluntary hospital (CS25) and the not-for-profit chain (CS9,10) had no external owners. Their boards were formally controlled by an annual general meeting of members. The CHS social enterprise (CS23) was a variant on this architecture in that (like others of its kind) its board included five senior employees along with four non-executive directors (retired from business, the police etc.). It was more independent of external control than the NHS trusts.

7.b.iv. Doctor-controlled structures

The OOH social enterprise (CS24) was governed by a Management Council, ten of whose 15 members were GPs elected by its GP membership. Every GP working for this OOH provider was entitled to be a voting member. The Management Council determined the society's strategy and plans in consultation with the Management Executive. The elected GPs appointed a medical director, chief nurse, chair and two non-executive directors. Various sub-committees controlled clinical governance, audit, remuneration, information governance and nominations to the council. In ownership, structure and control if not in name and legal personality, this social enterprise was essentially a GP co-operative.

The OOH co-operative had formed when the many local single-handed practices wanted an economical approach to managing out of hours calls, but also one which involved them. Some local GPs therefore set up a non-profit making, subscription-based OOH cooperative, which paid its members who worked shifts for it. At annual general meetings, which were not usually well-attended, finances and workload were discussed. The member practices elected a committee of nine GPs

'and they're the ones that decide on which paths [organisation] take' (CS20/M55).

It had one lay member (a retired GP) and sub-committee structure. It appointed a salaried medical director and a director of operations. By the time of this study this organisation was a limited not-for-profit company. Its shareholders were local general practices (only), whose shareholdings and annual subscriptions reflected practice size. The practices were also charged per patient call. Notwithstanding its legal status, this organisation also remained essentially a GP cooperative in structure, ownership and control.

The general practice providing CHS (CS31) was like most general practices owned and controlled by a partnership of GPs. One GP (the ‘managing partner’) managed the employed staff. The whole was organised and managed as a single partnership with four surgeries.

7.c. Convergent coordination structures

7.c.i. *Convergence on hierarchy*

With the partial exception of the doctor-controlled organisations, all the case-study organisations had a hierarchical, bureaucratic structure for coordinating everyday service production. They all employed their non-medical clinicians, sometimes (but reluctantly because of the cost) supplementing them with agency staff except for the NHS trust supplying OOH services (CS16), which employed ‘bank’ nurses rather than agency staff. Hence the character of daily managerial work was largely convergent between the case-study organisations, although still with some differences of detail. A manager at the corporate CHS provider (CS3) explained that her day-to-day work had changed little with the change in ownership, except for the introduction of mobile working which gave her more information for use in supporting business cases. Except for marketing (see below) the same range of ‘staff’ management functions (HR, finance, IT etc.) and similar ‘line’ management structures (of operations, nurse, therapy, administrative and ancillary services managers) existed. Routine (typically monthly) monitoring arrangements were similar, covering service quality, any serious untoward incidents, and workload. A corporate hospital informant added

‘And of course the numbers comes into it as well. And that’s, to be fair, in acute [i.e. NHS trusts] that was what you had as well’ (CS2/M018).

Within these overall structural similarities there were nevertheless some smaller differences in this hierarchical component between the differently-owned organisations, as outlined below.

Informants who had formerly worked in NHS trusts, and informants in other organisations who dealt with NHS trusts from outside, often commented on the slower, labyrinthine, frustrating and more cumbersome character of some NHS-trust decision-making.

‘So [outside the NHS] I don’t think we have to wait for permission, so to speak, it feels a bit less bureaucratic, it feels like you don’t have to go through committee to committee to get something signed off, you can actually be brave and try things’ (CS3/M40).

'If you think about my NHS experience, any decision, people would only, ah, they'd only do it through a formal environment of a board meeting or an exec team meeting, or senior management team, an ops meeting. And secondly, no one would ever make a decision until someone had written a paper' (CS8/M10).

Informants at the free-standing voluntary hospital made similar remarks. Paradoxically, more 'bureaucratic' decision-making did not always mean tighter control:

'in an NHS organisation you just carry on overspending or without there being proper demand and controls in place' (CS23/M34).

Most of our informants outwith NHS trusts also talked of being more accountable than before, as were those whom they line-managed.

A small organisation requires fewer tiers of management and can therefore have a 'flatter' structure, shorter chains of command and simpler management arrangements than a large organisation with just the same spans of control. In one of the corporate hospitals interviewees described how its small size meant that

'the medical and nursing staff, and everyone else for that matter, but for the clinicians to actually be much more involved in the running and the change management of a smaller organisation' (CS2/M19)

Similarly in the former proprietary OOH:

'because we're small you would actually struggle to see ... the governance structure in quite the same way you would see it in the NHS. So in the NHS you'd see governance committees and assurance committees, and all of these sorts of big things. Actually ours is quite simple. So we have pretty much just a regular weekly quality review done by a group of operational managers with others' (CS8/M10).

The differences in decision-making and 'bureaucracy' between the NHS trusts and the other case-study organisations will therefore have been partly – not necessarily entirely – a consequence of the NHS trusts being larger and providing a wider range of services. But that range of services itself indirectly reflects different kind of ownership, in that policy requires NHS providers to provide a full spectrum of services so that all healthcare needs can be met.

More than other case-study organisations the CHS social enterprise encouraged employees' participation in decision-making. Its board rewarded and recognised staff performance through

‘success stories’ with a staff group administering a programme to adjudicate staff awards which are presented at an annual event hosted by the enterprise.

‘So we’re all engaged in that whether we’re the cleaners, the IT team or the nursing team’ (CS23/M34).

Appraisals were seen as developmental rather than punitive. Dismissal was rare, and rarely for performance.

Staff pay and conditions differed between the NHS trusts and social enterprises (on one hand), and the other study providers. The CHS social enterprise voluntarily applied the national terms and conditions agreed within the NHS or local government,

‘so effectively there isn’t anything really you can do [as staff incentives] in terms of either financially or career’ (CS23/M35).

Staff transferred under TUPE to another organisation also retained NHS pay and conditions but newly-appointed staff did not. Corporate CHS (CS3) pay scales, cost of living enhancements, sickness benefits and other staff terms and conditions were less generous than in the NHS. Staffing levels had been reduced to those in neighbouring providers. For all three NHS trusts the cost control pressures were more severe than for non-NHS providers, the former being

‘inherently more expensive because we work on Agenda for Change [salaries and conditions] and we have overheads that private providers don’t have’ (CS16/M04).

In all three NHS trusts we heard accounts of how work tended to be divided across uniprofessional ‘silos’, a long-established coordination-structure (and internationally widespread). The CHS trust (CS15) had formed from two earlier trusts, partly with the aim of moving away from professional silos towards inter-professional services and teams, and towards coordination structures based on natural communities and care groups (e.g. by combining physical and mental health services for older people), structured by localities (with locality managers) matching those which the local authority used, plus divisions for urgent care and city wide-services (e.g. acute mental health care).

7.c.ii. *Accommodating the doctors*

Within hierarchical coordination structures, doctors were accommodated in three different ways. One of our corporate hospitals (C2) used all three. Most consultants working there were employed by the local NHS hospital trust (CS13) and had admitting rights, but its orthopaedic surgeons were directly employed and its ophthalmologists sub-contracted from chambers. Other clinicians were directly line-managed. One corporate hospital (CS1) had few directly employed medical staff, who also worked elsewhere (divisionally for the company or for other providers). The second corporate hospital directly employed all its orthopaedic consultants. Consultants in other specialities were seconded by agreement from the nearby NHS hospital trust (CS13). Indeed

‘[M]ost of our general surgery is provided by them, some urology, some ENT surgery’ (CS2/M019).

At the corporate hospitals (CS1,2), whose activity levels militated against direct medical employment, one form of medical subcontracting was with external medical ‘chambers’. In one of the not-for-profit hospitals however the anaesthetists had organised themselves as a limited liability partnership, putting them in a powerful bargaining position.

‘If, for example, I was to pick them up on something that they weren’t doing, it would be a very hollow threat to turn round and say, “I’ll withdraw your practising privileges,” because I’d have no anaesthetists’ (CS9/M26).

Alternatively, doctors could be subcontracted individually per session. The small corporate OOH provider (CS8) had about 115 sessional staff, mostly local GPs also working in diurnal general practice. The corporate CHS provider (CS3) employed doctors directly in its community hospitals, alongside service level agreements with NHS acute hospitals for further medical cover. It sometimes had non-medical clinicians line-managing doctors. The not-for-profit hospitals (CS9,10) and voluntary hospital (CS25) each had consultants with admitting rights, nearly all NHS consultants (over 100 of them, at each of the two NFP hospitals).

7.c.iii. *The semi-democratic exception*

In the social enterprise OOH provider (CS24), OOH cooperative (CS20) and partnership CHS (CS31), the organisation’s controlling bodies democratically represented the doctors in them. In these organisations the doctors doing the ‘front door’ medical work were mostly GP partners (in a member-practice, for the OOH providers) and so of course voting members of the enterprise. In effect the members collectively coordinated their own work by volunteering for shifts and finding

other doctors to fill any gaps. All three organisations coordinated the other occupations' work by employing them in a hierarchy managed by a chief executive (or equivalent) and ultimately the member-doctors. With variations in the specific mix, they employed such staff as receptionists, drivers, administrators, managers, nurses, mental health workers, counsellors, psychologists and, exceptionally, a few non-member doctors. The whole structure was seen as able to make decisions quickly and

'able to evolve and adapt quickly' (CS20/M55)

and with low management costs were (below £150,000 per annum for the GP cooperative (CS20)).

7.c.iv. *Obtaining external resources*

Case-study providers under different types of ownership varied how in their sources of recurrent income were distributed among the following.

1. NHS commissions: Most NHS-funded providers in our study had CCG contracts. Further details are in Chapters 6 and 8, but informants at the corporations (CS1,2,3,4,8) said that they found tendering for NHS work a laborious additional task: tortuous, expensive, distracting and time-consuming for managers:

'We live, eat and breathe it, yeah. No, I mean, I think it is hugely, yeah, apart from keeping the show on the road, so pretty much everything else has gone on the back burner a bit really' (CS8/M09).

HRG payments were income mostly for the acute hospitals, whether NHS trust (CS13), corporate (CS1,2) or not-for-profit (CS9,10,25).

2. Sales to private payers: The not-for-profit hospital chain (CS9,10) obtained well over half its income (many hundreds of millions of pounds) from privately-funded care. The NHS Trust (CS13) also had such income, but proportionately much less. Although we were given no figures, this was not among the ten or so NHS Trusts with the highest proportions of private-payer income, nor one with a large commercial subsidiary or joint venture.
3. Subscriptions: Only the OOH cooperative (CS20) relied upon its members' subscriptions. The main financial threat to it would be if members left. At the time of this project it was therefore co-bidding (successfully) for a CHS contract so as to diversify its income (spread risk) and equip itself better to tender for local OOH services should the cooperative cease to

be viable as a subscription organisation. Winter pressure monies had yielded a surplus because more agency locum doctors were costed in than were needed that winter.

4. Donations: Only the free-standing voluntary hospital received substantial charitable donations. Whilst recent acquisitions and expansion were seen as requiring a subsequent period of consolidation:

‘So from that perspective we’re financially sound, therefore we can perhaps make some decisions that are in keeping with our charitable values, which means that we don’t always have to drive the highest price, the cheapest cost, and all that sort of thing’ (CS25/M53).

Volunteers worked in the not-for-profit hospital chain and NHS Trusts (CS9,10,13) but above all the free-standing voluntary hospital which had about 100 of them, often former patients

‘because they’ve had a good experience and a good outcome and they decide they want to come and give something back’ (CS25/M53).

One consequence of a financialised structure was that the corporations could readily access capital, subject to a business case promising a profitable pay-back. Once that condition was satisfied one corporation we studied (CS1,2,4) had far shorter lead times than usual in the NHS:

‘Last year we replaced our endoscopy unit, new in totality. So I built the business case, and that was signed off and the order was placed within five days’ (CS1/M07).

The same system allowed an injection of capital to refurbish the treatment centre,

‘and you can’t get that investment through the main NHS route’ (CS2/M018).

Similarly the corporate CHS could

‘access capital to kick start innovations and to do some of the invest to save ... stuff if it’s in line with the business model’ (CS3/M39).

which was, to recoup efficiency savings (including staff reductions) over the five years of the contract rather than (as in the NHS) having to balance the books annually.

In contrast the not-for-profit chain financed its service developments entirely from its internally-accumulated surpluses, which might help explain why it set each hospital a profit target and why starting new capital projects was harder and slower than in the corporations:

‘[Our] hospital division turnover is somewhere in the region of half a billion pounds a year. Locally, if I want to spend more than £1,000 on a capital item I have to get authorisation for it’ (CS9/M26).

Authorisation was subject to ceilings and available budget at regional level, and was in effect subject to (internal) competitive bidding with business cases projecting the resulting additional revenue. Managers saw this system as favouring incremental changes rather than strategic planning or long-term projects (such as new buildings).

An operating surplus also underpinned the free-standing voluntary hospital’s ability to develop two inter-organisational MSK networks in collaboration with other organisations. However the margins on that work were lower (staff but not management costs were covered) than for other work so its charitable status and operating surplus were key to the hospital’s diversification. In theory any debt would fall to the hospital board but that was

‘Inconceivable, there is no – obviously over the years we’ve built up reserves and so reserves are available in time of need, but we don’t plan to need them. Yeah it has to be completely different to the way the NHS works’ (CS25/M50).

7.c.v. An imputed NHS identity

At the time of our fieldwork none of the corporate providers in this study (CS1-4,8) were above ten years old (although the corporations owning them were older) so most of their staff had recently worked for the NHS. Their hospital consultants still did. Uniformly our informants argued that in some sense they still contributed to the NHS, not least because they offered a service to NHS patients:

‘you know, we’re there supporting the NHS so that they can deal with those real acute and chronic situations’ (CS1/M05).

At the corporate CHS:

‘The misconception that, you know, it’s private is completely wrong, it’s an NHS contract providing great levels of care, or the best that we can do... I still consider myself to be in the NHS even though I work for [Corporation]’ (CS3/M42).

Lastly, at the ex-proprietary OOH corporation:

‘You know, first and foremost it’s about the patient, and when you arrive here you could be fooled into thinking this was an NHS organisation’ (CS8/M10).

This attitude was not necessarily found outside the corporations:

‘staff are reluctant to come in to [Corporation] because I think they feel that they’re stepping outside the NHS. And we have to battle quite hard to recruit staff’ (CS3/M43).

Neither was this identification with the NHS much expressed at the not-for-profit hospital chain, even though the clinicians (and one manager) that we interviewed were NHS-trained.

7.c.vi. Marketing – or not

Corporate marketing was generally more salient and developed in the corporations and not-for-profit hospitals than in the NHS trusts or social enterprises, and more salient and developed in the patient-choice than the competitive-tendering parts of the NHS quasi-market. Indeed as reported above one of the corporate hospitals had gone through a phase of bidding for almost any work. One corporation advertised both to patients (on-line, with links to the NHS Choices website) and GPs, with whom

‘at the end of the day, if we don’t have a good reputation for giving care we won’t get referrals, so we’ll die on our feet. It’s very simple, it’s very, very simple’ (CS1/M07).

This was especially important in a city whose GPs barely used the ‘Choose and Book’ system. Indeed GPs were a key marketing target for all the corporate and not-for-profit hospitals we studied (CS1,2,9,10,25). All five ran such events as GP education evenings and arranged for their staff to visit general practices to encourage referrals. To increase the hospitals’ visibility they developed links with community organisations (for the CS2 hospital, Sikh Temples, both local universities, the University of the Third Age, a local football team (which they sponsored), a local youth club,

primary schools and charities). The free-standing voluntary hospital had begun active marketing more recently, and justified that by arguing:

'you can advertise to patients or GPs, or whatever, to increase activity. ... [W]e are here for the benefit of patients, and the wider we can spread that knowledge the better. So from our point of view the more people we can get in here and show them what we're doing and hopefully, you know, take that to other places, means more patients will benefit. So therefore that meets our charitable purpose' (CS25/M52).

Being commissioned through competitive bidding, the CHS corporation had less need of marketing to GPs or patients:

'I think in the early days we did look at, you know, marketing aggressively and where we could get to. But actually there isn't the market in this area, there's too many competitors, so we focus on doing what we're supposed to be doing, contracted activity. And if the opportunity comes up to develop, then we'll always look for that opportunity to do more' (CS3/M42).

Nevertheless, branding and marketing was one of its hallmarks. It advised its staff on how to present themselves on the corporation's behalf. It standardised the placement of the corporate and NHS logos, and templates for presentations. Its communications and compliance/PALS teams were aware of media issues and did 'horizon-scanning' regarding national policy. It especially responded to external events concerning clinical quality (e.g. whether the Mazars report into Southern Health had implications for their own organisation). After acquisition by the equity company, the ex-proprietary OOH provider (CS8) gave itself a more generic brand-name:

'[County] Medical Services sounded a bit too parochial, but we were trying to, sort of, compete on a national scale' (CS8/M09)

but otherwise its marketing activities were more modest.

The social enterprises surveyed patients and encouraged certain forms of patient participation (see Chapter 10) but had no further marketing activities or infrastructure. The corporation (CS4) and the NHS trust (CS16) offering OOH services both referred to other independent providers under-pricing OOH work then later asking commissioners for more money.

7.d. Summary

Across our case-study providers different types of ownership appeared to produce divergent top-level controlling structures. Coordination structures in their national and regional headquarters, and at provider level i.e. within the particular hospitals, community health or OOH services depended on whether doctors owned the organisation. When they did, doctors' work was controlled and coordination in a more-or-less democratic, self-governing way. In the corporations and NFP providers some doctors were subcontractors or had admitting rights. Otherwise, usually, and regardless of organisational ownership the work of employed doctors and non-doctors was coordinated through a bureaucratic hierarchy.

An organisation's legal status was not always a clear indicator of its *de facto* ownership, control and organisational structure. The 'social enterprise' category and its legal counterparts 'community interest company' and 'company limited by guarantee' contained organisations that were owned and democratically controlled by doctors, and what were in effect arms-length public firms.

An organisational structure not only coordinates, but selects and develops, work processes which managers think will accomplish its owners' goals. This raises the question of whether the convergence among coordination structures may reflect exigencies of the work process, irrespective of ownership. Chapter 8 considers that.

Chapter 8. Work processes: service development and innovation

- External controls, evidence-based medicine and professional cultures made working practices converge across differently-owned providers.
- Innovation was largely policy led. Technical innovation tended to emerge from NHS trusts, innovations in service delivery from providers of all ownerships.
- Providers with private patients differentiated services for them from services for NHS patients.
- Cost-reducing innovations focused on demand reduction and, in non-NHS providers, reducing staffing costs.

Next we report how case-study organisations under different ownership converged or diverged in their working practices and innovations, depending on their ownership.

8.a. Common approaches to managing care processes

8.a.i. *Common process and outcome standards*

The regulatory standards discussed in Chapter 6 penetrated work processes themselves and tended to make them convergent. An informant at the corporate hospital (CS1) who had also worked for Circle and the NHS stated that:

‘we have guidelines, NICE guidelines, NNC, codes of conduct, those sorts of things ... so our standards are measured in a relatively standard way, I would say, across NHS and independent sectors. The rules are the same, they don’t change’ (CS1/M05).

The medical director at one corporate hospital (CS2) suggested that although it had some stark differences to the NHS, they were not cultural or technical but:

‘a lot of the difference comes because we’re such a small organisation [...] the way people work, people’s motivations, what they’re here for, the patient care, etc., is absolutely no different’ (CS2/M19).

Interviewees at the social enterprise CHS said that in effect they were still carrying on traditional NHS work but under a different organisational structure. These providers all used what were essentially the NHS procedures for handling complaints and serious incidents. After 1997 NHS-

funded primary care providers increasingly included corporations, social enterprises, mutuals, 'groups of existing GPs', and various hybrids but doctors' working practices and the division of labour within them did not appear to differ systematically from those in traditional professional-partnership general practices.⁶²

NHS consultants' private practice in non-NHS hospitals was a less obvious source of standardisation. The voluntary hospital (CS25) achieved venous thromboembolism (VTE) accreditation by involving their consultants so as to standardise the relevant working practices across the hospital.

All the case-study organisations saw scope for improving patient care through data-sharing, hence inter-operable IT systems. The free-standing voluntary hospital (CS25) used NHS reporting mechanisms for submitting all data, ensuring common content. The ex-proprietary corporate OOH service (CS9) had a history of IT innovation and was an early implementer of the NHS Pathways software. Its telecare team had access to the social services, including the emergency duty social services, systems and were transferring their telecare system to a data warehouse so as to facilitate reporting. The corporate CHS provider (CS3) planned (if it kept its contract) to take electronic records into the community hospitals, enable patient assessments to be entered electronically, and introduce an interoperability platform so that GPs could access CHS records. However ownership issues also limited IT convergence. The corporate (CS4) and Social Enterprise (CS24) OOH providers, and the partnership CHS provider (CS31), told us that permission and IT interoperability problems) with GP practices remained a barrier to good patient care. Out-sourced IT was another:

'the people that provide the IT system used by the mental health trust do not want to allow them to plug in to our system. So the blockers aren't even necessarily with the providers of the service, sometimes it's an IT thing' (CS4/M59).

Providing all and only the services specified in their contracts was normal commercial practice for the corporate and not-for-profit providers. The corporate CHS (CS3) stated that GPs seemed to lack knowledge of what the CHS contract covered, but the corporation's own staff did know:

'We have to have absolute clarity on our numbers, I think all of the staff now are much more aware of their contract, what they're specified to do, what their activity is, and they know their budget ... we invested quite a lot in educating the ground level staff in just simple things about contracts really' (CS3/M39)

so that, for example, district nurses felt empowered not to deliver just everything that GPs asked of them. Financial pressure also forced the CHS trust (CS20) to do nothing beyond its contract. An informant at the local NHS hospital trust described how the CHS trust

‘decided suddenly they’re not commissioned for physio following hip and knee procedures. Well, they’ve been doing it for ten years, so they may not have a bit of paper that says do this [physiotherapy], but certainly it’s in their portfolio and in their staff group, and everything else. And suddenly they’re refusing to do that any more’ (CS13/M44).

Exceptionally, however, corporate providers, both of hospital (CS1) and OOH services (CS4) would sometimes do additional, off-contract work in order to help out nearby NHS providers and maintain goodwill with them and the CCGs.

8.a.ii. Staff shortages

Almost all our case-study organisations reported difficulty in recruiting and retaining staff, especially nurses, GPs in inner-city areas and therapists. The national policy of extending general practice working hours intensified the GP shortage:

‘there are a lot of services that have been put in place that extend GP access and offer enhanced rates to GPs to, you know, open ‘til 8 o’clock in the evening or open Saturday morning. But that directly affects our workforce here, and we’ve lost lots of clinicians to those pilots or services’ (CS4/M59).

All four OOH providers all reported this same difficulty, which the aging GP workforce (OOH cooperative (CS20)) and increasing cost of indemnity (CS8,15,20) aggravated.

Local conditions sometimes compounded these problems. The corporate CHS (CS3) was in an area with high living (especially housing) costs and therefore faced shortages of qualified staff and healthcare assistants. In the free-standing voluntary hospital (CS25)

‘we’re always looking for, you know, additional spinal surgeons, well, all three specialities, but yeah, we’re not being successful at this moment in time, they’re just not locally available’ (CS25/M54).

In recruiting and retaining nurses the NHS hospital trust (CS13) was competing with other hospitals in easy commuting distance. Using agency staff had bigger impacts on NHS than on corporate providers because the agencies paid staff two or three times local pay rates for nurses, so:

‘even the independent sector can’t compete ..., let alone the NHS’ (CS1/M05).

In the free-standing voluntary hospital (CS25) the main consequence was difficulty meeting the 18 week referral times norm. Another consequence, reported in the social enterprise OOH (CS24) was to inhibit innovation:

‘At the moment the main objective really is around the workforce. We’re suffering really quite a drastic workforce crisis in primary care and it’s very difficult to attract GPs onto the rota and also nurses, so our main objective at the moment is just to keep the service going sadly’ (CS24/M01).

A not-for-profit hospital (CS9) had additional reasons for wanting to maintain high staffing levels on its wards:

‘we were becoming a little bit rushed, clinically we were safe, we had the right number of nurses, all the guidance was being followed. But what I didn’t feel we were doing as well as we could do was to give that extra special service, because at the end of the day that’s what we need to be doing to maintain our, you know, status as being a private hospital, if you like’ (CS9/M26).

Policy-makers had intended TUPE protections to be only a transitional arrangement but labour shortages sometimes gave NHS pay and conditions a longer life. In order to recruit to hard-to-fill posts, the corporate CHS (CS3) continued to offer NHS ‘Agenda for Change’ terms and conditions for those posts and so (for some posts) had the corporate OOH (CS4). The social enterprise CHS (CS23) had not at first offered NHS pensions even to transferring staff, but changed that position (we were not told why).

8.a.iii. Policy-driven innovation

CCGs stimulated innovations in local providers on the basis both of national policies and the CCGs’ own requirements, so these innovations did not reflect providers’ ownership. Insofar as CCGs could pay for these innovations, provider responses seemed not to differ much by ownership.

A corporate hospital (CS1) suggested that some innovations were really dictated by the CCG and their assessment of local need, with the hospital making some adjustments (e.g. treating glaucoma and age-related macular degeneration (AMD) and the introduction of eyelid surgery). It, one of the not-for-profit hospitals (CS9) and the free-standing voluntary hospital (CS25) took

‘quite a lot of transferred activity from the trust when they’re breaching on their timeline, so they’ll transfer over hernia patients and ophthalmology patients and endo patients’ (CS1/M07).

After severe winter pressures at the local acute hospital, its CCG asked the social enterprise CHS (CS23) to establish a community assessment hub at a community hospital, providing treatment and tests without a hospital stay. The corporate CHS (CS3) had been paid by its CCG to increase their rapid response capacity (in-reach nurses at the NHS hospital) to avoid unnecessary admissions of frail patients, and asked to pilot a scheme whereby

‘district nurses are going to work with the ambulance to proactively support patients who are frequently falling’ (CS3/M40).

The CCG commissioning the NHS Trust OOH service (CS16) funded additional mobile units during the winter because of the increased need for home visits.

As for nationally-mandated innovations, its CCG pressed the social enterprise CHS (CS23) to prioritise IAPT services, although the social enterprise itself had to try to generate demand to meet the uptake targets. Weekend working proved expensive for the NHS hospital (CS13) and patients showed little demand for it. Several case-study organisations had been drawn into MSK ‘partnerships’ (i.e. referral networks) instigated by their CCG. The corporate CHS (CS3), free-standing voluntary hospital (CS25) and partnership CHS (CS31) all changed their orthopaedic services to conform with the national policy of introducing MSK pathways. The network prescribed certain pre-treatments before referral for surgery, and unified treatment thresholds. The CCG which commissioned the and partnership CHS (CS31) had also been pressing it to introduce additional (dermatology, orthopaedics and possibly paediatrics) care pathways on similar lines to the existing MSK pathway.

We were told of two main obstacles to developing more integrated referral networks. The corporate OOH (CS4) service for diverting patients away from its local hospital was, like similar services elsewhere (e.g. case studies 16,24), not fully utilised because the latter wanted to retain full

payment (tariff payments were a perverse incentive). The NHS hospital trust (CS13) recognised the need for a network approach to avoiding admissions, standardising discharge arrangements and promoting rehabilitation and social care, but

‘it’s very much in the very hard box with no money’ (CS13/M47).

Expansion of the social enterprise CHS (CS23) arose because the CCG wanted a single CHS to serve their locality, whose GPs wanted access to the social enterprise’s range of services, including 24 hour district nursing, urgent care and acute care at home. Additionally the CCG and the local authority were

‘really keen to have social care integrated within healthcare’ (CS23/M35)

and the social enterprise was able to respond, leading to a combined health and social care budget. It took over the city council’s adult social care assessment service and its ‘Pathways for adults with complex needs’ contract.

8.b. Divergent care processes and innovation

8.b.i. *Selection of NHS work*

For corporate and not-for-profit providers the business case (future profitability) was all-important in deciding what NHS work to take on. Thus the corporate OOH (CS4) no longer bid for new tenders unless they were financially viable, with a robust risk assessment in advance. In the not-for-profit hospital chain (CS9,10) long-term strategic plans could be outlined as part of the annual budgetary process but funds could still be diverted elsewhere if another hospital made a better business case. Conversely the ex-proprietary OOH corporation (CS8) reduced its telehealth service because our informant found himself presiding

‘over an organisation where commercially it was a nightmare actually because all the money, the margin that we were making on the rest of our business was just being lost almost pound for pound in telehealth. So we finally offloaded that bit of the business to one of our sub-contractors, only about two or three months ago, but have kept the telehealth capability’ (CS8/M09).

The social enterprise CHS (CS23) had decided that given the risk of LA budget cuts it would only tender for 'sustainable' services i.e. those that covered their costs and were not facing significant funding or recruitment problems.

Within their chosen care groups, corporate treatment centres under contract to the NHS did not cherry-pick patients by severity. At individual patient level any occasional 'lemon-dumping' took the indirect form of transferring patients who developed complications to an NHS hospital. In both corporate hospitals not only resuscitation but services such as pathology were provided by the local NHS trust hospital. In both corporate hospitals (case studies 1,2) the absence of emergency facilities on site meant that pre-assessment triage assumed considerable importance. At the other corporate hospital (CS2), the use of NHS acute trust doctors meant collaboration was imperative and a very strong service level agreement was in place to secure it

'so if we have a patient that unexpectedly deteriorates post-op on the ward, we can transfer there, quite rightly' (CS2/M19).

Rather, corporate, NFP and voluntary providers 'cherry-picked' *between* care groups, when – based on a business case – they decided which care groups to provide services for. In practice that meant, in our case-study organisations, treating less complex or acutely ill patients. Hence:

'the major difference between the NHS and the private sector is these are elective patients so you don't have so much the acute side of nursing to contend with on a daily basis' (CS1/M05).

Ninety percent of the free-standing voluntary hospital's (CS25) activity was elective orthopaedic (hip and knee replacements) and MSK services, including physiotherapy and acupuncture. That decision was manifested concretely in buildings designed only for low-acuity care. The hospitals with an elective-only case-mix had a calmer atmosphere for both patients (see Chapter 10) and staff.

At one of the corporate hospitals (CS1) waiting lists were generally much shorter than the local NHS trust hospital where, as various informants noted, elective surgery was often cancelled to give more urgent treatments priority. Our case-study¹³ like most NHS acute hospitals also treated complex and high-risk patients. The parallel urgent and emergency work meant

'That's a frightening experience, for patients who have to come here and the elderly, coming to a hospital our size and an ophthalmology service as big as ours, if they're used to going to a smaller setting that's really difficult for them' (CS13/M45).

In contrast the corporate and not-for-profit hospitals' calm, orderly ambience was possible because they were only delivering elective care. This difference reflected ownership only because corporate and not-for-profit hospitals were allowed to select their care groups and NHS acute hospitals were not.

Its tertiary status meant that the NHS hospital trust (CS13) was involved in

'leading edge stuff... so the genomes stuff which is just, you know, the medicine of the century going forward' (CS13/M38).

It was a teaching hospital, hence a research centre whose partners included the local university, Medical Research Council and Wellcome Trust. It could provide the latest advances in eye care, so patients stayed longer and could be admitted at a later age with conditions (e.g. advanced macular degeneration) requiring repeat visits.

There were no such marked differences in patient experience, clinicians' work pressure and managerial roles between the differently-owned OOH services, all of which had much the same case-mix. The same applied to CHS. GP partnerships and publicly-owned providers had little choice over what care groups to serve. The NHS trust, social enterprise and corporate CHS providers we studied (CS3,15,23) all had to provide for a full-spectrum case-mix. (The social enterprise CHS (CS23) provided 71 distinct services including community hospital and mental health services.) Partnership general practices provided the full case-mix of primary medical care, but some also had more specialised services (such as the MSK services provided by our partnership CHS provider (CS31)).

8.b.ii. Expansionary development

Availability of finance for innovations varied by type of ownership. Provided that a business case showed a likelihood of profit, the corporations had swift, easy access to capital. Despite some variation between its sites, a consultant at the corporate hospital (CS1) also noted that it tended to have

'the highest quality up to date equipment and [consulting rooms] usually' (CS1/M08)

As a NHS locum he had worked in a small cubicle.

Not-for-profit, cooperative and partnership providers financed developments from retained surpluses. The free-standing voluntary hospital (CS25) argued that its charitable status gave it

freedom to innovate and fewer cash constraints in doing so. The social enterprises were not allowed to make sufficient surplus for that. NHS trusts faced cost reduction programmes, hence pressure to focus on cost-saving and policy-mandated innovations. Scope for major capital developments had been limited for a long time. The case-study NHS hospital trust (CS13) operated from 30-year old estate on a congested site (which patients often commented on):

‘we’re not a PFI hospital, most of our beds are in four bedded bays, they’re not en suite bays, you know, the bathroom’s down the corridor’ (CS13/M46).

Certain of the case-study providers attempted in various ways to increase demand for their services.

1. Adding services when re-tendering an NHS contract. One of the corporate hospitals (CS1) extended its ophthalmology tender to include ENT, audiology and dermatology services, MIU appointments and endoscopy. It also added social care to support early discharge to its re-tender, and 72-hour home care for major joint replacements. The not-for-profit hospital (CS9) added preventative secondary care diversion services (physiotherapy, self-help, exercise classes, group work, psychology) for NHS patients as part of their referral package. In re-tendering for a CHS contract elsewhere, the corporate CHS provider (CS3) proposed adding care co-ordination centres (including a salaried GP employed by the CCG), and single points of access. The ex-proprietary corporate OOH provider added telemedicine (CS8).
2. Proposing new services for CCGs to commission. With an external commercial partner the corporate CHS (CS3) trialled an SEM scanner (which measures tissue viability and identified patients at risk) before making it the basis of a proposal to the relevant CCGs. The corporate CHS provider (CS3) proposed a local CQUIN for end-of-life care which its CCG took up for all that CCG’s providers, and local amendments to make the national health and well-being CQUIN more applicable to CHS. However it could also follow its expansionary instincts even when that was not necessarily financially rational for them. An informant in the corporate CHS (CS3) suggested that:

‘I think they suffer from naïvety in that they don’t really understand health, and how you can’t always make a business out of health’ (CS3/M43).

Some managers tended, for example, to assume more business could always be generated, without understanding the referral process, capacity issues, or the financial implications of expanding its workload under a block (fixed-price) contract. The social enterprise CHS (CS23) had with CCG support re-designed children’s mental health services so as to reduce

waiting times and persuaded its CCG to finance ‘a big investment into the district nursing service’ (CS23/M33). A CSU informant stated that the NFP hospital (CS10) had put forward business cases for new services,

‘And you know, they have been accepted as well’ (CS10/C13).

3. Diversifying services in order to spread contractual risks. This was why the free-standing voluntary hospital (CS25) acquired a plastic surgery centre with a completely privately-funded patient list, and added ophthalmic services, to increase their patient catchment. The social enterprise OOH (CS24) had focused recent innovations on diversification, including a talk-line service, GPs working in A&E departments, in-reach to nursing homes and in-hours home visits.
4. Joint ventures: The free-standing voluntary hospital (CS25) made its greatest expansion by creating a joint venture company with a social enterprise, and two NHS Trusts, which then bid successfully to run MSK services in two localities.

Even corporate providers could not necessarily make innovations which depended on future income from a CCG already under financial pressure. The corporate OOH service (CS4) abandoned several innovations for that reason: a hotline for care home staff, weekend GP ward rounds at community hospitals and walk-in-centres, and an OOH clinic for patients who had inappropriately referred themselves to A&E. The corporate OOH (CS4) provided GP cover for weekend ward rounds at the local community hospitals and at the walk-in-centre (on behalf of the local hospital trust but funded by the CCG) which, despite reducing calls from the community hospitals, fell victim to the CCG’s financial constraints. A local authority which commissioned the ex-proprietary OOH corporation (CS8) asked it to deliver a telecare response service as

‘a clinically focused operation that would tryand manage people and keep them at home’ (CS8/M09)

rather than just call an ambulance. After a pilot scheme (judged successful by its participants) the corporate OOH provider (CS4) wanted to establish its nursing home hotline on a permanent footing but only one CCG was interested because other CCGs had already implemented different referral-reducing projects. Both the OOH cooperative (CS20) and the partnership CHS provider (CS31) introduced an Acute Visiting Scheme (AVS). The cooperative’s version was both ‘active’ (e.g. telephoning nursing homes to identify incipient problems) and reactive, and included chronic care re-visits but after local CCGs merged the funding was halved which restricted the service to being

only reactive and for patients over 65. The CQC had told the NHS hospital trust (CS13) to refurbish its critical care wards, but:

'the lack of money in commissioning and try and push the rehabilitation agenda is quite a challenge' (CS13/M47);

When CCGs could finance pilot projects, they could not necessarily sustain the funding afterwards. Therefore at the NHS hospital trust (CS13)

'I do think we have a habit of chasing these priorities, so we end up with, what, pilotitis, where we're doing the pilots' (CS13/M47).

Another effect, reported at the NHS OOH provider (CS16) was that:

'everybody is very protective about their own little bit of the world and fundamentally what everyone is saying is are you doing your job in your area so that it won't impact me?' (CS16/M04).

Tight funding could also fuel disputes. Informants at the CHS Trust (CS20) told us that although a lead has been appointed for the various community sector interests (increasing consistency) tensions over funding remain between the local authority and the voluntary sector, which constrained progress.

CQC had told the NHS hospital trust (CS13) to refurbish its critical care wards, but:

'it's going cost £12 million, £13 million, £14 million, we haven't got it. So what do you do? You have to borrow it' (CS13/M44).

At the OOH Cooperative (CS20):

'The difficulty for ongoing funding [of the acute visiting scheme] is that the CCG are bankrupt, in effect' (CS20/M56).

As an informant at the NHS trust OOH provider (CS16) put it,

'if [CCG]'s only got 50p to spend on something it doesn't matter what policies or structures come out' (CS16/M04).

The CCG for the Partnership CHS (CS31) was in a similar position. One informant at a not-for-profit hospital (CS9) framed things differently:

‘There is enough money, it’s how you use it. ... it’s people’s perception and behaviour that changes things.’ (CS9/M32)

Even she, however, acknowledged that the commissioners were financially on ‘the back foot’.

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In sum, the financial leeway for innovation was clearly greatest (conditional upon profitability) in the ‘financialised’ corporations. NFP providers could draw upon their accumulated operating surpluses and donations. Fiscal barriers constrained innovation in NHS trusts, social enterprises, the GP partnership and cooperatives.

8.b.iii. Private patients

Another effect of different ownership arose from hospitals’ varying proportions of privately-funded and NHS patients (see Chapter 6). Our NHS hospital trust (CS3) did not have a large income from private orthopaedics or ophthalmic patients. The corporate hospitals (CS1,2) had been built under the ISTC programme and therefore mainly – but not exclusively – treated NHS funded patients, as did the free-standing voluntary hospital (CS25). The not-for-profit hospitals had a large majority of privately-funded patients.

Where hospitals depended heavily on non-NHS patients, it was important to managers to differentiate privately-funded care from NHS-funded care in order to justify the private payment, so that free, NHS-funded care would not ‘cannibalise’ privately-funded work. The not-for-profit hospital stressed that:

‘we’re not an NHS hospital, we offer it as an option and we have to be sensible with the fact that we’ve got private patients here as well’ (CS25/M27).

Clinical treatments did not differ between NHS and private patients but access did. Unless there was a clinical need a private patient would receive an appointment more quickly

‘and would pick when, where, who, whereas an NHS patient would be allocated an appointment’ (CS25/M27).

The not-for-profit hospitals (CS9,10) offered private patients treatments not provided to NHS patients, e.g. certain ophthalmic services (laser eye surgery, cyst treatment etc.) and an enhanced recovery pathway using the hospitals’ health gyms. One not-for-profit hospital wondered whether it might reduce its NHS work:

‘then there’s an opportunity to increase our private work which gives us a better margin, let’s be honest about this’ (CS9/M26).

In addition the corporate and not-for-profit hospitals tried to attract more private referrals alongside their NHS work. Managers at one of the not-for-profit hospitals (CS9) were seeking ways to increase the work of its small High Dependency Unit (HDU) in order to generate additional private general surgery work, considering buying a static MRI facility (to bring diagnostics in-house) and offering IVF treatment. It also promoted fitness and well-being events which included free ‘mini MOTs’ (cholesterol checks, blood-pressure checks), an app for monitoring one’s own health and a free gym pass for a week, which the hospital thought fitted the hospital’s charitable status:

‘[It’s] around keeping people well, supporting them when they get injured or ill, but the focus being on keeping people well, and that we can do that, whereas other players in the market can’t necessarily.’ (CS9/M32).

Another way was by marketing to private payers services which the NHS did not fund. Both not-for-profit hospitals (case studies 9,10) therefore began marketing procedures of limited clinical value (e.g. a second cataract operation, knee replacements for high-body mass index patients). They saw sales opportunities

‘for things like IVF and cataracts, you know, where the NHS wants to limit access then we should be an NHS provider because that then gives us access to the self-pay market. We don’t join up the NHS thresholds with actually the insurers, so we’ll probably move that way as well’ (CS9/M32).

For IVF:

‘NICE says three [cycles], most places do two, the hard pressed ones like Essex do one. So do we want to provide IVF in somewhere like Brentwood? Well, it’s a good idea because if we’re the first provider of the first cycle, then potentially people are going to want to carry on if it’s not successful and they’ll convert over to self-pay’ (CS9/M32).

Because they depended almost entirely on NHS-funded patients the corporate ISTCs simply lost work when PLCVs were filtered out and the corporations could not (so to speak) market them back in as privately-paid patients. CHS and OOH services, whose patients were all NHS-funded, were in a similar position.

8.b.iv. New models of care

National policies for care ‘integration’ (see Chapter 2) usually involved different providers jointly assembling a single, cross-organisational care pathway – a referral network²⁴³ - for a particular care group. ‘Vanguard’ models of care (PACS, MCP etc.) supplemented informal referral networks with more formal coordination and governance arrangements.

The OOH and CHS providers commissioned under block contract were irrespective of ownership setting up care hubs to try to reduce demand, deflect it or handle it more cheaply. The corporate (CS4) and NHS trust OOH (CS16) services wanted their hubs to include some combination of NHS111, mental health and district nurses, GPs, nurse practitioners, pharmacists, midwifery, mental health, social care and telehealth, with a common access point and interoperability platform. The social enterprise CHS (CS23) had similar plans. The ex-proprietary OOH (CS8) provider participated in its local council’s rapid integrated domiciliary health and social care service for people in crisis at home. The OOH cooperative (CS15) operated a 24/7 call centre as a single point

of access to other services, including hospital avoidance schemes. The partnership CHS (CS31) planned to redevelop their two larger sites to create hubs:

‘where we can engage with other local community providers as well to provide more of an integrated service’ (CS31/M43).

They argued that its constitution as a partnership produced greater cohesion and momentum than a federation of general practices would, pointing out that the partnership was offering new services and local GP federations were not.

The CHS Trust (CS15) had been involved, with another CHS trust, in setting up a Multi-Speciality Community Provider covering one of the cities in its territory and three rural localities, although at the time of our fieldwork this innovation was more aspiration than practice. Contrariwise the Social Enterprise CHS (CS23) argued that it practically already was an MCP:

‘the person caring for people with dementia is going to be sat beside someone who’s an expert in district nursing or wound care or tissue viability or IV drugs, or... You know, we do all those sorts of things in the community and that’s what you’ll get from one organisation, whereas in [another provider] they’d have to go out to some other organisations to actually provide those bits of care’ (CS23/M33).

It operated community hospitals (including an in-patient stroke service), district nursing, occupational therapy, physiotherapy, re-ablement and early supportive discharge services, a minor injuries unit, and - unusually for CHS providers - four general practices, employing GPs and nurse practitioners to serve about 5% of its client population. These practices were:

‘the ones that are non-profit making that local GPs wouldn’t want to provide in deprived areas’ (CS23/M34).

However the high cost of locums absorbed almost all the enterprise’s operating surplus, so this scheme had to be abandoned.

As a first step towards vertical integration between providers (the Primary and Acute Care Systems’ focus), the NHS hospital trust (CS13) ‘aligned’ each of its geriatric consultants with a number of GP practices, offering in the longer term the prospect of aligning hospital with community services and virtual wards. It

‘was always about having no walls, and actually you’re a consultant tier as part of a geriatric team who had happened to have their acute beds at [acute trust], their rehab beds

in [community health trust], they had covered these GP practices and this community model' (CS13/M47).

Although national policy had only promulgated the MCP and PACS models of care during the later stages of our field, in our sample it was the NHS trusts, partnership CHS provider and social enterprises (CS13,15,16,23,31) who had taken the first concrete steps towards implementing them, as had both CCG and local authority commissioners. NFP, not-for-profit and corporate providers had done less.

8.c. Innovation to reduce costs

The case-study organisations used four main kinds of innovations for reducing costs of care: revising the care process itself; changing its division of labour; staff reduction; and wage-reduction. These are each reported below.

8.c.i. *Revising the care process*

A care process could be made cheaper simply by re-sequencing it, for example replacing a batch²⁸⁰ with a flow process. Patients at one corporate hospital (CS2) had originally been called in as one group for each operating list but

'That's ages to just sit and wait when you can't eat or drink' (CS2/M19).

Staggered individual admissions reduced patients' waiting times and allowed earlier opening and closing times for the post-operative day wards, which reduced overnight admissions.

IT was often used to help rationalise care processes. One corporate hospital (CS1) was increasingly using electronic communications to reduce costs. The corporate CHS (CS3) worked with an American company to unify patient records across the different existing IT systems so as to give full mobile access to reports and the incident management system, and to reduce travel and increase patient contact time for its community nurses. The NHS hospital trust (CS13) began to use telephone conferencing for outpatients' appointments, leading if necessary to an x-ray at a provider nearer the patient, which removed the need for qualified staff (e.g. physios) to travel from patient to

patient. The CHS Trust (CS20) introduced more integrated electronic records and stock control systems.

8.c.ii. Innovative skill mix

Innovations in job demarcations and professional jurisdictions addressed both costs and labour shortages. Regardless of provider ownership, the main approaches were to: redefine professional demarcations; widen staff roles; and make greater use of multi-professional teams.

Nurse practitioners with experience of walk-in centres and minor injuries units were deployed partly to replace GPs in the corporate OOH (CS4), although not for diagnosing and treating young children, pregnant women or psychiatric patients. The ex-proprietary OOH corporation (CS8) employed nurse practitioners interchangeably with their sub-contracted GPs, as did the cooperative OOH (CS20) (which also them to replace expensive locum cover). The dispersed treatment centres belonging to the NHS trust OOH service (CS16) were generally operated by nurse practitioners and a receptionist. The CHS Trust (CS15) had substituted technicians for some clinical staff. The NHS hospital trust (CS13) transferred its least complex ophthalmic treatments to a GP consortium, and obtained funding from a pharmaceutical firm to provide AMD injections as a community rather than hospital service. They also ran a mobile diabetic retinal screening service and were considering a multi-site ophthalmic service.

Greater use of inter-disciplinary teams was made by the ex-proprietary OOH (CS8), which established a clinical triage team of nurses, paramedics and therapists. The CHS Trust (CS15) developed some early supported-discharge teams by adding psychiatric nurses and physiotherapists to existing primary care teams; and the social enterprise CHS (CS23) added OTs and social workers to its community crisis response, acute care at home, hospital discharge, substance misuse and learning disability teams. The partnership CHS provider (CS31) established an urgent care team of advanced paramedic practitioners, clinical pharmacists and nurse practitioners working alongside the duty doctor.

As for widening professional roles, at week-ends especially both the corporate (CS4) and the NHS trust OOH (CS16) services employed (or hired agency) pharmacists to divert prescription-only calls out of their triage queues. The free-standing voluntary orthopaedic hospital (CS25) re-trained its physiotherapists as extended scope practitioners in order to increase its preventative work. The ex-proprietary OOH corporation (CS8) and the NHS hospital trust (CS13) introduced a 'front-door'

admission avoidance scheme, placing staff there to facilitate discharge and raise awareness there of what community services could do. The NHS hospital trust had

‘a team that will go in to the emergency department, practitioners, nurse practitioners, because we know that if frail elderly people get through from ED that they will be admitted whether they need to be admitted or not’ (CS13/M38).

This was combined with work with GPs and nursing homes on admission avoidance, support for older people on the wards and a ‘hospital at home’ scheme. The CHS Trust (CS15) and the social enterprise OOH provider (CS24) used in-reach staff for these purposes and the latter also out-posted NPs to local general practices. Both the trust (CS15) and social enterprise (CS23) CHS attempted to provide primary medical care in areas where GPs had been unavailable but the costs of GP input proved prohibitive.

8.c.iii. Fewer staff

Lower staffing levels were another cost-reduction method. An informant at the Corporate OOH (CS4) noted that in its pre-corporate days as a cooperative

‘they had more doctors, they had more surgeries open, and more cars on the road as well’ (CS4/62).

Also,

‘Within [Corporation], because there are a lot of people that are on zero hours the staffing is always the exact number you need.... [and] the key resource that we have which is the GPs, aren’t actually employed by [Corporation]’ (CS4/M63).

The corporate OOH (CS4) senior management team had an explicit target of reducing clinical costs per hour. Apart from the CHS Trust (CS15), we had no reports of staffing levels being reduced in the other case-study providers.

8.c.iv. Wage reduction

A final innovation was purely financial: setting staff pay, terms and conditions below NHS levels. The corporate hospitals (case studies 1,2) were ‘unable’ to pay NHS salaries and offered different employment conditions (annual leave, sick leave, maternity/paternity leave) even though that

adversely affected staff recruitment, retention and satisfaction. Pay scales, cost of living enhancements and sickness benefits were lower at the corporate CHS provider (CS3) than in the NHS. The corporate hospital (CS1) was moving towards paying consultants per procedure not per session.

At the social enterprise CHS (CS23) pay protection for transferred NHS staff was maintained, but (unlike NHS practice) not indefinitely:

‘So you could be in a job a band lower but we’d still pay you a band higher. So we’ve put some time limits around that, and that will actually focus everyone to make sure that they actually are either found a job at the right band, or people accept they’re working at a lower band and get paid accordingly’ (CS23/M33).

The corporate CHS (CS3) did likewise. It was not clear how employees’ (as opposed to partners’) incomes at the partnership and cooperative compared with NHS levels. Against this, the smaller exproprietary OOH corporation (CS8) paid its clinical triage nurses, paramedics and therapists at approximately NHS rates, with a bonus scheme too. However, as reported above labour-market shortages limited how far non-NHS providers could in practice reduce staff pay and conditions below NHS levels.

8.c.v. Demand reduction

Demand-reducing innovations originated in the providers of competitively-tendered services under block contract and those whose care groups had open access to services, whether NHS trusts, corporations, cooperatives and partnerships.

Shortage of domiciliary care placements for patients was the main ‘downstream’ cause of provider overload for the NHS hospital trust (CS13), but we also found ample evidence of overload from ‘upstream’ there, and in OOH services. For the NHS trust hospital:

‘You know, there’s obviously the CQC priorities, and the front door work really, the capacity challenges, you’re constantly on black and red alert, and the four hour waits and the pressures’ (CS13/M47).

The corporate OOH service (CS4) reported its clinics were

‘pretty much are fully booked all the time. If you’re in [town 1] or [town 2] you get people coming in from A&E as well’ (CS4/M60).

Of these calls:

‘Actually I would say 60% of our work could, should be done in hours but they can’t get appointments with their own GPs’ (CS4/M60).

Innovations to reduce demand tended to focus ‘upstream’. At the corporate OOH provider (CS4), because of:

‘[T]he way we’ve led our doctors and the additional training, and facilities we’ve put in place for our doctors. They are able to close a lot more of the calls that are coming through as advice, whereas this time last year they may well have been sending those on for a face to face visit, thus increasing the activity within the service’ (CS4/M58).

They had also introduced point-of-care testing (at primary care centres and in cars) for deep vein thrombosis, avoiding the need to send patients to A&E for a blood test and enabling treatment to start immediately. The CHS trust (CS15) had run a ‘safe slippers’ campaign for patients moving from hospital to community care which had reportedly reduced falls and fractures. The social enterprise CHS (CS23) invested in providing acute care at home (including intravenous antibiotics and electrocardiograms) and medical oversight of rehabilitation beds.

8.d. Summary: divergent ownership, divergent innovation?

National and regional mandates (see Chapter 6) tended to make our sample of organisations converge in their work processes and innovations. Financial pressures made providers irrespective of ownership unwilling to exceed the service provision stipulated by contract. Staff shortages weakened wage differentials between providers under different kinds of ownership. Neither did the organisations in our sample differ, by ownership, in their tendency to manage demand and reduce costs by using IT, reconfiguring professional demarcations, and (in two cases) reducing staffing levels. Irrespective of ownership all providers paid under block contract and facing demand overload made demand-containment innovations such as clinical hubs or strengthening multi-professional teams outside hospital.

Partly the divergences stemmed from health policies (see Chapter 2) allowing corporate, not-for-profit and proprietary, but not NHS, social enterprise, cooperative or professional-partnership providers, to select which care groups to serve. Work-processes and innovation consequently

diverged for NHS trust and other hospitals. Corporate and not-for-profit providers selected innovations by 'business case', i.e. expected profitability, which happened to be low-acuity, predictable case-loads, services for which could be provided on a small scale in calm settings. Often these settings were also more modern because, provided the profitability condition was met, corporate providers had quicker and easier access to capital than not-for-profit providers and cooperatives, and the latter readier access to capital than the NHS trusts, social enterprises and professional partnerships did.

Corporate, voluntary and NFP chain providers tried to stimulate demand for their services and innovations. The latter diverged further in being willing to market secondary care procedures of limited clinical value and configuring services so as to differentiate those offered to NHS patients and to privately-paying patients. The not-for-profit and (with once exception) corporate providers contributed less than the NHS trusts and social enterprises did (at this still early stage) to MCP and PACS formation.

Chapter 9. Responses to commissioners

- Corporate providers were generally willing to take on additional work in response to changed CCG requirements, provided it was paid and profitable.
- NHS budget restrictions were reducing NHS trusts' flexibility in responding to workload changes.
- Providers' relationships with commissioners came to become more informal and negotiative over time.
- The transaction costs of commissioning (bidding, providing information) were considerable for providers, irrespective of ownership.

Next we report how diversely-owned providers and their NHS commissioners related to one another, and the extent to which differently-owned providers were responsive to their NHS commissioners' demands. (Chapter 6 reported what external configurations of NHS commissioners and other payers the case-study providers faced.)

9.a. Budget constraints and local healthcare needs

When it came to responding the changes in CCGs' financial circumstances and in local healthcare needs, corporate providers were generally willing to take on additional work. The lead CCG for one of our studied ISTCs (in its Commissioning Intentions document, 2015) saw the ISTC as being able to help reduce emergency department (ED) admissions. Supported by GP feedback about how services might be delivered differently, that CCG had also begun to commission more community services from the ISTC, including ophthalmology, dermatology, ENT and audiology. Such developments were, partly, responding to the NHS hospital trust

'who are locally incentivised to suck work in. We are over-performing with them and don't really have any innovative ways of managing their contract' (CS1/C10).

The CCG saw **the ISTC** as an alternative, innovative provider who would meet their needs:

*'they [NHS Trust] weren't able to deliver that so we went out to **[corporation]** as a pilot' (CS1/C10).*

They also saw them as

'a good organisation to work with; they're very flexible; they are innovative; they will work with us' (CS1/C10).

The CCG's assessment of the corporate ISTC's approach was mirrored by one of the ISTC managers who similarly felt the CCG considered them:

'very flexible, able to respond to their needs. And I think one of their [CCG] frustrations with the Trust, is that they don't [respond]. So, I guess, as a [corporation], as a private provider, we have to almost be yoga-like, like we have to be that flexible' (CS1/MO7).

Its CCG's contract with one of the NFP hospitals (CS10) had shifted in 2016-17 from a yearly to a two-year contract, and they contracted it directly not as a subcontractor to an NHS trust. The NFP hospital saw this as enhancing their relationship with the CCG hence creating possibilities for developing services and innovation. To keep its market, the free-standing voluntary hospital (CS25) had little choice except to enter a CCG-orchestrated MSK referral network. Another example of flexibility was the ex-proprietary OOH provider's (CS8) quick responses to the CCG (e.g. to their winter pressures funding or pilot projects). Whilst the provider's staff were

'well-established in the organisation and are well-known and respected within the CCG as well' (CS8/C03)

the corporation was changing, having received external investment and appointed new senior management. Meantime the stability of the OOH contract and its (adequate) funding was reflected in the quality of the service provided:

'[CCG] were able to say "We think we have a really good out of hours service", you know. To be fair, one of the reasons they do is because we're properly funded' (CS8/M09).

The CCG feared that this provider might *"lose their localness as they grow"* (CS8/C03). Being local, trusted and having NHS links had, as with the first example, helped make this provider flexibly responsive to its commissioner.

However there were limits to provider flexibility of response. Another instance of commissioners' expectations of provider flexibility were changes to the social enterprise OOH service requiring a 24/7 presence in the local acute hospital. For the social enterprise this demand had threatened the financial viability of its contract and proved damaging to its relationships with the local acute hospital and well as the (already challenged) CCG.

Rising demand for services and financial pressures made NHS providers *less* flexible. CHS and mental health service commissioning had, in the CHS trust, led to downscaling services and removing anything not in the contract. That had made it difficult to cover 'winter pressures' (and recruit staff on a short-term basis).

'The last year of contracting negotiations was very tense – blood on the carpet and walls at times, around what they [CCG] wanted us to deliver' (CS15/M21).

Yet the CCG reported that other NHS trusts were even less flexible:

'There are other Trusts where they will say "No, it's not in the contract, therefore you can't have it." Well, [CHS Trust] have never been like that' (CS15/C17).

This comment also revealed the former flexibility of NHS trusts under less adverse conditions. Financial stress also impacted negatively on the preventive agenda in particular. Innovative services introduced as pilots by the CHS and OOH services in particular were often weakened or jettisoned because of inadequate long-term funding:

'it's something we try and do but we're very aware of the financial implications of everything we do at the moment' (CS24/C01).

This seemed to have most impact on the smaller (hence independent) providers such as the OOH social enterprise and cooperative and potentially the CHS professional partnership. For such providers concerns over sustainability and workforce issues also constrained the ability to develop new services or innovate:

'this year we haven't put any bids in' (CS24/M01).

9.b. Patient safety and quality: CQUIN

CQUIN was the main means by which commissioners attempted to influence the *quality* of providers' services. Previously, although they had been able to include some quality specifications in contracts, commissioners had lacked leverage over the quality of provider work. Meeting CQUIN targets returned a percentage of the contract payment to the provider (2.5% maximum). These payments had been used inter alia to agree quality improvements with commissioners, improve pathways across the local health economy, and patient care (including in one city cross-organisational indicators (CS2, CS13)). They were also used for increasing value for money, with innovation seemingly more a possible consequence rather than prime motive.

Both NHS and corporate providers were responsive to CQUIN, for both financial and 'real side' (e.g. reputational) reasons. The 'real side' in the corporate CHS' contract included CQUINs for

community nursing, integrated working, MDT working and paediatric therapy waiting times. In this instance the provider had proposed a local CQUIN about the end of life care and the CCG adopted it (CS3, M40). The NHS hospital trust (CS13) had stimulated agreements about quality with the commissioner and improved patient pathways across the local health economy. A trust manager commented:

‘So the [patient] safety stuff we’ve done were in CQUINs, so we delivered the CQUINs last year which were some really significant successes’ (CS13/M38).

The lead CCG’s CQUINs were considered

‘quite reasonable, quality improvements, trying to change the pathways, those sort of things’ (CS13/M44).

Corporate providers were keen to use and access CQUIN. Because they were not formally eligible for national CQUINs (and small numbers might preclude their achievement) local CQUINs were the object of these discussions. One of our corporate ISTCs was

‘very open to having those sort of conversations’ (CS2/C05).

Its medical director identified areas such as sepsis and infection control which might form local CQUINs. Nevertheless CQUINs seemed less relevant to smaller, specialised providers. The lead CCG for one such (CS10) recognised, following guidance from NHS England, that using CQUIN may not be a good use of the commissioner’s or provider’s time. Instead they were considering developing local quality requirements to the same ends but (importantly) without financial incentivisation (CS10/C13). The OOH cooperative was in a similar position.

9.c. Under-performance

Corporate, NHS and social enterprise providers in our sample all underperformed against their urgent care contracts (by having high volumes of low-complexity activity), a reflection of the funding available for the services and the national policy of converting NHS Direct to NHS111, and pressures on general practice. This posed problems for providers in other parts of the local health economy, as in CS8 where OOH, NHS111 and the ambulance service were provided by three different organisations and a CCG officer claimed that

'111 is still sending 30% of things to the ambulance service that it shouldn't. If the ambulance service is still taking 30% of people to ED that it shouldn't, why is that happening?' (CS8/C03).

Similar problems related to the ambulance service contract.

Being a social enterprise changed case-study organisation 23's attitude to overspending:

'But it's still the same as it ever was [with the acute trust]. As a social enterprise, we're a limited company, so as directors of the company, we're not permitted to go bankrupt' (CS23/M34).

This same inability to overspend was noted by the social enterprise OOH service, suggesting they might have to rescind their contract as they were unable to trade at a loss (CS24/M15). The CHS social enterprise signalled to its CCG through 'activity query notices' that demand was changing and it was time to revise the contract, unlike in an NHS organisation which would simply continue to overspend (CS23/M34). Contractual uncertainty also contributed to the under-performance, as in the social enterprise and corporate OOHs where uncertainty consequent on the urgent care review constrained workforce development.

9.d. Diverse providers' methods of responding to commissioners

9.d.i. *Relationality*

Corporate providers often dealt with their commissioners in 'relational' ways: that is, they tried to establish close, dense, negotiative relationships with their commissioners. One ISTC (CS2), for example, saw "open dialogue" and conversational phone calls with its commissioners as the norm for raising queries. A director of the ex-proprietary OOH similarly spoke to the commissioner

'at least once a week, if not more' (CS8/M12).

Here, the commissioner's relationship with the provider was described as so good that in the CCG

'everyone felt that the [ex-proprietary] contract was an award; everyone wanted to look after the [name] contract' (CS8/M11).

The CCG confirmed that they felt

'very fortunate with the current relationship and performance we've got with [ex-proprietary]' (CS8/C03).

Similarly a great deal of contact between the OOH cooperative and its commissioner took place outwith meetings:

'I suppose it's not really a traditional commissioner-provider meeting with [the provider], it is, because we know them so well and because they're all local GPs anyway. It's just lots of phone calls go between the meetings, day-to-day things' (CS20/C19).

Other studies²⁸¹ have also suggested that commissioning meetings sometimes have the rather ritual character of endorsing arrangements made outside the meeting.

There was also evidence that the smaller contracts were run on a light touch basis (see e.g. CS31), reducing potential conflict. Relational contracting was more developed for providers that were considered long-term members of the NHS 'family'. Nevertheless commissioner-corporate provider relations had a good deal of mutual respect and understanding.

'I think we've got a very good relationship and I think they'd say the same' (CS8/MO6; C1, p.8)

In the quality manager of one of the corporate ISTCs (CS1) and the CCG met before joint service reviews to 'iron out' any quality issues beforehand, ensuring the review meeting only needed to focus on the 'headlines'. The small size of both corporate ISTCs meant, where separate contract review and clinical quality review meetings were held, that the same people tended to attend, making relationships often less formal and less 'bureaucratic' than in, say, NHS trusts (CS2). CCG staff attended some of the provider's internal meetings and *vice versa* (CS2/C05)), which blurred the provider-commissioner boundaries. The provider also described, and we observed, their openness with commissioners in the clinical quality review meetings. The lead CCG attributed the 'honesty' of the ISTC to the size and evolution of that organisation.

'When you're starting from scratch...you have no reputation and you have to build the confidence' (CS2/M18).

In this ISTC managers used the commissioners as advice and sounding boards, not just as performance managers, in contrast to CCGs' sometimes more adversarial relations with NHS

hospital trust managers. Another consequence of favourable relationships between commissioners and non-NHS providers was to embed the latter more fully in the local health economy.

It took time for such relational contracting to develop. In CS3, where relationships between the lead CCG and corporate CHS were initially strained, they were gradually easing:

'It's only in the last, sort of, three years we've actually had dialogue with them at all. Prior to that, I couldn't have told you who was commissioning the service... So, I mean, that has improved to a degree but, as I say, it's still very remote' (CS3/M43).

(Three years was longer than the whole duration of some other contracts.) In CS10, relations between the lead CCG and the NFP chain had reportedly improved during the previous year.

However:

'because actually we're [provider] not a natural fit to NHS processes, so we do need to work and think a little bit differently' (CS11/M29).

And

'It's a shame we're not seen as a capacity, rather than thinking, you know, instead of thinking of us as an independent provider, just think of us as capacity' (CS11/M30).

A prior connection with the NHS appeared, on balance, to help relationality develop. The CHS social enterprise felt that its CCG did not know how to relate to it as an organisation even though many of the CHS staff were recent ex-NHS employees:

'We were sort of the old NHS because we were sort of the old faces. So we were there but under a different label' (CS23/M37).

Nonetheless, the CHS social enterprise felt that its CCG was supportive towards it. This was endorsed by the CHS professional partnership where the provider reported having

'a really good relationship with the CCG' (CS31/M43)

not least because the operations manager in this small organisation had previously worked closely with the CCG. The NHS trust providing OOH services described its CCG as

‘quite easy going. They’re quite – they’re very supportive of [provider] so they’re quite relaxed really I suppose’ (CS16/M03)

and was so

‘because we’re NHS. It’s not an adversarial conversation, which it could be’ (CS16/M04).

Similarly for the CHS trust:

‘Many of them [CCG staff] were in former PCTs. Some have been in operational roles within the provider organisations. So I think there’s quite a good foundation of knowledge of the patch [local area], but also of the personalities and a willingness to be involved in clinical modelling as well’ (CS15/M21).

From their side, the lead CCG for this NHS trust stated in its documentation that it sought to *‘promote positive relationships’*, be *‘driven, resilient and fair’*, and *‘use cooperation and competition*, and our informants at the trust confirmed that was happening.

Four of our providers (a NFP multi-site, single site and two of the ISTCs) dealt primarily with the CSU rather than the CCG. This tended to reflect size of contract and had caused problems for relations in two instances, one (CS10) where it was felt to detract from the ability to influence strategically, and one (CS10) where information channels had been compromised. In marked contrast the CSU for the NFP single site was seen to operate in a far more strategic and pro-active role (reflecting seniority) and relations were stronger with this one contract manager than with individual CCGs .

‘[I]f I wanted advice I would always go to [contract manager’s name] who’s our contact at the CSU’ (CS25/M54).

9.d.ii. Provider scepticism, resistance

Yet relations between commissioners and independent providers were not always positive. The size and complexity of contracts with the CHS trust were partly responsible for some strained commissioning relations, compounded by the publication of critical reports on the provider’s services (including one from the CQC). Neither were corporate and NFP chain perceptions of their CCGs always positive, with some strained relationships in either direction. The NHS hospital trust took an unflattering view of its main CCG:

'most of the improvement stuff that we would do, we have identified it for ourselves already' (CS13/M38).

Informants at the NFP chain hospital greeted with laughter the suggestion that the CCG might bring ideas for new services. Rather, they thought the CCG *'quite controlling'* of the range of services the hospital provided (CS10/M29). Several providers, NHS trusts and corporate, thought that CCGs lacked sufficient skills and capacity to undertake tendering (eg. CS 13). The CHS trust provider stated that commissioners still tended to be numbers driven (eg. length of stay, numbers on caseload, readmission rates etc.) rather than focused on outcomes. One corporate manager (CS8) suggested that the provider had more capable and competent staff than those who commission their services, which reflected the immaturity of commissioning and the segmentation of the population. He implied that CCGs were *'transactional'* organisations, responding to challenges, not setting the agenda.

Zero-sum financial negotiations were a predictable source of provider inflexibility and hardly reinforced a sense of relationality and common interest. The change to a national standard contract with an associated national tariff had had a financial impact on the ISTC:

'but from the commissioners' perspective they're on budget and that was the main concern' (CS2/C07).

The parties were finding difficulties resolving the partial pathway transfers inherited from the previous DH contract. Previously NHS acute hospitals could transfer patients (subject to patient choice) to the treatment centre when the hospital risked breaching the 18 week waiting target but this arrangement ceased with the new contract. The CSU preferred transfers to be done under a sub-contract but the NHS hospital trust resisted because then they would incur fines for breaching the waiting times target. The two local ISTCs had also transferred patients between themselves in emergencies. The corporate ISTC argued the introduction of PLCVs as a filtering device might also lead to delays and divert some patients to A&E if they felt that they could not access specialist services quickly enough. The corporate CHS (CS3) suggested its block contract, which excluded only a few services, did not lend itself readily to *'incentivising'* the corporation.

In CS8, as elsewhere, many NHS hospital trusts wanted to keep their CHS contracts which were a way of managing demands on the hospital and contributed to their overheads. During our fieldwork the NHS trust providing OOH services was asking for an 8% growth in its 999 contract yet the CCG's budget was substantially reduced. The financial stress of the local economy was placing the CCGs under strain and this affected their relationships with providers, as one respondent noted:

'We are seeing a lot more aggression from commissioners to try and make their books balance' (CS13/M044).

9.e. Threat of competition

The CHS social enterprise's commissioner threatened to put services to tender if the social enterprise performance did not improve; which did not seem to foster constructive relations .

Because of commissioners' prior decisions, however, many providers had no such threat to respond to. Two of the CCGs commissioning the CHS Trust for example used competitive tendering only if providers were unable or unwilling to comply with the commissioners' requirements. Others had not re-tendered recently. The NHS ambulance trust OOH service (CS16) had never been re-tendered since 2004 but its contract, including its KPIs, was renegotiated annually. The hospital trust in the same CCG as the social enterprise CHS held its contracts without a procurement process, although the social enterprise's (CS23) contracts were renewed every 3 years. Even when commissioners might have wanted competition, potential new competitors were often sparse, partly because of the local geographies and partly because of the particular nature of the services. Urgent care was also a 'limited market' on the supply side because:

'They [alternative, diverse providers] all know each other very well. They know each other's strengths and weaknesses... I'm sure they'll all come into it in some shape or form' (CS8/C13).

Nevertheless we did find some instances of providers responding to competition or the threat of it. Both ISTCs had been the subject of recent re-tender, attracting interest from several providers, NHS and otherwise. In CS1 this was used both to introduce some new services and improve others. The corporation recognised that through this competitive tendering:

'That's where all your innovation comes in because that's what makes you better than the competition' (CS1/MO6).

Local knowledge was a competitive advantage which tended to favour NHS or recently ex-NHS providers. For example, when a CCG was considering commissioning a pharmacist to support its NHS111 and OOH services, the manager said:

‘So being able to have that discussion within someone like [provider] who can actually see the system benefit – it’s just not an organisational issue. I mean, if there’s that as well, that’s great’ (CS8/C13).

9.f. Integrated care

During the study period NHS England intended⁸ to achieve integrated care by diversifying the range of NHS organisations and networks, introducing MCPs and PACSs beginning with ‘Vanguard’ sites.

Plans to develop these new models of care came from local collaborations typically including NHS trusts, GP practices, local government and social enterprises. Corporate and not-for-profit providers played a lesser role. Respondents from all providers agreed that the biggest challenge was the delivery of national policy commitments, including this form of provider diversification, within such constrained budgets. Only our largest study LHE embraced any vanguard initiatives: a large MCP (with a key role for our case-study CHS trust) and a smaller PACS. Only one year’s funding was secured for the MCP, and drastically reduced for the second year (by which time the STP was introduced), making it harder to sustain momentum. The social enterprise OOH provider, only part of which lay within the PACS vanguard, expressed frustration both about the available funds and that despite ostensibly focussing on older patients with complex needs, the proposal emphasised integrating core services in-hours rather than the interface with OOH services. Nevertheless

‘we are there at those discussions having quite a loud and I think annoying voice for them’ (CS24/M02)

Following a national review, several commissioners wanted to align the commissioning of OOH and NHS111 services to simplify commissioning and service coordination, and reduce transaction (contracting) and service costs. However that would also replace several, possibly diversely-owned providers, with just one. In CS4 our corporate provider took over the OOH services in March 2014, successfully re-tendered for the contract and also operated the NHS111 service (as sub-contractor to an NHS ambulance trust). The corporation now feared that the CCGs might expect them to terminate their contract early so that the CCG could commission both services together with fewer clinical staff. In our main study LHE a local walk-in centre was closed and its services centralised at the corporate ISTC (CS1). The ex-proprietary corporation expected that the next round for

procurement for NHS111 and OOH would procure simpler arrangements, helped by the fact that the CCGs' NHS111 and OOH contracts ended at the same time, although if the combined 'hub' were to be located elsewhere it would undermine the work that they had already undertaken.

All these developments were however at an early stage of development. What non-NHS providers' role will be largely remains to be seen.

9.g. Cost control

Cost control policies during the study period mainly took the forms of HRG tariff reduction and the implementation of cost containment plans, above all through STPs, as reported in Chapter 6. Interestingly one of the consequences of a desire to control costs appeared to be separation of previously combined contracts (as in the CHS corporate and social enterprise examples) and a proliferation of individual contracts, except for OOH services.

9.g.i. *Tariff changes and their consequences*

Not-for-profit and corporate providers' response to tariff reductions and restrictions was often not to offer the services. Thus at the NFP chain hospital (CS9):

'So, for instance, we don't do ENT – primary reason, most ENT procedures require an MRI and we don't get paid for the MRI scan that they have. So that could be £600 or £700 worth of MRI scan' (CS9/M28)

Chapter 5 reported further instances, outside our study LHEs, of not-for-profit and corporate providers withdrawing from services which they could not profitably provide at current NHS prices. Commissioners themselves wanted to shift some services off tariff payments. The lead CCG for one ISTC (CS1) had shifted some elective work from tariff to sessional payments.

9.g.ii. *Financing service developments*

The payback period for financing service development differed across differently-owned providers, above all because some providers (particularly corporations) sometimes had longer-term, or at least more complete, contracts. The ISTC's first contract (following the national pattern) had been for 7 years. That guaranteed increased investment payback over this period but the CCGs welcomed its replacement by the standard national contract:

'So in the end, there was about a 20% difference between the cost of the treatment centre to a normal acute hospital ... service quality spot on [but]... The cost, however – that hurt the CCGs a lot' (CS2/C07).

A stable contract also gave the CHS social enterprise some leeway to innovate because

'We're not having to respond to the latest target or directive from central control. We have a contract that we're going to have for a number of years which won't change but we can change it if we want to with innovation' (CS23/M34).

When the NHS Trust suffered penalties under its OOH (and 111) contract, its CCG (which was under less financial pressure than most)

'rather than take the money generally [via contract penalties], will look for the re-investment of that to get to where we need to be' (CS16/M20).

The CCG favoured a collaborative approach and tried to avoid using formal processes if the NHS trust's performance could be improved by other means:

'The approach is much more around working with them if there are challenges and difficulties... Because if you have a service that isn't delivering, penalising financially so that you make it harder for them to deliver, is not really a sensible approach' (CS16/C02).

This was in marked contrast to the situation faced by the social enterprise OOH service where the penalty was seen to be threatening the continued delivery of the contract, even though the providers felt the commissioners would actually prefer to commission a local community benefit society than a corporate (CS24/M15).

In general, though, financial and operational (workload) pressures in a local health economy often reduced the 'head space' (for all providers) to deliver or develop services:

'I think when you've got a system which... is performing well, it enables the commissioner to have significantly greater head space planning around moving from good to great, and to give them some of that time to work with their partners' (CS15/M23).

Such conditions were necessary to develop, innovate and test new services, such as those linked to new models of care. However, this contrasted with commissioners' need to see outcomes quickly.

9.h. Transaction costs: provider responses

9.h.i. *Contracting*

Providing information to payers is a major transaction cost in any governance structure. Irrespective of ownership, providers who wanted NHS contracts had little choice but to bear the transaction costs of commissioning (which were mostly hidden, taking the form of extra managerial work rather than spending money). Re-tendering the corporate ISTCs was time-consuming. One director became detached from the day-to-day running as a result:

'I've spent two years much more focused on, you know, developing the bid strategy, getting the bid in, doing all that kind of stuff. So I, kind of, moved myself out for a while' (C2/M18)

New national HRG tariffs also compelled providers (irrespective of ownership) to track individual activities such as physiotherapy appointments, which was challenging even for corporate providers because it required new ways of data recording. A more subtle hidden cost was that during tender periods potential bidders (again irrespective of ownership) had to step back from any existing relational dealings with commissioners. For example, the new ISTC contract in LHE A started on 28th October rather than the 1st April, meaning a period of non-alignment with other providers.

Interestingly, the single site NFP suggested that, despite the multiplicity of contracts for its services, the costs of providing information to an increased number of commissioners was not important because common systems were used (the provider having been mainly responsible for the format of the original template). There was, however, a resource cost associated with attending more meetings and with preparing to answer different questions. Their CSU suggested that the small contracts were in effect left to manage themselves and did not get the commissioners' attention they deserve,

meaning they could become moribund. Specifically, he suggested the focus was too much on ‘*money and activity*’ and not enough on ‘*clinical care and how we can improve performance and share learning*’ (CS25/C15). This reinforces some of the concerns expressed above concerning relationality.

One NFP provider also operated as a prime contractor through the medium of a joint venture company. Contract management in this situation was tense, partly reflecting the immaturity of the contractual and collaborative working arrangements, particularly the difference between hierarchical NHS trusts and the smaller, hence flatter, NFP structure. Partly too the tension reflected a need to distinguish clearly the NFP’s responsibilities as a commissioner (of sub-contracted providers) and as a provider.

‘So the important thing to remember here, here we weren’t meeting our partners, we were meeting [provider] as our subcontractor, that’s the relationship’ (CS25/C08).

The use of block contracts for ambulance and A&E services meant that decreased attendances did not save money for the CCGs.

9.h.ii. Information

Information requirements created (or failed to create) the conditions for provider transparency to commissioners. Many providers, both NHS and corporate, thought commissioners’ information demands excessive, sometimes redundant. This was seen to be in the interests of patient safety but often focussed more on inputs and work-processes than outcomes, and was also becoming a burden.

Compliance was nevertheless a condition for NHS funding. One corporate ISTC employed a (dedicated) quality manager and a data support function to obtain and send information to its CCG. This ISTC thought that the reporting requirements were

‘Microscopic in terms of they want to know everything about everything’
(CS1/MO7).

These requirements (including monthly and quarterly monitoring reports) were specified in the contract but had increased in complexity. The ex-proprietary corporate OOH provider also thought that the CCG always wanted more information as the external landscape changed. Its CCG wanted to move to outcomes-based reporting, partly because the local authority already had. This

corporation nevertheless thought itself a good supplier of information: it had never refused an *ad hoc* request for information, for example (CS8/M12)).

At the NHS trust OOH service the CCG often made *ad hoc* requests for information but the trust often responded by reminding the CCG that it already sent it by another route.

'I honestly don't think they read half of them [contract reports]... I think 22 reports at the last QMM [quarterly monitoring meeting] and I'm not sure how many of those were read' (CS16/M03).

Providers who thought that commissioners' information requirements were excessive, even redundant, were therefore sometimes reluctant to provide that information.

Intermediary structures could also cause problems. One ISTC (CS1) had sub-contracted its community audiology service to the local acute NHS hospital trust. The latter failed to make its data returns to the ISTC, and CSU (acting as another intermediary) failed to explain to the ISTC that without these data returns the ISTC risked being out of time to claim payments for the audiology work. Eventually the CCG intervened because

'there seems to be misalignment in understanding around what data should be shared and by when, and what the consequences of that' (CS1/C12).

although the corporation did take

'data quality more seriously than potentially some of our NHS providers' (CS1/C12).

The CCG offered to bring its weight to bear on the acute trust and to get the CSU to allow a late claim as an exception. Similarly the CCG for the corporate CHS provider described difficulties with data interpretation and contextualisation, and the reporting system (largely inherited from NHS days) was scanty:

'it's been an on-going process to confirm with [provider] what we need and how we need it' (CS3/CS18).

At the time of our fieldwork the CCG was continuing to work with the provider to improve the consistency, accuracy and presentation of data. According to the lead CCG, this provider was especially protective of information about

'the information they'll share around their establishments and their organisation'
(CS3/C18).

One positive consequence of the increase in demand for information was that both providers and commissioners were increasingly seeking to use information intelligently, looking for trends and ways to improve performance, rather than just receiving data. Some providers and CCGs were emphasising the need to contextualise the data and look for trends, not just present numbers.

There was also a trend towards more openness and transparency. Where this was not apparent providers were called to account. For example a CSU informant was critical of the lack of transparency and communication in the way that the stand-alone voluntary hospital dealt with matters outside the review meeting, which prevented open interrogation or dissidence:

'it's disappointing that we're not having a conversation in the meeting, we're having it after the meeting, what's the point in coming today? If there's a problem let's talk about it, let's be open about it' (CS25/C15)

Although providers of all ownerships complained about how much data CCGs demanded it was particularly burdensome for OOH providers who all had to make frequent (in the case of the social enterprise OOH sometimes daily) reports about shifts filled and system capacity at times of peak demand.

Overall, four providers appeared to have no problems providing commissioners with good quality information, and indeed initiated information improvements. They were two corporate providers (an ISTC (CS2) and the ex-proprietary OOH service (CS8)), the stand-alone voluntary hospital (CS25) and the CHS social enterprise (CS23). That calls into question the corporate (CS3) and CHS trust (CS15) providers' claims that providing the requested information was too difficult. Seven other providers had no real problems providing information but largely responded to CCG demands without initiating improvements themselves. They were: the two NFP chain hospitals (CS9,10), two NHS trusts (the hospital (CS13) and the one providing OOH services (CS16), two other OOH service providers (one corporate (CS4) and one social enterprise (CS24)), and the professional partnership (CS31). Two providers had problems supplying the requested data to an appropriate standard but were attempting to improve their systems (one corporate ISTC (CS1) and the GP co-operative (CS20)). The remaining two (corporate CHS (CS3) and the CHS trust (CH15)) had similar problems but showed little sign of initiating improvements.

9.h.iii. *Bargaining position*

How providers responded to commissioners also reflected the providers' resource dependencies i.e. whether one provider faced multiple commissioners or, if it faced just one, what proportion of its income depended on that contract.

As other studies²⁸² report about other places, a major NHS hospital, especially a teaching hospital, is so large as to dominate its local commissioning system. The hospital trust (CS13) had contracts with 11 CCGs, the two largest each of about £120million, together about half of the trust's annual income. One of the not-for-profit chain hospitals felt that their low proportion of NHS income (estimated at 25%) and the limited autonomy allowed by their NHS contract reduced their need to be very responsive to the CCG who also took a transactional approach in their dealings with that provider.

Some of our case-study organisations had to deal with multiple commissioners who had different interests and required different responses. One corporate ISTC was commissioned by three CCGs, one of whom took the lead. However

'Each of the CCGs have different ways of working, different personalities, different priorities, and to try and juggle that from a team that works across all three can sometimes be a challenge' (CS1/C10).

Similarly, in the other ISTC, four CCGs were party to the corporate ISTC's contract but a CSU managed this contract on their behalf (except for the ISTC's dental contract with NHS England). As a CHS example, the CCGs commissioning the corporate CHS provider all advocated different models of care integration, including (between them) requiring that district nurses be available 24 hours a day, an enhanced district nursing service in one CCG, and community matrons across all the CCGs so services had

'developed and grown and evolved the service in line with [the] visions [of the different CCGs]' (CS3/M39).

All these conditions strained the commissioners' joint bargaining power.

9.i. Convergence or divergence across differently-owned providers?

These findings suggest certain convergences in diverse providers' responses to commissioners. All had an unsurprisingly negative response to contract renegotiations about how to allocate spending cuts. Providers irrespective of ownership complained that funding pressures and workload pressures reduced the time and financial 'headroom' for service development and innovation. All providers gradually came to respond to commissioners in more 'relational' ways although this took time to develop, periods of formal tendering sometimes interrupted it, and the providers' starting point was an often unflattering view of CCG and CSU commissioning capacity, methods and demands for information. Providers' bargaining power depended on their 'market' share and how many commissioners' they dealt with, rather than their ownership. Providers' behaviour sometimes differed in response to commissioners' behaviour, including whether the CSU was involved and its behaviour, not for reasons of provider ownership.

The divergences began with providers' approaches to taking on additional work, although the financial pressures on NHS trusts were reducing this difference. Corporate and not-for-profit providers were usually willing to take on additional work provided it was profitable (see Chapter 8) and they were paid for it. They withdrew from, or never started, providing NHS commissioners with services whose reduced tariff no longer covered the costs. In the past NHS trusts had been more accommodating in absorbing workload increases within their existing contracts but, as noted, the fiscal pressures on them were reducing that flexibility. Overspending had long been customary for large NHS trusts, but social enterprises (and corporations and not-for-profit providers) could not legally become bankrupt or trade insolvently. Local knowledge and networks were of practical advantage to providers in understanding and responding relationally to commissioners' suggestions for local health system changes and developments. NHS, local organisations (e.g. the cooperatives and partnership) and recently ex-NHS providers (e.g. our recently ex-proprietary OOH corporation, the social enterprises), and of course NHS trusts, were more likely to have such knowledge and networks, especially initially, than a newly-commissioned non-local corporate or not-for-profit providers. These differences may also explain why, at least initially, corporate and not-for-profit providers seemed to have greater practical difficulty (not necessarily unwillingness) in meeting commissioners' information demands. NHS trusts appeared more responsive to policy requirements than non-NHS providers. At this early stage in their formation, NHS trusts played a more central and active role in establishing the new models of care (MCP, PACS) and STPs.

Chapter 10. Patient choice and experience

- For competitively-tendered services, introducing non-NHS providers still did not usually give patients a choice of provider.
- Where patient could choose their provider they often chose not to choose (relied on their GP's decision). Those that did chose sometimes chose NHS provision.
- Patients found the ambience of secondary care in non-NHS providers – and in CHS services irrespective of ownership – very different to that in NHS acute trusts. The critical difference was case-mix not ownership.

This chapter reports patients' choice and experiences with diversely-owned providers. Our focus was not on clinical outcomes *per se* but the policy outcomes of choice and patient experience.

10.a. Choice of provider

10.a.i. *Commissioners choosing the provider*

For services whose providers were selected by competitive tending ('competition *for* the market'), the commissioning system chose which provider(s) patients would use. This was typically the case for community health services OOH services. Which provider a patient used resulted from *force majeure* (the circumstances of the patient's health problem, including need for urgent or emergency treatment), the operation of standard referral pathways and commissioners' tendering decisions.

For OOH services a patient's main choice was where initially to refer herself. Different forms of urgent care were available and to that extent a choice of service, but there was just one provider for each service and a defined division of clinical labour with provider-controlled triage (on the basis of clinical need or case-mix) from NHS111 to ambulances, A&E, minor injuries units and walk-in centres. Often patients were confused about the difference between NHS111 and OOH. Many 'phoned NHS111 first, with A&E or 'phoning 999 as last resorts. Having been selected as the first-contact provider, that organisation then determined that patient's future direction (subsequent provider) at triage, usually following a standard referral pathway.

Many CHS patients arrived there following an A&E admission with subsequent transfer to CHS (often as an inpatient) for rehabilitation or therapy. This group included patients with limiting long-term illnesses, often older and frailer than those receiving our hospital tracer services. The corporate CHS patients, for example, were referred there by the hospital, GP (or occasionally 'other'

practitioners such as a neurological consultant or specialist nurse) with the patients often unsure of the rationale.

‘And I said, “Well, what is it? Why am I going there when you can treat me here, it’s only down the road?”’ (CS3/P51:70).

The only instances of patient choice of provider within NHS community health services were to use of an optician rather than community hospital for diabetic retinopathy testing; a local community hospital for blood tests (where appointments could be booked) rather than the general hospital; and a choice, in one LHE, between CHS and the local acute hospital for physiotherapy.

Commissioners’ tendering decisions usually resulted in the selection of one provider for a given service for all the commissioner’s population; and therefore what referral pathways existed. For these services, differences in provider ownership influenced patients’ destination of provider only insofar as commissioners responded to differences in provider ownership, as reported in Chapter 9.

10.a.ii. Patients choosing their providers?

Our hospital tracer services were within NHS quasi-market structures based, national policy assumed (see Chapter 2), on patient choice of provider. A repeated theme both in interviews and focus groups was that choice and awareness of different providers were limited in practice. Patient informants’ awareness of the choice agenda was generally low, except among those holding formal representational roles. Our ophthalmology and orthopaedics patients:

1. Were not always aware that they could choose their provider
2. When they were aware of it,
 - (a) Their GP sometimes steered their choice
 - (b) They sometimes wished to abdicate that choice to an expert.
3. Having chosen a provider, they sometimes ended up on standard referral pathways to further services with no choice of provider.

Again, however, the *force majeure* of, say an accident, fall or exacerbation of an existing health problem meant that a patient could only go to A&E, after which a standard referral pathway might

take them to a provider that the patient could have chosen had her circumstances been different (though even then she might not have chosen it).

Patients were more likely to consider whether to seek private or NHS care than to consider choosing between different types of provider as an NHS-funded patient. Many felt the absence of choice was not an issue provided that they experienced efficient, good-quality care. Some patients (but not all) were aware that as NHS patients they had a choice of provider, but less often aware of who owned which provider. Patients knew the NFP's ownership and that of the acute trust but generally not that of ISTCs, CHS, or OOH – all were assumed to be provided by the NHS. There was a broad consensus amongst both focus group participants and interviewed patients that choice was welcome and gave people more responsibility. Those who favoured choice of provider felt that it afforded them a degree of control (and flexibility) over the medical encounter that patients valued. Those offered treatment as an NHS patient by an independent provider often felt privileged to have had the choice.

Some felt that the specialised nature of their condition foreclosed the choice of provider anyway. The fact that for orthopaedics and ophthalmology the non-NHS providers were generally offering a specialised service was an obvious attraction:

'Well, clearly in the case of joint surgery a hospital that specialises in that, it's a no-brainer, isn't it, that you choose that' (CS25/P42).

Patients often relied upon the expert gatekeeper's – GP or consultant – attitude and advice. Many felt they did not know enough, so choice was confusing. Some thus

'just take their (the professionals) word for it' (LHEG/FP13).

For patients at the two ISTCs the initial choice of provider was most commonly made by the GP and reflected the GP's own knowledge and attitudes to choice as well as patient characteristics, particularly the degree of trust placed on health professionals:

'No. No, I go to the GP and rely on them to know these things' (CS1/P20).

Elsewhere, but for different reasons, GPs played a relatively minor part. In one NFP hospital's (CS9) CCG a referral management service triaged patients and offered them a choice of provider, and an MSK pathway (referral network) had also been adopted, emphasising non-interventionist methods of care. Delayed access and protracted pain then prompted a number of patients to seek private diagnoses, from which the consultant offered access to the NHS pathway. The single-site

NFP (CS25) had instead a well-informed patient base and the specialist provider had a good reputation locally. There was also a clear element of co-production:

‘Well, I said to [GP] I’d heard the [hospital] was good and what did he think. And he said yes, and then we flicked up the consultants on the computer, had a look and we chose it together’ (CS25/P74).

Just under a half the hospital patients in this study said they eventually made a choice of provider (some having been made aware of it by their GP, consultant or referral centre). Few of our informants had used published information or the web to research local providers or available treatment, and stressed that information had to be completely up to date to be of value. Like others^{4,88,283} we found that waiting (referral to treatment (RTT)) times were almost universally the most important criterion in patients’ choices. RTT came under considerable scrutiny in contract review meetings. For one patient making their choice at an ISTC this was the basis on which the information was presented:

‘[T]hey said to me, “You can have,” I think it was, “[DGH in neighbouring county] which will do it in so many weeks and [DGH in same county] will do it in so many weeks, or we [ISTC] can do it,” she said, “Next week.”’ (CS1/P13)

However this information was not always to hand:

‘And with me it was basically the time, I wanted to know which one had the shortest waiting list. But they said they didn’t have that information, you just had to pick one. So I picked the [NFP] (CS9/P30:20).

Many (particularly the older old) did not have computer access. Networks, contacts and what some saw as privileged information, helped some patients choose alternative destinations that might not have been common knowledge:

‘No, I knew...the first surgeon, [name], again a super guy, he lives just up the road here’ (CS25/P42)

Focus groups and individual patients said that the non-NHS hospitals (CS1,2,25 & generally 9) tended to offer quicker access (RTT time) than local NHS acute trusts generally (not just our particular case-study trust). The two corporate treatment centres had typically short RTTs:

'You mean today's Monday and you'll do it Wednesday?' (CS1/P13).

They contrasted that with the local NHS Trust (CS13)

'if you're going to the [NHS hospital], you're talking months' (CS2/P36).

Several patients interviewed at the NHS Trust, for example, described occasions when they had gone privately in order

'to get it done quicker' (CS13/P57:383).

At the NFP chain hospitals NHS-funded patients fell into two roughly equal groups, those who had been seen quickly and those (typically patients who had chosen a particular consultant as the result of private consultation) who reported long waits from consultation to treatment (in one case 19 or 20 weeks). An NHS-funded patient's choice of provider could however be revoked. For example patients might choose the NHS hospital closest to home but then be offered a quicker appointment elsewhere.

10.b. Choices at the provider

Having chosen a provider, or had it chosen for them, patients might then face further choices within the differently owned providers.

10.b.i. *Choice of treatment*

Choice of treatment depended above all on a patient's physical condition, referral thresholds, and consequently what care or treatment options (pathways) current technology can offer. In CHS choice of treatment seemed to be confined to simple treatment decisions such as whether to attend group physiotherapy sessions or to accept items of equipment, or about waiting times and location. These limited choices were not felt to be problematic if options were acceptable and tailored to the patient:

'No, I was very happy with what I had anyway' (CS23/P28).

When patients were discharged was also largely clinically determined following prescribed pathways. As noted, the only choice in OOH services was the initial one of whether to self-refer to NHS111, A&E, the ambulance service or somewhere else.

Irrespective of provider ownership, hospital patients also had little choice beyond the initial decision

‘whether to have the surgery or not. There was clearly that choice. I was encouraged to have it’ (CS1/P12).

A few treatment choices were nevertheless offered, for instance in the NFP hospitals as to location and duration of physiotherapy, and at the voluntary hospital over its method, phasing and sequence. Such choices were if anything slightly more common in the NHS Trust, reflecting its wider range of services and specialities. Patients gave examples such as choosing between conservative treatment rather than an operation, choice of appliance, and the patient deciding whether casts be replaced. The few flexibilities in treatment plans reflected the nature of the care pathway and scope for discretion in clinical care rather provider ownership.

Neither did most patients choose their time of discharge. Many were simply happy to be going home and frustrated by any delays. In general, such choices were subordinate to recovery for the patients we encountered. Furthermore, as a patient in the NFP single-site provider pointed out, ultimately:

‘they want the bed, end of, like every hospital in the country’ (CS25/P74:185).

Few patients expressed reservations about lack of choice in these respects.

10.b.ii. Choice of practitioner

Generally CHS and OOH patients had no choice of practitioner. In OOH services the triage process chose the practitioner (including the practitioner’s profession; whether doctor, nurse practitioner, paramedic etc.).

‘We didn’t particularly ask for a doctor, but whoever it was that was on the phone thought it was, you know, they called for the doctor’ (CS8/P04:69).

This choice, or rather lack of it, was similar across all the CHS and OOH providers we studied irrespective of ownership.

For the hospital services, ISTC patients did not report having a choice of consultant. Indeed some suggested that without supporting information that choice was an irrelevance:

'He was just appointed and that was it. I didn't ask for anybody else, I wouldn't know them anyway [laughs] (CS1/P21).

Many, however, valued the relational continuity of seeing the same consultant for initial assessment and operation:

'you build up a confidence with them, don't you' (CS1/P14).

In the NFP chain hospitals a consultant whose first consultation with a patient or diagnostic services had been privately-paid could then offer the patient the opportunity to return to see them on an NHS pathway.

'I said to him, "If I do wait for the NHS would you still do it for me?" Because if not then that would be the deciding factor, and he said, "Oh yes, I'll do it for you"' (CS9/P33)

but with the consequence of waiting 19 or 20 weeks as opposed to 10 days if she had gone privately. The stand-alone voluntary NFP hospital had a similar working practice.

10.b.iii. Flexible time of treatment

Choice of time of treatment is only possible for planned care. For the many inpatients who accessed CHS following an emergency or OOH for urgently-needed treatment, that choice could not arise. After that, CHS appointments tended to be flexible within clinical constraints (the need for regular monitoring or to respond to test results for example). For mobile clinics the choice of a convenient time would dictate the location, or vice versa. However flexibility as to timing was particularly commented upon in the two corporate ISTCs (1&2):

'I just thought it was very efficient ... being able to choose when you could go almost, rather than, you know, like, I know I shouldn't criticise the National Health, but rather than having to wait months and months and months' (CS1/P11).

Paradoxically this flexibility reflected a case-mix entirely of planned treatments. For the same reason operations were less likely to be cancelled in the non-NHS hospitals (CS1,2,9,10,25) than in NHS acute trusts (again not just our case-study example). Stories abounded in focus groups and patient interviews of operations cancelled multiple times, even when the patient was gowned up or on the anaesthetist's table. One patient had experienced six cancellations at an NHS trust before being treated at one the NFP chain's orthopaedic hospitals. Patients electing for operations outside

the NHS trusts were unlikely to have their operation cancelled, which was important if they relied on a working family for aftercare:

'it needed to be planned' (CS9/P55).

Waiting times *within* hospital were also commonly longer in the NHS hospital than non-NHS providers (CS1,2,9,25). All three NFP hospitals were typically described as very efficient. At one it was

'very streamlined, you feel you're on a conveyor belt, and that is the way they run it' (CS25/P43: 280).

Service at the two ISTCs was also punctual:

'if they say your appointment is 11 o'clock it is 11 o'clock' (CS2/P36:284),

and rapid (except for cataract operations, where patients had to wait for eye drops to take effect). Unfavourable comparisons were often made between the non-NHS and NHS hospitals in a variety of locations:

'It wasn't like the three hour wait that I had at [NHS hospital]' (CS25/P40).

About a quarter of respondents, irrespective of provider, felt that they had to wait too long for a response from the NHS111 or OOH services:

'absolutely no reply...just dreadful, dreadful' (CS24/P)

and wait again at the (centralised) clinic although, as with one 3-hour wait, this was normalised:

'It takes a long time but you know that's going to happen, I think, if you get to A&E [laughs], don't you?' (CS24/P08).

Satisfaction about waiting times seemed greater at the corporate OOH provider. It provided both OOH and NHS111 service and gave a choice of clinics with one patient describing how he was told:

"In five minutes' time somebody will ring you." And he did, and he said, "Can you be at [local community hospital] in half an hour?" (CS4/P8).

In the social enterprise CHS several patients had experienced delays in accessing physiotherapy, and in the NHS Trust CHS delays in recall caused some consternation. The charitable and NFP hospitals showed a degree of negotiation about transport and availability of family support at discharge.

‘I asked if unless they need to really kick me out could I stay for the extra, which also gave my sister a rest because she was dashing to and fro to visit me. So I was, sort of, a guest really on the fourth day, they supplied medication and food, but I was left to my own devices to recover a little bit more, and then I came home’ (CS9/P29)

10.b.iv. Choice of place of treatment

Where choice was offered (e.g. physiotherapy following discharge) waiting times and location were key defining factors rather than the provider. CHS patients transferred from hospital had as noted no choice of place:

‘Absolutely no. It was a case of “We are moving you to...”’ (CS3/P52:).

There was a limited choice of place for some community therapies, sometimes (as in the CHS Trust) between attending different community hospitals or outreach clinics (and for some patients, treatment at home) and occasionally, as noted above, a choice of provider but these choices were very variable even within the same organisation. All OOH providers except the social enterprise (CS24) offered a choice of clinic locations, which seemed to help patients access the service and reduce their waiting times.

10.c. Other differences between differently owned providers

10.c.i. Ambience

Hospital patients mentioned ambience as a key factor in their experience. The non-NHS secondary care providers (corporate ISTCs, NFPs (CS1,2,9,25)) were all described as being smaller, slower-paced, more patient-centred, quieter, and comfortable.

‘Yes, it’s just a nice environment, it doesn’t feel too hospitalised, and it doesn’t smell too hospitalised either’ (CS1/P11).

At the single-site NFP

'it's so peaceful, it's so calm, it's so helpful, you know' (CS25/P44),

Patients described the accommodation at these non-NHS providers as clean, tidy and comfortable:

'Well, you had your own room, television, you had your own bathroom, a dressing gown, slippers, and choice of menu, and physiotherapy treatment' (CS9/P22.)

whilst the ISTCs were described as

'lovely, they are, spotless and quiet' (CS2/P36).

Patients felt that this ambience reduced their stress levels and gave them a greater sense of control. They were not *'on tenterhooks'* worrying they might have been missed in the busy NHS hospital reception. The only adverse comments concerned lack of air conditioning at the multi-site NFP provider (during a hot summer) and the pre-treatment layout of one ISTC was felt not to give privacy.

Community (CHS) hospitals also had this ambience, irrespective of ownership. Comparing them with NHS trust district general hospitals, patients again commented upon the smaller unit size, smaller wards, better staffing ratios and more relaxed atmosphere.

'[It] still is very relaxed there and you feel very comfortable there, I prefer it to [district general hospital]. You know, at [district general hospital] it's all hustle and bustle, yeah, but [community hospital] isn't' (CS23/P26)

Several of the community hospitals also provided inpatients with their own room:

'Yes, [community] hospital consists entirely of private rooms with little attached loos, and things, which I thought was an absolutely wonderful way of devising a hospital' (CS3/P54:95).

Again patients attributed this in part to caseload. One NHS Trust patient, for example, always went to the local community hospital for minor ailments,

'because it's a smaller hospital and it's quieter and it's not so hectic' (CS15/P23).

Another recognised the role of routine:

'Yes because they give you a time' (CS15/P86).

Community hospitals too were typically described as relaxing, comfortable and clean:

'[T]he place was swept to death, cleaned to death, you know. It was beautifully clean'
(CS23/P31)

The NHS hospital trust had a busier, chaotic, pressurised ambience

'[I]n the [ISTC], there's no rushing around or anything like that. I know the [hospital] is different, but you feel as though you're in a whirlpool' (CS2/P36)

The 'major general hospital' was described as

'more like a shopping centre, until you get into the bowels of it' (CS13/72)

where patients were sometimes disoriented. Many patients described the stresses of the busy and unpredictable NHS hospital environment (the only one to treat emergencies), but also commented adversely on block bookings and a lack of information, all of which raised their stress levels. The accommodation in NHS hospitals generally was also often praised for cleanliness but sometimes not:

'[W]e have all these fancy hand cleaners, and all the rest, and the places don't particularly smell brilliant. Often the toilet facilities are not quite as wonderful as they should be' (CS2/P38).

Patients in other study LHEs also talked of their local DGH in similar terms of impersonality, size, with other patients on wards being upsetting to be with and frequent visitors disruptive of recovery. They expressed concerns about being moved frequently, being moved in the night and being discharged late in the evening. The acute hospitals were criticised for a seeming over-dependency on ward stations and non-awareness of the limitations of old age (hearing, mobility, uncertainty over where to go, concern over continence), all of which increased patients' stress.

One other location that stood out was the co-operative OOH service's clinic. All other accommodation there was praised but late at night and unaccompanied, a patient had two encounters which left her feeling vulnerable:

'It was like, the first impression I thought to myself, "Are these all drug addicts? Is that why they don't have proper seating, comfy seating, because they think it's going to be wrecked? Surely this is not all they could afford?'" (CS20/P59: 618)

What determined the difference of ambience across providers was therefore not ownership but case-mix (planned admissions only *versus* a case-mix with high proportions of emergency and urgent care), hence the range of specialities and therefore the scale of the provider, and indeed its case-load. Building stock was the other physical factor causing a good ambience or bad, depending on the case.

10.c.ii. Apparent pressure on staff

Patients at the NHS hospital trust (CS13) commented on the pressure under which staff were apparently working. That inhibited some patients from asking questions. Lack of staff continuity also contributed to a poorer experience for some patients. However some patients at the corporate CHS also though they observed similar pressures including a lack of continuity in nursing staff, which patients variously attributed to the size of the organisation, its shift patterns and use of bank staff. In contrast patients at the social enterprise CHS commented on its high staffing ratios and the staff having good engagement and communication with them.

We speculate that these differences may not reflect provider ownership so much as each provider's geographical setting. The social enterprise CHS was not exposed to the health labour market difficulties of south east England.

10.c.iii. Provider ownership itself

Patients' attitudes to diverse provider ownership tended to take one of three positions. Some patients did not realise that non-NHS organisations had provided their care. Few, for example, understood that community health services were anything other than NHS-owned:

'I haven't got a clue. All I know is sometimes if it works you don't bother to challenge it'
(CS15/P86);

nor that the ISTCs (in our case-study LHEs) were run by private providers. They thought they were receiving an NHS service.

'No, I'd just automatically thought that's where you went to have this particular procedure done. So I was quite happy to go' (CS1/P14).

In the focus groups too several described seeing a consultant in the NHS and then agreeing the treatment that (s)he proposed:

'they're telling me where to go – I'll go' (FG1).

i.e. to an ISTC (badged with the NHS logo) without realising that it wasn't an NHS organisation.

A second group knew non-NHS providers were involved in their orthopaedics or ophthalmic care but were indifferent to it. If their treatment was very specialised they might want to ensure they had the same specialist irrespective of provider:

'And I wouldn't have cared where I'd gone, to be honest, as long as the chap that was doing it was, kind of, you know...it was more to go and see him, as opposed to where he was working from' (CS25/P46).

Pain and delayed access could also lead people to wherever they could rapidly get diagnosis and treatment:

'and the pain got so very much worse that I paid for a private appointment just for a diagnosis' (CS9/P33).

Despite thinking that private services might be leaving a core of difficult problems to the NHS,

'As long as it doesn't affect the Health Service, I think, no, I think it [choice of provider] is good' (CS9/P55).

Alternatively, as a Healthwatch engagement officer said:

'they don't really care who it is that's providing that service, as long as they're able to access it' (FP019)

The third group emphasised loyalty to NHS. Some specifically opted for NHS treatment believing that

'if something does go wrong within the NHS set-up they'd be better able to cope with it' (CS4/P76)

or that

‘the NHS will look at possible treatments and then choose the treatment which is most appropriate’ (CS13/65)

whereas private providers might be more motivated by potential income. Both the focus groups and interviewees expressed such views as:

‘the whole of notion of a service being free at the point of contact is so, I think, embedded in our culture now, ...So I think it’s worth defending?’ (CS4/P76).

Some felt the profit motive and health did not mix well, mentioning the US health system where some people would not be *‘allowed in the ambulance’* without health insurance. Others opposed to choice of provider either on grounds of equity:

‘I’d prefer a far better service for everybody’ (CS8/P03)

or because they felt it was inappropriate in a public service. If more responsibility fell to the patient, some people would be excluded and risk receiving a residual service. Some perceived that the choice agenda was about the dismantling of the NHS.

10.c.iv. Cross-sectional discontinuity of care

One particular barrier to care coordination and patient co-production of care was the often-reported problem of departments, or even whole organisations, acting as parallel ‘silos’ rather than in concert:

‘[T]here’s the urologist dealing with one problem, cardiologist dealing with something else, occasionally there seems conflict between the two of them, and the GP is somehow in the middle. So you come sometimes to the end, you’re seen, you get treated, and sometimes you’re not terribly clear, “Well, what’s my next step?”’ (CS4/P76)

In two instances (both in the NHS hospital trust) this demarcation extended to specialists within the same department:

'[t]here's this distinction between back of the eye and front of the eye people all the time' (CS13/67).

This problem reflects the range of specialities in the hospital. Its connection to ownership is the indirect one that non-NHS hospitals in our studies 'cherry picked' care groups (not individual patients) and therefore elected not to contain such a wide range of specialities (see Chapter 8).

10.d. Similarities across differently-owned providers

Our responses from patients suggested certain service characteristics were much the same across the differently-owned providers. They described positive staff attitudes and quality of care across all the secondary care and CHS providers, often remembering particular staff by name. The same generally applied to communication between staff and patients. Information flow was generally felt to be improving, in particular the availability of computer notes, diagnostic results and staff who were trained to engage with patients. Patients did not consider confidentiality of personal information to be a problem in any provider type. For in-patients, food was generally felt to be acceptable in terms of quality and choice.

Irrespective of provider ownership, care from the OOH services included examples of encounters that were typically too short to explain problems or ask questions. Patients often felt that triage (typically by NHS111) was a barrier to accessing care.

10.e. Factors other than provider ownership affecting patient experience.

Non-ownership factors sometimes outweighed any consequences of diverse provider ownership for patients' experiences.

10.e.i. Geography

Proximity to home was an important service attribute for many patients, especially convenience of access (including bus routes), ability to park and accessibility for visitors. It made some patients feel more secure:

'Well, somewhere close to home, yeah, don't want to go miles away... I think you feel a bit more tense when you're miles away from home' (CS3/P53:246).

In more rural areas, one in particular, patients emphasised that health services were difficult to access and that community care (now provided by non-public agencies) was not universally available at all, let alone a choice of provider. More surprisingly, a similar restriction was reported in two of the conurbations we studied, arising from closure of a hospital and a walk-in-centre. None of the providers that we studied offered patients a choice of location for our focal services. The only way patients who were place-sensitive could influence that was through their initial choice of provider, if even that existed (see above).

The NHS hospital trust we studied (CS13) was particularly difficult for parking which many patients described as ‘atrocious’ (and costly). Car-parking is important for older patients whose mobility problems and dementia can make walking and dropping off difficult for them. In contrast at the nearby ISTC it

‘was just very easy because it’s much smaller, you can almost park the car and see your department, well, you could, you could just see it straight across, so that was a joy’
(CS13/P75).

Parking difficulties at the NHS hospital (and CHS trust, where patients reported similar problems) reflected not their present ownership but their inherited sites and infrastructure; conditions which often take decades to change in response to changes of ownership (or for any other reason). The social enterprise CHS provided transport for inpatients requiring diagnostics at another location:

‘But they took me, brought me back again, no problem.... They even give you a packed lunch when you go at lunchtime’ (CS15/P28).

10.e.ii. Informational continuity of care

Information availability varied by service type (care group) rather than provider ownership. Information handling was generally felt to be improving with notes more accessible by computer and patients, with GPs included in the loop. Patients felt that this was re-assuring and removed a (presumed) responsibility from them.

Of the secondary care case-study providers it was notable that the ISTCs and NFP staff were generally felt to be well informed (drawing variously on computer, records diagnostics and notes), although some patients drew a distinction between information relating to this specific episode and wider awareness of their medical background. CHS computer records were generally available (occasionally almost to the point of influencing the consultation²⁴¹):

'it didn't matter where you went in to, who you saw, it was on the screen. So they had to the up to date information' (CS23/P28).

In the social enterprise CHS, as a partial exception, some patients felt therapists did not necessarily have records to hand, but also that the records were not necessarily needed at the moment when patients had come for a treatment-specific assessment (e.g. for physiotherapy). In the NHS hospital trust matters appeared complicated with information exchange between providers and sites both locally and sometimes at a distance, creating more opportunities for (say) x-rays not to appear.

OOH services were an exception with less recorded information available both (for example) at MIUs and home visits. For most patients this was not problematic but a patient with more complex needs felt the lack of records keenly:

'They didn't know, none of them' (CS8/P03).

In the corporate OOH patients thought their GPs had at least sometimes been briefed by NHS111 but in the social enterprise OOH, which was separate from NHS111, even news of a patient's appointment would not always filter through to OOH reception:

"No, we haven't heard anything, we never hear from 111," this lady said to me [laughs] (CS24/P10).

The clear exception was the co-operative OOH service where the general practices' participation meant their records were always available:

'[T]hey have it all on computer, you see, it's all linked' (CS20/P59).

10.e.iii. Staff characteristics

Many hospital and CHS patients spoke positively of the staff attitudes and quality of care they had received (*'superb'*, *'caring'*, *'sympathetic'*, *'friendly'* etc.). They thought that reflected attributes of the provider organisation (training, provider ethos, staffing ratios etc.) as well as individual character, to the extent that many would describe staff as being very professional which they took to include being compassionate, empathic and respectful. This was similar across providers irrespective of ownership.

Again OOH was somewhat different. Every case-study included at least one patient who felt they were treated unsympathetically, given too little time or assessed wrongly. Patients tended to

attribute that to pressures on the system but even so mostly remained satisfied with the service they had received individually, and most felt listened too and reassured:

'it provided us with a lot of confidence that there was some help available as soon as we wanted it' (CS8/P7).

10.e.iv. Communication

Most users of hospital services and CHS that we met felt that the providers' communication and explanations about what would happen them were clear and informative, reducing the need to ask questions. What patients termed their 'bible' at the free-standing voluntary hospital received particular praise for its comprehensiveness, covering preparation for routine operations, the operation itself and post discharge arrangements including exercises and contact numbers:

'the most astonishing piece of publication, really is. That really answered 99% of any questions I could think of' (CS25/P47).

Communication was harder when the system was overloaded. Some OOH patients (across all our case studies) felt their encounter with the service was too short to explain problems adequately or invite questions:

'Yes, I did, yeah, I did feel, you know, that I was a burden rather than... You know, maybe I was asking all stupid questions or whatever, I didn't feel relaxed and comforted enough to say how I felt' (CS24/P09).

10.e.v. Follow-up

NFP, ISTC and NHST providers all followed up treatment by providing patients with information, access to equipment, and follow-up appointments (possibly on a different site than the initial treatment). OOH patients were generally made aware of the time frame during which they might expect a call back or home visit and offered appointments if they had to come into a clinic. There were also examples in the NHS Trust OOH of patients feeling able to ring NHS111 back if they felt their condition deteriorating.

The NFP hospital chain offered different post-treatment follow-up for private and NHS patients, although this was not something that emerged from patient interviews. Follow-ups reported by NHS-funded patients included contact from an infection control nurse, a return visit to see the duty consultant and a consultant visit when a patient was later admitted to the local NHS hospital, but not care packages at home.

10.e.vi. Satisfaction

Overall, patients informed were mostly satisfied with the services they received from all the providers we studied. Where faults were identified they related to an individual staff member, individual unit or occasionally a process issue such as therapies that did not extend across the weekend, but there was no clear pattern by provider ownership.

NHS-funded patients knew that the single-site NFP did also take private patients but felt that they were given comparable care:

'I mean, had I paid for it I probably would have had the same treatment that they treated me. So it was exemplary, you know, that's the way to go in to hospital, and I felt very fortunate' (CS9/P22).

This belief contrasts with the NFP managers' concern (see Chapters 6,8) to avoid 'cannibalising' privately paid work by offering NHS patients identical services.

Whilst many OOH patients stressed that their treatment had been excellent:

'Very satisfied, I must be honest, I would recommend it to anybody' (CS16/P16)

they recognised that, irrespective of provider ownership, these services were under stress, leaving some patients feeling vulnerable and isolated and others concerned as to whether everyone would be able to articulate their needs.

10.e.vii. Voice: consulting the patients

The hospital trust in our case-study had a strong tendency to consult patients. Our informants described it as:

‘constantly asking for patient and carer feedback on different aspects of services that they’re looking to improve and change. And I think there’s quite a culture, specifically there, of wanting to engage patients and carers in the service’ (FP21).

In our ex-proprietary OOH our focus group participants also reported a high degree of representational involvement. And an informant from the corporate CHS suggested that if the organisation is looking to do something different or to change something it will

‘always take patients’ views in to account... it’s really important to us that we demonstrate back to patients that we’ve listened and we’ve heard, and we’ve made changes’ (CS10/M39).

All the providers in this study except the stand-alone voluntary hospital had some sort of mechanism (usually a PPI group or equivalent) for hearing patients’ views about their services. In addition, they had to supply the data on patient experience mandated by NHS Digital or QOF.

Consultation was least developed in the OOH services, where only the corporate and ex-proprietary services had taken some initiative. The NFP providers and the corporate hospitals tried to raise brand awareness through community engagement events: .

‘we will randomly write out to a significant group of patients, Invite people in for a lovely afternoon tea, bring their relatives or carers with them if they want to do that. And we literally sit down with, sort of, like groups of tables of maybe six patients to one member of staff, and we use a real broad band of staff across, it’s not just senior clinicians, we’ve had admin staff, people like that, who just enjoy talking to patients’ (CS25/M52).

From the focus groups, observation at the patient engagement events and interviews with managers, however, it was obvious that

‘getting people along and being interested in patient engagement is a constant battle’ (LHE1/FP21).

Patients also suggested that NHS organisations tended to treat communication and engagement as synonymous, and often had only limited knowledge of the community and voluntary sectors (LHE1/FP20). It may not have been co-incidental that the three providers specifically inviting us to attend their engagement events were a corporate hospital, the ex-proprietary corporation providing OOH and the social enterprise CHS. One example was given of where a voluntary support group was unable to advertise their services to patients in our studied NHS acute trust because of the cost.

CCG public engagement or involvement groups, under various titles, were universal as were Health and Wellbeing Boards. This activity and the involvement of organisations such as Heathwatch ensured a route (albeit with rather inconsistent terms of reference, interpretation of ‘public’, and effectiveness) for patient opinion to reach providers.

10.f. Patient experience and diverse providers

We found that the availability of a patient choice of provider depended on:

1. The structure of local NHS quasi-market. Competitive tendering did not usually offer a choice of provider for CHS and OOH services because (see Chapter 9) commissioners usually commissioned a single provider (whether NHS-owned or not) for each of these services (and most others). The patient-choice form of quasi-market structure did to some extent allow a choice among providers.
2. Within the patient-choice structure, the presence of diversely owned providers depended not only on commissioners (see Chapter 9) but on what services the non-NHS providers wanted to offer (see Chapters 5,8).
3. NHS triage and referral management systems built in a choice of provider. This was possible - subject to conditions (1) and (2) - even when tight budgetary constraints were causing NHS managers to apply these systems quite stringently.
4. Patient characteristics: when there was a choice of provider and it included providers under diverse ownership, many patients did not want to choose but preferred to rely on ‘expert’ advice. Others did choose.

Choice of provider and diverse provision were, we found, not the same thing. In several of our case-study LHEs, CHS and OOH patients had no choice of provider but they could access a corporate, social enterprise or co-operative provider. Neither did choice of provider depend on diversity of ownership. Outside our case-study LHEs, a number of treatment centres have been taken over by the NHS, giving patients in those care-groups a choice between conventional hospital or treatment centre, both under the same ownership.

Once patients had chosen a provider, or had it chosen for them, there were few differences in the range of choices of treatment, practitioner, place of treatment, time of treatment or time of discharge between the diversely-owned providers for each of our focal services. Our focus groups suggested

that patients often used private diagnostics to get fast-track access onto an NHS pathway, though if they then also insisted on seeing one particular consultant that second stage could actually be slower.

In contrast, and especially for secondary care, patient experience did differ between providers. Patients described a very different ambience in the corporate and not-for-profit providers than in the NHS acute hospital. They described a similar ambience to the former in the community hospitals run by CHS providers, including the NHS. The difference in ambience therefore was not due to differences in ownership so much as due to differences in case-mix, function (inclusion of emergency and urgent unplanned care), range of specialities and degree of overload (GP referral-only patients *versus* self-referral). Patients' experience of care was also determined above all by their health status, hence what care pathways and 'technologies' they needed, and to a lesser extent by the geographical dispersal of the providers. If diverse ownership has any effect on these factors, it will only become apparent long after this study finishes. Patient voice, through consultative mechanisms, played a rather minor role in all the case-study LHEs, irrespective of provider ownership.

Chapter 11. Discussion and results

11.a. Discussion

Certain caveats and qualifications of course apply to these findings. After stating them we summarise our results, i.e. empirical answers to each research question, following the sequence of our initial analytic model.

11.a.i. Empirical limitations

Our findings do not cover general practice, hybrid ownership, ‘functional privatisation’, joint enterprises, or NHS trusts’ services for privately patients. None of the NHS trusts that we studied had large commercial or other private incomes, donations or endowments. The study duration and resources gave no opportunity to study any *long-term* differences arising from the differently-owned providers’ different access to capital, and indeed their different fundamental aims. Our corporate secondary care providers were ISTCs, not in-patient services. We have not studied how clinicians’ and managers’ intrinsic motivation varied across providers, nor clinical outcomes as opposed to certain policy outcomes (see Chapters 1,2). Not all our case-study organisations had suffered penalties for non-compliance with contract so we could not compare differently-owned providers’ responses to such penalties. PPI in this study did not include ways of obtaining patients’ insights on the eventual findings. Our study is limited to England.

11.a.ii. Research design limitations

A stronger research design would have been to complement patients’ accounts of their experience with analyses of routine administrative data about more clinical outcomes. In its absence we have had to rely on theoretical generalisation^{284,285} (‘qualitative generalisation’) to assess whether our findings might be generalisable. We were able to compare the case-mix, in broad terms, of our focal services in our case-study organisations with that for the rest of England for secondary care, but not for the CHS and OOH case studies, hence must be still more cautious about generalising findings from them. Like any comparative study we have had to assume that no unrecognised confounders bias our results.

Obtaining verbal data directly always carries the risk that informants will make what they think are the socially expected replies about their organisations. For example, non-NHS providers might report good relationships with their CCGs in the belief that was the ‘acceptable’ answer to, say, DH

readers. Informants in organisations that changed ownership might still be able to provide data about the organisation during its previous ownership, but at the risk perhaps of justificatory bias in favour of the current regime. If that is a psychological trait one might expect such self-justification to occur across all organisations, but not if it is an organisational trait that takes different forms in organisations under different ownership. Then our findings might be biased towards the type of organisations with the most self-justificatory cultures, and we have no *a priori* way of knowing which those are. Our method for reducing this risk was to triangulate data across case studies. Having providers select patients for us to interview introduces the risk that patients will be hand-picked to give favourable accounts, but once the patients had been invited the providers had no further dealings with them so far as this research project was concerned. Providers also selected managers for use to interview, and in the corporations we did not interview anyone at the ‘financialised’ level (i.e. in the holding or property companies). We have assumed that two and a half years (the study period) is sufficient for the effects of diverse ownership to become evident in services which had changed ownership shortly before. When a service changes ownership one would not expect different work processes to appear immediately but to emerge through the subsequent service developments and innovations, but a longer time may be required for effects of innovation and investment to diverge (if they do), or for a culture characteristic of their new employer to supplant any cultural inheritance of the NHS in transferred staff.

11.a.iii. How typical were the study sites of their kind?

Where possible we concentrated case studies into the same LHEs in order to minimise local environmental differences between them. We sampled four focal services in order to cover the range of ownership types whilst minimising the potential for ‘technological’ differences between providers to confound the effects of different ownership. Even so, our sample still covered several different LHEs for each focal service. To isolate, so far as possible, the effects of ownership rather than technology we grouped and compared providers by focal service. Inferences drawn from this comparison would be stronger to the extent that the differences between their local (‘inner’) environments were not so gross as to confound the effects of diverse ownership upon the policy variables we studied. Generalisations from the case studies, and from the comparisons between them, would be more valid to the extent that each case-study organisation was typical of others of the same ownership (i.e. our NHS hospital trust was typical of other NHS hospital trusts, and so on).

Chapters 2 and 3, and our primary data, suggest that the most obvious possible confounders when comparing our case-study organisations for planned orthopaedics and ophthalmic care would appear to be:

1. Non-overlapping case mix, in which case different clinical requirements might explain the differences in patient experiences.
2. Differences in catchment population size sufficient to cause different degrees of commodification of services across providers, regardless of provider ownership.
3. Differences in availability of alternative providers, as an alternative possible cause of different patient experiences and/or provider behaviour towards commissioners.

The most obvious possible confounders when generalising from our case-study hospitals to others under similar ownership would appear to be differences in:

1. Case mix, sufficient to confound generalisations about professional roles, the management of clinical quality and commodification of care.
2. Availability of alternative providers, which might confound generalisations about market segmentation and provider behaviour towards NHS commissioners.
3. Availability of privately insured patients, sufficient to prevent generalisations about marketing segmentation and cannibalisation.
4. Workload (demand), sufficient to prevent generalisations about ambience and patient experience (if other providers faced much greater demand pressures).

There may of course be additional unknown confounders.

For secondary care, we therefore used record-level bespoke extracts of HES data and nationally-published routine administrative data based on HES data to evaluate whether our case-study organisations were broadly typical of their kind in the above terms. We compared elective activity at our case-study orthopaedic and ophthalmology hospitals with elective activity at all other such providers in England, yielding the summary statistics in Tables 5 and 6 below (further details are in Appendix 3).

Table 5: Orthopaedic case-study providers: Statistics for all orthopaedic episodes [hip arthroplasties / knee arthroplasties in square brackets]

		CS1 (corporation A)		CS2 (corporation A)		CS9 (Not-for-profit hospital chain)		CS10 (Not-for-profit hospital chain)		CS13 (NHS hospital trust)		CS25 (stand-alone voluntary hospital)	
Number of Orthopaedic episodes [†] per annum, 2011/12-2015/16:	2011/12	614		2,466		547		213		7,818		4,307	
	2012/13	615		2,351		816		656		6885		3,943	
	2013/14	512		2,524		816		1,007		7,224		4,272	
	2014/15	306		2,204		1,020		1,279		8,021		4,609	
	2015/16	212		2,167		938		1,065		8,500		4,844	
Residents, mid-2013*		875,000		765,000		363,000		1,491,000		711,000		212,000	
Elective Episodes, 2014/15		292	[- / -]	2,063	[174 / 252]	970	[128 / 153]	1,221	[120 / 144]	4,584	[369 / 436]	4,397	[910 / 925]
Other non-NHS providers (N)*		2	[- / -]	3	[3 / 3]	1	[1 / 1]	1	[1 / 1]	4	[4 / 4]	3	[0 / 0]
Mean patient age, 2014/15		58.3	[- / -]	57.1	[69.2 / 67.8]	55.5	[64.4 / 67.7]	59.5	[70.7 / 70.4]	47.9	[67.7 / 66.2]	63.2	[69.0 / 70.6]
Mean waiting time, days, 2014/15		35	[- / -]	37	[47 / 48]	114	[117 / 113]	78	[16 / 19]	87	[113 / 136]	105	[108 / 125]
Mean episode duration, 2014/15		0.00	[- / -]	0.74	[2.87 / 3.17]	1.48	[4.11 / 4.11]	0.65	[2.96 / 2.87]	2.49	[8.54 / 7.97]	1.40	[2.76 / 3.46]
Mean IMD2015 Score, 2014/15**		20.9		23.1		20.6		19.8		17.6		13.0	
Mean drive time (minutes) 2014/15		13.1	[- / -]	15.3	[17.4 / 17.6]	22.3	[19.7 / 21.8]	11.0	[12.0 / 11.7]	28.6	[23.0 / 25.3]	37.1	[44.5 / 40.7]
Market share, 2014/15*		2%	[- / -]	16%	[11% / 17%]	13%	[15% / 17%]	5%	[5% / 5%]	28%	[24% / 24%]	42%	[57% / 58%]
HHI Score, 2014/15*		0.26	[- / -]	0.15	[0.14 / 0.15]	0.31	[0.35 / 0.35]	0.09	[0.09 / 0.10]	0.14	[0.13 / 0.14]	0.23	[0.37 / 0.37]

[†] Extracted from NHS Digital, Hospital Episode Statistics, Admitted Care – England, 2011/12 – 2015/16 (<http://content.digital.nhs.uk/searchcatalogue>), these counts include elective & non-elective episodes. Only the NHS hospital trust (CS13) includes more than 10% non-elective episodes. All other figures in this table are based on an analysis of record-level HES data and refer to elective episodes only.

* For 30-minute drive time catchment area

** Higher score means more deprived. Population-weighted IMD2015 mean for England = 21.8.

Table 6: Ophthalmology case-study providers: Statistics for all ophthalmic episodes [cataract operations only in square brackets]

		CS1 (Corporation)		CS2 (Corporation)		CS10 (NFP hospital chain)		CS 13 (NHS trust)	
Number of Orthopaedic episodes [†] per annum, 2011/12-2015/16:	2011/12	760		902		716		4,007	
	2012/13	734		1,110		865		4,162	
	2013/14	862		1,384		1,034		4,993	
	2014/15	1,097		1,579		968		5,186	
	2015/16	1,458		1,337		952		5,581	
Residents, mid-2013*		875,000		765,000		1,491,000		711,000	
Elective Episodes, 2014/15		1,600	[1,600]	1,645	[1,385]	953	[952]	4,407	[2,786]
Other non-NHS providers (N)*		2	[2]	2	[2]	1	[1]	3	[3]
Mean patient age, 2014/15		75.4	[75.4]	73.1	[76.0]	74.4	[74.4]	66.5	[72.7]
Mean waiting time, days, 2014/15		35	[35]	29	[30]	84	[82]	68	[74]
Mean episode duration, 2014/15		0	[0]	0	[0]	0	[0]	0.04	[0.01]
Mean IMD2015 Score, 2014/15**		16.8		21.5		17.8		15.5	
Mean drive time (minutes) 2014/15		15.7	[15.7]	11.9	[11.9]	15.0	[15.0]	22.8	[20.6]
Market share, 2014/15*		11%	[21%]	16%	[21%]	6%	[9%]	38%	[37%]
HHI Score, 2014/15*		0.39	[0.26]	0.23	[0.21]	0.14	[0.14]	0.22	[0.22]

[†] Extracted from NHS Digital, *Hospital Episode Statistics, Admitted Care – England, 2011/12 – 2015/16* (<http://content.digital.nhs.uk/searchcatalogue>), these counts include elective & non-elective episodes. Only the NHS hospital trust (CS13) includes more than 10% non-elective episodes. All other figures in this table are based on an analysis of record-level HES data and refer to elective episodes only.

* For 30-minute drive time catchment area

** Higher score means more deprived. Population-weighted IMD2015 mean for England = 21.8.

The findings suggest that the independent orthopaedics providers all have a broadly similar elective case-mix. The NHS hospital trust (CS13) is, however, somewhat distinct. Its average episode duration is much longer for orthopaedic procedures generally, and for hip and knee arthroplasties

specifically, suggesting that this hospital tends to deal with more complex cases. The independent ophthalmic providers also appear to have broadly similar elective case-mix, almost entirely cataract operations. All ophthalmic cases (including cataract operations) at the independent providers are day cases whereas the NHS hospital trust has a small proportion (3.2%) of episodes lasting more than a day. It also has a notably younger mean patient age for ophthalmic patients (66.5 as opposed to 75.4, 73.1 and 74.4 at the three independent providers) and 37% of episodes concern non-cataract related procedures.

All the case-study providers co-existed with other independent providers within 30 minutes driving time, and the NHS trust with most, although specifically with respect to hip or knee arthroplasties the stand-alone voluntary hospital (CS25) did not face competition from other local independent providers. This provider is, in fact, something of an outlier in respect of its uniquely affluent local population (amongst our case studies) with very few LSOAs within a 30-minute drive-time falling into the two most deprived IMD2015 quintiles; the exceptionally high number of arthroplasties undertaken (putting it near the top of the distribution); and its unusually high market share. The latter however reflects the hospital's original 'mission' character as a specifically, and specialised, orthopaedic hospital, and therefore its ownership (rather confounding the effects of ownership).

All case-study local catchment areas, including the one for CS25, have slightly younger than average age profiles, very similar and very average General Health profiles, and a slightly lower than average proportions of owner occupiers. Our NHS hospital trust (CS3) does not have a large income from private patients in orthopaedics or ophthalmology, but that makes it typical of all but a few NHS trusts (see Chapter 5).

Under the competitive bidding system, the selection of localities in which to provide services will for corporate and NFP providers depend on the expected profitability; and for social enterprises, partnerships and co-operatives upon whether it is their 'home' locality. These conditions do not directly depend on population characteristics. However, we also hypothesised that providers which heavily depended on private patients (in this study only the NFP and not-for-profit hospitals, CS9,10,25) would gravitate to the least deprived areas since a greater proportion of the population there is likely to have health insurance or be able to pay out-of-pocket. Patients from the most deprived LSOAs did indeed tend to be under-represented at all three, particularly with respect to hip and knee arthroplasties and cataract operations. Yet the NHS hospital trust patients came, unexpectedly, from still less deprived areas. Only the free-standing voluntary hospital (CS25) had a stronger 'pro-affluent' bias. Conversely, one corporate provider (CS2) took its patients from more deprived areas than the NHS trust (CS13). As Appendix 3 explains, however, this may largely reflect local population characteristics rather than any provider cherry-picking of individual patients, and is to be expected for the treatment centres since they are almost entirely NHS-funded.

With respect to orthopaedics generally and hip arthroplasties specifically, the profile of NHS-funded patients treated, either at any provider or specifically at CS25, tends to reflect the underlying population characteristics. HES figures do not include privately-funded patients at private hospitals.

Generalisations from the case studies, and from the comparisons between them, would be more valid to the extent that each case-study organisation was typical of others of the same ownership. Our corporate secondary care providers belonged to a chain which provided secondary care quite widely across England, making it reasonable to assume that their organisational arrangements are typical, certainly, of others owned by the same corporation. The same applies to the two hospitals owned by the not-for-profit chain. The stand-alone voluntary hospital was, so far as we were aware, unique. As already noted, the NHS hospital trust was typical of most (except the ten or so largest tertiary trusts) in having only modest commercial income. The organisational structure and internal management of NHS trusts is essentially standardised across England.

Unless further unknown factors confound the comparisons (an important proviso), cautious generalisation of our inferences about the effects of ownership from our case-study LHEs to others of their kind across England may therefore be warranted.

Much less information was available for making analogous checks for (dis)similarities among our OOH and CHS case-study organisations; and for comparing each case-study LHE with others of its ownership-kind for either service. Because these services were let by competitive tender for whole populations, the possible confounders of the relationships between ownership and policy outcomes were fewer and different than for the secondary care studies, because:

1. once commissioned, providers may not select which services to provide;
2. there is little scope for selling services to privately-funded patients;
3. patients have little choice of provider.

The most obvious possible confounders when comparing our CHS providers of different ownership are differences in:

1. size (measured by size of population served), reducing the scope for
 - (a) automating and rationalising the administrative support infrastructure
 - (b) commissioners to use CQUINs as a means of managing service quality.

2. geography: a more dispersed population reduces, irrespective of ownership, the scope for reducing staff travel time ‘overheads’ but increasing the benefit, insofar as it exists, for replacing face-to-face with, say, virtual contact when the health worker is purely monitoring or providing information to patients.
3. population health needs, which if large might necessitate different skill mixes and professional roles across providers independently of ownership, with possible implications for service costs and profitability. With the available published data, the closest we could come to capturing any such differences was to utilise practice-level 2015/16 Quality and Outcomes Framework (QOF) data to compare the relative health status of the populations served by the project’s Out-of-Hours (OOH) and Community Health Service (CHS) case-study organisations in respect of a variety of conditions (Coronary Heart Disease (CHD), hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Cancer).
4. the number of general practices served. A higher number makes coordination more difficult and may require larger, more complex administrative structures (but also give greater scope for automating administrative work).

The same possible confounders apply when comparing OOH providers.

As Appendix 3 explains more fully, our CHS case-study providers served somewhat different populations in terms of size and health status (Table 7).

Table 7: Comparison of CHS case-study organisations by scale and health burden

	Population	Density (Residents / Hectare)	General practices	Mean IMD Score** 2014/15	Health burden*
Corporate (CS3)	1,306,000	7.24	145	9.6	Generally lower
NHS trust (CS15)	1,623,000	4.21	171	14.0	Near average
Social enterprise (CS23)	305,000	2.91	43***	22.3	Generally higher
Partnership (CS31)	39,000	4.08	3	11.5	Generally higher

* Compared to England average for the QOF-reported conditions listed above.

** Higher score means more deprived. Mean for England = 21.8.

*** Including 4 owned by the social enterprise itself.

Here, the obvious outlier is the partnership CHS (CS31). Its small size compared with the other CHS case-study organisations was an effect, rather than a confounder of, its ownership.

Nevertheless it was about three times the mean practice size for England at the time, which may limit the generalisability of findings about it to other general practices (few of which currently provide CHS) – at least until policies for general practice ‘at scale’⁸ take effect. With caution on that point, our other findings may generalise more widely again, subject to the condition that no additional unknown confounders be at work.

Among our OOH case-study organisations (Table 8) the obvious outlier in terms of social setting was the cooperative (C20). Since the health burden imposed on OOH services by its population is likely to be greater than in the other four case-study organisations, if our findings err at all it may be by representing the OOH cooperative in a less favourable light than if it served a population more typical of England as a whole.

Table 8: Comparison of OOH case-study organisations by scale and health burden

	Population	Density (Residents / Hectare)	General practices	Mean IMD Score* 2014/15	Health burden[†]
Corporate (CS4)	826,000	6.79	103	9.2	Generally lower
Ex-proprietary (CS8)	480,000	1.45	56	13.5	Near average (but hypertension and cancer higher)
NHS Trust (CS16)	754,000	2.80	98	16.4	Generally higher
Co-operative (CS20)	176,000	12.85	36	29.8	Substantially higher
Social Enterprise (C24)	218,000	2.47	20	10.8	Generally lower

* Higher score means more deprived. Mean for England = 21.8.

† Compared to England average for the QOF-reported conditions listed above.

As to whether these case studies were typical of others of the same ownership, NHS trusts’ organisational structure and internal management is (to repeat) essentially standardised across England. The same applies to the social enterprises providing CHS. Notwithstanding their different legal personalities, the OOH cooperative and social enterprise both had similar structures and control, both typical of other co-operative⁶¹ and re-badged cooperative OOH providers. Both the large corporations we studied serve other populations across the UK, and our findings suggest that their managerial practices were quite similar to each other (and with the other branches of either corporation). The partnership (CS31) had the same structure as most English general practices.²⁵⁸

Again we conclude that with due care our other findings about ownership in OOH services and CHS may also generalise more widely, subject to the important condition that no additional unknown confounders be in play.

11.b. Findings

We now draw together our empirical findings on each of these relationships in order to answer our initial research questions.

11.b.i. Environmental constraints

Two main kinds of environmental constraint confronted our case-study organisations: the NHS policy environment; and their resource, especially financial, dependencies.

Our findings suggest that many differences between NHS trusts and non-NHS providers of secondary care stem from the long-standing policy that non-NHS providers can choose which services to provide whilst NHS organisations must provide universal access to the full range of health services that populations need. The consequences of this difference are most apparent in terms of patterns of service innovation and patient experience, summarised below. Similar latitude has not been allowed for non-hospital services, where commissioners (or for general practice, the GMS contract) specify in advance, what services and population any provider must cater for.

Irrespective of provider ownership, national and regional mandates specified certain clinical process, outcome and quality-management standards, innovations, information-collection and reporting (see Chapter 6): a force for convergent behaviour. Against this, NHS trusts faced stricter requirements than non-NHS providers regarding safe staffing levels (compliance with the Francis Report recommendations), reporting their costs, NHS Improvement mandates, and to a smaller extent some CQUIN targets.

During the study period (2015-2017) controlling public spending on the NHS was the dominant health policy, giving all providers irrespective of ownership an incentive to make innovations that would quickly reduce costs. The corresponding financial pressures on commissioners tended especially to limit the corporate provision of NHS-funded services. Potential new corporate providers would not bid for services which they could not see ways of making profitable and existing corporate providers withdrew (see Chapter 5). These financial pressures made NHS

providers converge on non-NHS providers' practice of not exceeding the service provision stipulated by contract.

Whether a provider depended on NHS income alone, or predominantly privately-funded patients, was a resource dependency difference which had (in the marketing sense¹⁶²) segmentation consequences for patients. So that NHS-paid services would not 'cannibalise'¹⁰³ privately-paid ones, NFP providers which offered both differentiated those for privately-paid patients from those for NHS-paid patients, including the option to obtain privately what the NHS had defined as procedures of limited clinical value. In those ways the behaviour of secondary care providers that simultaneously sold services to private payers and to NHS commissioners diverged from the behaviour of providers that did not. This differentiation did not occur when non-NHS providers tendered competitively for commissioner-defined blocks of NHS services for which parallel private funding was not available.

Only the for-profit providers had access to substantial new capital to finance service developments, provided that a business plan demonstrated future profitability (see Chapter 8). The not-for-profit chain had to finance its service development from retained profits, as did the voluntary hospital but that also had substantial donations to draw upon. In theory the partnership was in the same position as the not-for-profit chain, but in practice the partnership did not pursue capital-intense innovations. NHS trusts could only make cost-saving innovations that would finance themselves quickly from savings not investments, and standardly within one year. Otherwise, they could only turn to PFI-like schemes which were highly cost-inefficient for them.²⁸⁶

Providers' main physical resource dependency was skilled staff. Pervasive shortages reduced non-NHS providers scope for reducing staff wages, and therefore staff costs, compared with NHS providers and in those respects therefore reduced divergent behaviour among the differently-owned providers.

11.b.ii. Organisational structures: divergent at the top, convergent below.

Diverse ownership was reflected in differences in our case-study organisations' top-level organisational structures, i.e. those above the management of the individual hospital, clinic or call-centre. The corporate providers had a financialised structure in which an operating company was subordinate to a holding, or perhaps property, company and through them to equity capital owners. NHS trusts were the lowest tier in a quasi-hierarchical network^{90,107} of public organisations which was highly centralised upon government. The OOH social enterprise was a GP cooperative in all but

name, with a partly-democratic structure. Like the partnership, its structure was vertically divided with a democratically self-governing group of professionals as its owner-managers. The three exceptions were the voluntary hospital, non-for-profit chains and CHS social enterprise, which had a self-appointed top management tier within a unified, free-standing organisational structure.

Except in the partnership and GP cooperatives (including the one which was nominally a social enterprise) where the partners themselves performed much of the core productive process, day-to-day work was coordinated through a hierarchical, bureaucratic organisational structure with 'hybrid' managers at the interface between clinical professions and non-clinical general managers.

These structural differences had three main consequences:

1. Different geographical distribution of services. NHS trusts serve a whole population but only within defined locality, corporations the reverse. NHS Trusts thus work as essentially separate units, the corporations and non-for-profit chains shared learning between sites offering similar services. NHS trusts, small voluntary organisations, cooperatives, partnerships and social enterprises were localised, with their controlling bodies on (or in the case of those commissioned by multiple CCGs, near) the commissioners' own territory, and that extent more accessible and likely to be amenable to relational influence, an important medium of control for commissioners.³⁸
2. Ownership churn (see Chapter 5) resulting in merger and market concentration, hence convergence of managerial control, among corporate providers. Changing managers and owners might be expected to weaken commissioners' scope for relationally influencing 'churned' providers. Insofar as 'churn' lead to concentration on the supply side of the quasi-market, that would increase providers' bargaining power vis-a-vis NHS commissioners.
3. If doctors owned the organisation, non-doctors were accommodated within a medically-controlled hierarchy. Otherwise, doctors were accommodated either as non-employees with admitting rights, as sub-contractors or (most often) as employees within semi-detached professional hierarchies.

11.b.iii. Diverse innovation?

These differences affected how differently-owned providers responded to potential innovations, their speed of response and ensuing service changes (**RQ 1a**). For the providers with latitude to select which care groups to provide services for, the substantive criteria (return on investment, mission, professional interest etc.) for selecting which care groups to serve depended on the

provider's ownership. Because of their easier access to capital the corporate and, to a lesser extent the voluntary and not-for-profit, providers could fund much faster, therefore respond much faster, than NHS trusts to potential innovations, *provided that* they were profit-increasing innovations. That aim could be achieved by increasing demand and/or offering services not provided by the NHS and/or reducing costs. Not being allowed to retain much operating surplus, the social enterprises that we studied found it almost impossible to respond to innovations that had non-trivial development or implementation costs. In respect of cost-saving innovations, NHS trusts were limited to those which required, so to speak, a still quicker response, being only able (without commissioners' agreement) to fund those whose savings came within a year. Corporate, not-for-profit and voluntary providers had a longer period (contracts of three years or more) to achieve payback.

Within those constraints two instances of technical determinism were at work. The first arose from the combination of three conditions:

1. giving urgent and emergency treatment (both for referred and self-referred patients).
2. having insufficient capacity to accommodate fluctuations in urgent and emergency referrals and self-referrals, or *a fortiori* permanently insufficient capacity for those referrals.
3. The provider could (indeed had to) transfer the overspill of patients from those services into other departments or wards.

Then, the emergency and urgent workload with its characteristic ambience (speed; unpredictability; transferring patients, staff or equipment; noise) also spilled over into, indeed dominated, other services. This did not happen in other providers whose services were insulated from these conditions. This insulation resulted partly from managerial decisions (both in the non-NHS providers and, for ISTCs, government⁴³), but also from the physical infrastructure of our study NHS hospital trust which (like most others) housed these together. These differences only reflected diverse ownership because the different policy-status of differently-owned providers in the NHS, in terms of freedom to select care groups.

A second instance of technical determinism concerned the actual care techniques for each care group. National guidance and regulation, evidence-based medicine, and professional norms all produced a technical convergence of clinical working practices and standards of care irrespective of provider ownership, for those care groups subject to such standards. They tended to produce more 'commodified' care, in the sense of standardised care design, terminology, process and outcomes.^{274,287} We found little evidence of difference in technical working practices or innovation across providers for the same care group, if anything the opposite when the same consultants

worked in diversely-owned providers. Differences in innovations in service provision were not at the clinical level so much as in the organisation of the overall care pathway (e.g. flow *versus* batch handling of booked patients; separation of booked from urgent and emergency care). Where technical innovation was found, among our case-study LHEs, was in the NHS hospital trust, which as a university hospital was unlike the other secondary care providers the home of technical research and development projects.

Hence *the ways in which differently-owned providers of NHS-funded services (in particular, for NHS Foundation Trusts) varied in their use of freedom to innovate (RQ 1b)* depended on their access to development funding, the time allowed for (financial) payback of development projects, whether planned care was insulated from emergency and urgent care, and whether the provider was affiliated to a university and medical school. These differences correspond to ownership differences partly because of previous policy decisions giving secondary care providers under some forms of ownership greater latitude than others, and partly due to NHS hospitals' inherited physical infrastructure.

11.b.iv. Responses to NHS commissioners

Providers' role in service design (RQ 2a) was limited and differed somewhat by provider ownership. Under competitive tendering, commissioners wrote service specifications almost unilaterally. In the patient-choice part of the NHS quasi-market, corporate, not-for-profit and cooperative providers tended to offer ready-designed services to NHS commissioners, treating NHS commissioners as 'service takers' rather than 'service makers'. To a certain extent public firms, social enterprises, cooperatives and the partnership we studied did so too, but when it came to designing MCPs, PACSs and other vanguard models of care, and combining urgent with OOH services, they treated NHS commissioners more as 'service makers' than providers under other ownership did.

What issues provider-commissioner interactions focused upon (RQ 2b) did not differ much across differently-owned providers. The main issues were dealing with cost control and day-to-day problem-solving, e.g those arising from access and overload problems; payment; and information returns for the commissioners (in which providers were mostly responsive rather than initiators (see Chapter 9)). Occasionally providers proposed additional services to commissioners. More often, commissioners initiated service re-design, often at the instigation of national guidance and policy.

During the study period NHS commissioners' most pressing requirements were for cost reduction (see below) and all the new models of care. *What responses to their requirements local*

commissioner had from differently-owned providers (RQ 2c) varied according to what the requirement was. All providers, especially the corporates and voluntaries who had more capacity for it, were ready to take on an increased workload if that was paid for and profitable. Hitherto NHS trusts generally had been flexible about taking on extra work, and often about overspending too. During the study period financial pressures were making it harder for them to respond so flexibly. Corporations, social enterprises, cooperatives and partnerships were not legally permitted to trade insolvently anyway. So in this respect NHS trusts were converging on the other providers' less responsive behaviours. Established local providers were (because of their relational dealings with commissioners) better placed to understand and respond constructively to commissioners' requirements.

How differently owned providers *responded to national policy requirements (RQ 2d)* also varied by ownership. In response to more restricted payments, including tariff reduction, corporate and not-for-profit providers often ceased, or would not start, providing NHS-funded services. As noted, the new models of care were developed by CCGs in collaboration with NHS trusts, social enterprises, GP partnerships and cooperatives rather than corporate or not-for-profit providers. In general, NHSTs were more policy-attuned and policy-responsive than providers under other ownership. Not one informant spontaneously mentioned the 'Level Playing Field' policy which had been announced just before this study was commissioned, or was aware of it by name even upon prompting.

We found some *differences between differently owned providers in terms of their transparency to commissioners and provision of information for commissioning purposes (RQ 2e)*, but with one exception the differences seemed likely to be transient. New providers, in particular the corporations, wanted to build up the commissioners' trust in them and were therefore inclined to be responsive in providing commissioners with information on request. In our sample, corporations spanned the range from 'able to provide good information and initiated information improvements' to the opposite (Chapter 9). One NHS trust was in the latter category but providers of all kinds (in our sample, NHS trusts, corporate, not-for-profit, social enterprise, and partnership) fell into a middle category of supplying commissioners with satisfactory data on demand but not initiating information-reporting improvements. We would have noted one other difference only in passing were it not that a similar issue arose with serious consequences at Serco.¹⁷⁴ We were told that the corporation providing CHS was mostly responsive to commissioners' requests for information, but least so for information about staffing.

11.b.v. Patient experience

To ask how differently-owned providers of NHS-funded services varied in their responses to patient choice, including patients' rights to choose their healthcare provider (**RQ3a**) presupposes that patient choice of provider actually occurred. We found that the availability of a patient choice of provider depended on:

1. The structure of the local NHS quasi-market.
 - (a) Competitive tendering did not usually result in patient choice of provider for CHS and OOH services because (see Chapter 9) commissioners usually commissioned a single provider (whether NHS-owned or not) for each of these services (and most others).
 - (b) The patient-choice form of quasi-market structure did allow some choice of provider, subject both to commissioners' decisions (see Chapter 9) and what services the non-NHS providers wanted to offer (see chh.5,7). In our case-study LHEs, NHS triage and referral management systems built in a choice of provider, proving that to be possible - subject to conditions (1) and (2) - even when tight budgetary constraints were causing NHS managers to manage these systems quite stringently.
2. Patient characteristics; when there was a choice of provider, and that choice included providers under diverse ownership, many patients did not want to choose but preferred to rely on their GP's advice. Others wanted to choose and did, and some of them preferred NHS providers.

Choice of provider and diverse provision were not the same thing. In several of our case-study LHEs, CHS and OOH patients had no choice of provider but they could access a non-NHS provider (corporate, social enterprise or co-operative as the case might be). Neither did choice of provider depend on diversity of ownership. Outside our case-study LHEs, a number of treatment centres have been taken over by the NHS, giving patients in those care-groups a choice between conventional hospital or treatment centre, under non-diverse ownership.

Once patients had chosen a provider, or had it chosen for them, there were few further differences in the range of choices of treatment, practitioner, place of treatment, time of treatment or time of discharge between the diversely-owned providers for each of our focal services. A bigger difference was in patient experience, especially the ambience of care.

Especially for secondary care, patient experience did differ between diversely-owned providers (**RQ 3b**). Patients described a very different ambience in the corporate and not-for-profit providers than in the NHS acute hospital. They also described a similar calm, orderly ambience in the community hospitals run by CHS providers, including an NHS trust. The difference in ambience

was therefore not due to different ownership as much as differences in case-mix (inclusion of emergency and urgent unplanned care), range of specialties, size of hospital and degree of overload. Not least, patients' experience of care was determined above all by their health status, hence what care pathways and 'technologies' they needed, and to a lesser extent by providers' geographical dispersal. If diverse ownership affects these factors, it will only become apparent over the longer periods that divergent investment policies take to have effect. Patient voice, through consultative mechanisms, played a rather minor role in all the case-study LHEs, irrespective of provider ownership.

Chapter 12. Conclusions and further research

Finally we consider what implications and recommendations arise from the above findings.

12.a. Provider profiles

One way to summarise the differences arising from diverse provider ownership, and their implications for commissioners, is by assembling profiles of what types of services each type of provider, by ownership, tends to focus on and the characteristic behaviours of each provider type.

In table 9 each column represents a provider characteristic of interest to commissioners (see Chapter 9), the rows types of provider ownership (see Chapter 2) and, insofar as our case-study organisations were typical of their kind (see Chapter 11), the cells contain the corresponding typical provider characteristic. Column headings mean the following:

1. Context: Providers' other concurrent interests likely to influence their responses to commissioners **(RQ 2b)**.
2. Relationality: Ways (if any) in which relationality complements transactional contractual relationships between provider and commissioner **(RQ 2b)**.
3. Transparency (see Chapter 9): Differences in diversely-owned providers' transparency and what monitoring information they supply to commissioners **(RQ2e)**.
4. Flexible service provision: Responsiveness to local commissioners' changing requirements **(RQ2c)**.
5. Stability: of ownership and management, on the basis of the past five years, including patterns of re-organisation ('re-disorganisation'²⁸⁸) which may disrupt providers' relationships with commissioners.
6. Policy-responsiveness to national policy requirements (e.g. the Fair Playing Field Review, STPs, new models of care) **(RQ2d)**.
7. Locus of innovation (see Chapter 8): roles that different providers play in service design **(RQ2a)**, and whether the provider type leans towards developing specialised or commodified services

The above list focuses on the loci of variation between provider types, not the similarities listed above. There may also be variation among providers under the same ownership.

Table 9: Diverse providers: Ideal-type characteristics of interest to commissioners

	Context of provider-commissioner relationship.	Relationality	Transparency	Flexible service provision	Stability	Policy-responsiveness	Locus of innovation,
Corporate	Availability of privately-paid patients.	Adhere to contract plus occasional <i>ad hoc</i> help.	Low	Upwards flexibility. <i>Ad hoc</i> informal help to local NHS bodies.	Low	Low	Commodified care; ‘business case’; differentiate NHS & private patients
Proprietary (CS8, pre-corporate period only).	Collaboration with other providers, local government.	Strong relational links reflect provider origins in local general practice.	Reflects individual proprietor’s interests (in CS8, information-driven).	Upwards flexibility.	Low	Selective	Extensive replication into related activities.
Partnership	GMS alongside. Structural and accountability links between general practices and CCGs.	Low formality	High	Adaptive	High	High (new care pathways)	Professional interests and ‘mission’.
Cooperative	Strong links (in parallel to the CCG’s) with local general practices.	Tradition of low formality	High (to member-practices and commissioners)	Adaptive	High	High (new care pathways,	GP-centric.

	Availability of subscription income					MCP)	
NFP, voluntary	Availability of private patients; and for voluntary hospital, donations.	Adhere to contract	Low	Upwards flexibility.	High	Selective	Business case; 'mission'. Differentiate NHS & private patients
Public firms	Provider traditionally dominant. Common culture of public service ethic	Tradition of low formality, high flexibility.	High mostly, but low where managerially sensitive (e.g. whistleblowers)	Adaptive, but flexibility now decreasing.	Low (frequent NHS restructuring)	High (new models of care)	Technical-scientific, clinically led; short-term cost-saving; policy led
Social Enterprise	Provider traditionally dominant. Common culture of public service ethic	Adhere to contract.	High (IT capacity permitting)	Adaptive	Low (newly created)	High	Innovations requiring minimal initial finance.

12.b. Why such limited differences?

Except for the partnership/cooperative case we found few differences in care processes or management structures for care coordination at workplace level between diversely owned healthcare providers. Patient experiences depended more on provider case-mix and physical infrastructure than ownership (but for secondary care, ownership coincided with these factors, for policy and historical reasons). We speculate that the reasons why diverse ownership produced such limited differences in care delivery include:

1. Organisations are often privatised or (re-)nationalised as going concerns, so the new owners inherit established organisational and management structures. Through these changes, including the repeated attempts to reconstitute NHS providers as public firms, certain organisational structures have proved durable, particularly occupational (professional) silos and medical exceptionalism.
2. Ideology: Imitation of corporate management has been a pervasive norm of NHS managerial culture (e.g. in most varieties of the new public management), rather than developing public sector structures and management in ways that differentiate them and play to their specific strengths.
3. Convergent environmental pressures. Chapter 6 gives some evidence as to how narrow the environmental constraints were, that our case-study organisations described to us.
4. Separation of ownership from day-to-day control. Outside NHS trusts (close policy control) and GP partnerships (which have working owners), ‘absentee’²⁸⁹ owners made little contribution to, or interference with, day-to-day clinical work processes. ‘Tight-loose’ management systems focus on the owners’ predominant aim for the organisation, which for corporations and not-for-profit organisation tend to lie elsewhere than day-to-day work processes. (Here we are not interested in whether the separation of ownership and control increases or reduces profits or creates principal-agent problems between owners and managers,²⁹⁰ nor in Veblen’s²⁸⁹ famous contention - which incidentally our findings do not support - that this separation shifts control from the ‘capitalist’ to the ‘engineer’.)
5. Policy-makers have encouraged ISTCs to blur the distinction of ownership between them and the NHS (e.g. through contractual requirements for NHS branding⁴³). Patients were sometimes unaware they had been treated by a non-NHS provider (Chapter 10).

12.c. *Implications for future research*

This study reveals certain further research needs. In descending order of importance (in our view) they are to examine:

1. The longer-term effects of differences in investment patterns, across diversely-owned providers, upon the quality, safety, accessibility, provision, development, equity and cost of NHS-funded services. To obtain relevant evidence would probably require comparative studies with overseas health systems.
2. What the analysis of routine administrative data can show about differences between providers of different ownership in terms of patient outcomes, patterns of innovation and market selection.
3. What the implications of NHS trusts' commercial operations for NHS-funded services are, insofar as those commercial operations make NHS trusts resemble corporate providers regarding:
 - (a) Segmenting patient 'markets' to avoid NHS provision cannibalising services that NHS trusts wish to provide commercially
 - (b) seeking operating surpluses, and
 - (c) how project development is funded, and the implications for NHS-funded services, i.e. whether through the use of donations (as in the voluntary hospital we studied), retained projects (as the not-for-profit chain), or through joint projects with financialised corporations?
4. The role of intrinsic motivation among the managers and clinicians working for corporations and proprietary providers, including the impact of extrinsic incentives on 'crowding out' and 'crowding in'²⁹¹ intrinsic motivations.
5. What non-NHS providers' role will be, and why, in the development of MCPs, PACS, other new models of care, ACOs and STPs.
6. The balance of advantage between long contracts (making innovation easier by increasing the payback period) and short contracts (which strengthen providers' motivation to innovate); and whether these patterns vary by provider ownership.

7. What the consequences of provider financialisation are for the health system. If service specifications and prices remain stable, lower health worker pay rates and introduction of transfers of interest, rents, dividends to owners would appear to have redistributive effects.

12.d. Relevance to policy

Political supporters and opponents of plural provision respectively tend to assume that diverse provision will markedly improve or worsen the accessibility, provision, development or cost of NHS-funded services. At managerial level the corporate and not-for-profit providers especially downplayed their differences to the NHS ('we have a similar ethos ... draw on similar staff ... work across the car park' etc.). Some identified themselves as NHS-providers-by-proxy. Our findings suggest that until long-term differences in investment patterns and care-group selection take effect, the differences between diverse providers may not be as great as either side respectively hopes or fears. If so, diverse provision alone is meantime neither sufficient nor necessary for raising the quality of patients' experience, innovation in models of care, and increasing providers' responsiveness to NHS commissioning. Certain forms of diverse provision gave NHS commissioners the ability or opportunity to explore different service configurations, especially in face of local capacity constraints or recalcitrant existing NHS providers. These opportunities arose through commissioning additional, separately-managed capacity, whether or not separately-owned. Differences in patient experience reflected, above all, the insulation of planned from urgent and emergency care, not diverse ownership. Differently-owned providers' responses to commissioners reflected, in part, the commissioners' own willingness to bear risk, commissioners' managerial capacity, and the maturity of local inter-organisational relationships; and seemed to be starting to converge over time. Any evidence-based policy rationale for diverse provision must therefore lie in a different political or ideological domain than the policy outcomes considered above.

Our findings show in detail that privatisation, competition, patient choice of provider and provider diversity are not equivalent policies.

1. In competitively tendered services (e.g. CHS, OOH) provider diversity across the NHS as a whole does not in practice necessarily create or increase patient choice of provider because at local level CCGs let many contracts for whole populations. Providers compete for contracts ('compete *for* markets') not for patients ('*in* markets') so even when its ownership changes there is still only one provider per locality.
2. Where only one credible provider exists and is (or has become) a non-NHS provider, privatisation does not establish provider competition for patients.

3. In a health system without diverse provider ownership (e.g. provision is dominated by publicly-owned providers (NHS trusts) and professional partnerships (general practices), patient choice of provider is possible, indeed occurs, but (on the evidence of, say, the German health system²⁰⁴) requires some redundant capacity irrespective of who owns it.
4. The term ‘private provider’ conflates different kinds of organisations with very different owners, aims, structures and patterns of innovation.

Provider diversity alone is neither necessary nor sufficient to establish provider competition or user choice of provider. Additional policy and regulatory mechanisms would be required to establish these mechanisms including:

1. Yardstick competition²⁹² i.e. publishing all providers’ costs and prices as benchmarks for future tendering competitions.
2. Routine data comparing provider characteristics and performance (process and/or outcome indicators) being made publicly available to both commissioners and patients, including data which distinguish the different kinds of non-NHS (‘private’) provider listed above. Published data about that are not widely available,⁴² especially for non-hospital services, in particular CHS. Neither are the data published on PHIN remotely adequate for the purpose.
3. A guarantee of continuity of care for patients when providers leave the NHS quasi-market, so that irrespective of ownership, no provider be too big to fail.¹⁶¹

In addition our findings point up certain ‘policy messes’²⁹³ arising from a conflict, in practice, between diverse provision and other concurrent policies i.e:

1. Containing the growth of, or reducing, public spending on the NHS, since our evidence suggests that additional spending would be necessary to attract non-NHS, especially corporate, providers into the NHS quasi-market.
2. Promoting ‘efficiency’. Choice of provider (whether or not among diversely-owned providers) comes at the price of a margin of redundancy in service provision, higher transaction (contracting) costs and possibly (depending on circumstances) diseconomies of scale as a given workload is divided between smaller providers.
3. ‘Integration’ of care, insofar as integration requires reducing the number and heterogeneity of interfaces between healthcare providers.

4. Policy-responsiveness and political accountability to government of the providers of such a politically salient service as the NHS.

Hence there are trade-offs between diverse provision and the above policy aims. Table 9 also suggests more nuanced policy questions about which forms of diverse provision (ownership types) to encourage, and which to discourage, for particular services and in light of different policy trade-offs (e.g. between provider transparency and responsiveness to commissioners; between commodified and specialised care).

These findings have *implications for commissioning and managerial practice enabling the NHS to make better use of provider diversity (RQ4)*.

1. If they seek a 'level playing field' for differently owned providers,
 - (a) Commissioners should enable NHS trusts to have in practice the same payback period for service developments as non-NHS providers have. Hence;
 - (b) It is necessary to find a means of funding service development for NHS Trusts other than the (to them) highly disadvantageous PFI mechanism.
 - (c) It is necessary to create a means for social enterprises to finance service developments that require non-trivial start-up funding.
2. If they contemplate commissioning services from providers which (also) depend heavily on income from privately-funded patients, NHS commissioners might take steps ensure that NHS patients do not receive a service, choices or access times which compare adversely with those for privately-funded patients. This point may also apply to NHS trusts that develop privately-funded services, but there is even less evidence about what effects that has on services for NHS patients there.
3. Should the current healthcare labour shortage ease, commissioners should expect that corporate providers are likely to use a lower-paid work-force and consider the possible implications for staffing levels, skill mix and service quality.
4. When considering secondary care development commissioners have the option, subject to funding, of commissioning NHS trusts and/or social enterprises to provide a planned

services that are insulated from urgent and emergency care, hence with similar ambience to that found in corporate and not-for-profit providers.

5. Creating informational continuity of care²⁹⁴ between diversely-owned providers requires shared clinical records, implementing which has cost implications and (still more) appears to require a national mandate enforcing interoperability between different providers' information (especially electronic health record) systems.

We found few differences in workplace level management structures, or in care processes, between the diversely owned providers. The most evident differences arising from ownership were the differentiation of services for private patients, and pay policy. Differences in NHS-funded patients' experience reflected provider case-mix rather than ownership. This evidence suggests that any policy rationales for diverse provision rest upon a different basis. It calls into question whether, in times of austerity, it is worth spending the additional money that would be required to induce independent providers to enter the NHS quasi-market.

Chapter 13. Dissemination plans.

Two initial publications from this study are:

1. Sheaff R, Halliday J, Exworthy M, Allen P, Mannion R, Asthana S, et al. A qualitative study of diverse providers' behaviour in response to commissioners, patients and innovators in England: research protocol. *BMJ Open* 2016;6:e010680. <https://doi.org/10.1136/bmjopen-2015-010680>.
2. Sheaff R, Allen P. Provider plurality and supply-side reform. *Exworthy, M. & Mannion, R. (eds.) Dismantling the NHS?: Evaluating the Impact of Health Reforms*. Bristol: Policy Press; 2016. p. 211–31.

We plan further to disseminate this project's finding and outputs differently for different audiences. We will report our findings back to two groups of research participants:

1. Patient informants, via local meetings, for practical reasons probably one per study site. We will also publicise the findings through social media: blogs, institutional Twitter accounts, etc.
2. Managerial informants, probably in a single workshop involving all such informants since our experience in other research suggests that managers appreciate opportunities to discuss the practical implications of research findings with peers elsewhere. We will also feed back our findings to managerial informants (see Chapter 4) and other local managers by meeting them site by site. We will offer reports to the professional and managers press (e.g. Health Services Journal).

For managers and policy makers, we will submit presentations national and regional conferences and organisations aimed at service providers, professional bodies and professional leaders, for instance the NHS Confederation. With DH consent, we will circulate this report to relevant national bodies (e.g. NHS England, NHS Improvement, NHS Confederation) and think-tanks with the offer of seminar presentation.

We will also submit papers to academic and scientific conferences (e.g. HSRUK, European Health Management Association, Organisational Behaviour in Health Care, EgoS), to peer reviewed journals (e.g. Milbank Quarterly, Organisation Studies), preferring open-access publication where possible.

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Appendix 1: Interview schedule: manager

Universities of Plymouth and Birmingham, and London School of Hygiene and Tropical Medicine

Diverse Healthcare Providers: Behaviour in response to commissioners,
patients and innovations

Interview Schedule: Manager

Instructions to interviewers are in *italics*

Before starting interview:

1. *Check interviewee has seen PIS.*
2. *Invite interviewee to ask any questions about the research and what is expected of him/her.*
3. *Ask interviewee to sign consent form (two copies: one for interviewee, one for researchers).*
4. *Ask permission to audio-record.*
5. *Offer interviewee opportunity to see and correct transcript.*

Checklist of topics

*This is an **omnibus schedule**. Interviewer to select which items to pursue with particular individual informants, according to what appears relevant to the informant's role, the nature of the study organisation and what data the researchers already have.*

Study services: Community health services; out-of-hours primary medical care; secondary care (especially orthopaedics, ophthalmology) services for frail older people.

Informant's managerial background

1. Could you briefly describe your present role and background?

2. Have you previously worked in an organisation with a different type of ownership (e.g. public rather than private, or vice-versa; partnership rather than as employee, etc.)?

[If so,]

- (a) What kind of organisation was it?

3. What are the main services that this organisation provides?

[Prompt: check for orthopaedics and ophthalmology.]

Ownership, objectives, control

1. What is the governance structure of this organisation (i.e. the essential points of its constitution, articles of association etc, as applicable)?

2. Who is the residual claimant of any profits or surplus that this organisation makes?

3. What objectives does this organisation pursue, so far as services for older people are concerned (in particular orthopaedics and ophthalmology)?
 - (a) What objectives are formally documented as its aims?
 - (b) What objectives do senior managers in practice give most time and attention to?
 - i. During the past month, what objectives have you given most time and attention to?
 - (c) In practice, who sets these objectives?

[Prompts: Board? Partnership meeting? Shareholders? Holding company? Senior managers? Clinicians? Others (who)?]

4. What external events or pressures do senior managers in practice give most time and attention to, so far as services for older people are concerned (in particular orthopaedics and ophthalmology)?
 - (a) During the past year, what external events or pressures have you given most time and attention to? Specifically:
 - i. What national policies or guidance?

[Probe: e.g. for service quality, productivity, impacts on outcomes, public involvement]
 - ii. What commissioner requests or requirements?

5. By what criteria are managers' performance assessed?
 - (a) What success is rewarded (e.g. by promotion), what failures would be penalised (e.g. by disciplinary procedures or dismissal)?

6. *[For those who have you previously worked in a different type of organisation:]* What differences have you noticed between the different types of organisation regarding:
 - (a) what objectives they prioritised?
 - (b) their criteria of good/bad managerial performance?
 - (c) what external events or pressures they were most responsive too?
 - (d) services for older people (in particular orthopaedics and ophthalmology)?
 - (e) any other important differences in their management and working practices?

Commissioners and competitive tendering

1. Which commissioners does this organisation mostly deal with, so far as services for older people are concerned (in particular orthopaedics and ophthalmology)?

(a) Which would you select as having most influence on this organisation? Why?

2. Considering your organisation's dealings with that commissioner during the last year, and focussing on services for older people, orthopaedics and ophthalmology:

(a) What part did that commissioner play in influencing

i. the range of services your organisation provides?

ii. The intended outcomes of those services?

[Probe: service outcomes, clinical outcomes, financial, other]

iii. How your organisation responded to national policies and guidance?

iv. How your organisation responded to changed local needs for health services?

[Probe: e.g. changed referral patterns, collaboration with local authorities, targeting deprived populations, ageing population].

(b) How did the commissioner exercise this influence?

[Probe: Scrutiny? Persuasion? Financial incentives? Threat of penalties? Contractual terms? Threat of competition? Media exposure? Etc.]

3. What information does that commissioner routinely require from you?

(a) During the last year, what kinds of information or reports from your organisation has that commissioner responded to most actively?

- (b) During the last year, has that commissioner made any additional *ad hoc* requests for information? If so, for what information?
- i. Was your organisation able to provide that information?
 - ii. Was your organisation willing to provide it?
 - iii. Did your organisation withhold any information? Why?
4. Are there any other ways in which commissioners have influenced this organisation during the last year?
5. When your organisation is **tendering competitively** for service contracts for services for older people are concerned (in particular orthopaedics and ophthalmology):
- (a) which other providers (if any) would it regard as the main competitors or substitutes for the services you provide?
 - (b) which other providers (if any) would it regard as your main collaborators?
 - (c) In either case, how do their services differ from yours?

Patient Choice

Current policy says that NHS patients have the choice of service provider.

1. What effects has this policy had on your organisation in practice, during the last year?
 - (a) During the last year, has your organisation experienced any gain or loss of 'market' share for services for older people, orthopaedics and ophthalmology due to this policy?
 - i. If so, what caused those changes?

[Probe: what part did changes in patient and/or GP preferences play?]

2. Regarding **patients' or GPs' (or other referrers') choices** of service for older people, orthopaedics and ophthalmology,
 - (a) which other providers (if any) would it regard as the main competitors or substitutes for the services you provide?
 - (b) which other providers (if any) would it regard as your main collaborators?
 - (c) In either case, how do their services differ from yours?

3. So far as you are aware, to what extent do your patients (in particular older people, orthopaedics and ophthalmology patients) have a choice of providers in reality?
 - (a) Insofar as they do, what factors appear to influence their choices?

 - (b) What steps, if any, has your organisation taken in the past year to encourage (or to discourage) patients or GPs to choose your services for older people, orthopaedics and ophthalmology?

4. Are there any ways in which your services for older people, orthopaedics and ophthalmology are designed, to allow patients to choose:
 - (a) what kind of service they get?

 - (b) when?

 - (c) from whom?

 - (d) where?

5. What arrangements, if any, exist for feeding back patient opinion about services for older people, orthopaedics or ophthalmology to the Board (or equivalent)?

6. Are there any other ways in which patient choice policy has influenced this organisation?

Innovations

1. What are the main innovations your organisation has made in the last year in its services older people, orthopaedics and ophthalmology? Specifically, any:

(a) Clinical innovations?

(b) New models of care (e.g. more standardised services)?

(c) Changes in service location?

(d) Organisational innovations?

(e) 'Back-office' or IT innovations?

(f) Others (what?)?

2. Which would you select as most important, and why?

3. Thinking of that innovation, please describe how it was selected and implemented?

4. During the last year, were there any innovations in services for older people, orthopaedics and ophthalmology that your organisation wanted to make but were prevented by:

(a) commissioner(s)?

(b) national regulators, law or policy?

(c) lack of technical expertise or other resources?

(d) Other circumstances (what?)?

[Probe: e.g. lack of finance; remaining contract time; competitors; collaborators; media or other external pressures; internal managerial decision?]

5. Turning to risk management,

(a) What are the main risks that you foresee this organisation facing in the next five years?

[Probe: e.g. financial; contract renewal; competitors; changed healthcare needs; policy shifts?]

(b) How would this organisation usually plan to manage or deal with such risks?

Health Policy Context

1. To what extent have managers in this organisation been aware of the Fair Playing Field Review?

[Prompt: brief account of when the Review appeared and its main points]

(a) Which aspects, if any, most caught their attention?

(b) In what ways, if any, did this organisation change its working practices in response?

(c) In what ways, if any, did your main commissioner appear to respond?

(d) Did the Review have any other implications for this organisation?

2. What are the implications of the 5-year Forward Review for this organisation?

(a) for collaboration with other service providers?

(b) For services for older people, orthopaedics and ophthalmology?

Other Aspects

1. Is there any other important aspect of these topics which we have not yet asked about?

2. If necessary, might we telephone or e-mail you if on reflection we have further questions?



Appendix 2. Interview schedule: patient

Universities of Plymouth and Birmingham, and London School of Hygiene and Tropical Medicine

Diverse Healthcare Providers: Behaviour in response to commissioners,
patients and innovations

Interview Schedule: Patient

Guide to interviewer

Guidance to interviewers is in *italics*

Before starting interview:

1. *Check interviewee has seen PIS.*
2. *Invite interviewee to ask any questions about the research and what is expected of him/her.*
3. *Ask interviewee to sign consent form (two copies: one for him/her, one for researchers).*
4. *Ask permission to audio-record.*
5. *Offer interviewee opportunity to see and correct transcript.*

This is an omnibus schedule – a check-list of topics. Please select which items to pursue with each particular patient, according to what appears relevant to him/her and to the study site.

Your recent care

1. Which health services you have used (face-to-face or by 'phone, post or e-mail) in the past three months?

[Prompts: GP or GP surgery? OOH? A&E? Ambulance? NHS111? Pharmacy? Hospital department? Community health service? 'Alternative' healthcare?]

2. Which organisation(s) provided that care?

- (a) What were their names?

- (b) What type of services did they provide for you?

3. When you contacted these services:

- (a) What health problem(s) were you seeking treatment for?

[Prompts: High fever, severe diarrhoea, or cough; immunization; dental care; arthritis; asthma; heart disease; injury; other]

- (b) Did you consider any possible alternative services?

- i. If you did, which ones?

[Prompts: GP or GP surgery? OOH? A&E? Ambulance? NHS111? Pharmacy? Hospital department? Community health service? Social services? 'Alternative' healthcare?]

- (c) At the time, were you aware of having a choice of services?

[Prompts: About the kind of service? About who could provide the service? About time and place of the service? About public or private provision?]

(d) Who chose the one(s) you actually used?

[Prompts: You did, yourself? A family member or friend? Your GP? Hospital staff? Social worker? Someone else (who?)?]

(e) Why did you (or that other person) choose to use the one(s) you actually used?

- i. Did you (or they) base that choice on any published information (e.g. websites, leaflets, adverts)?

Choosing services

Once you were receiving health care, were you offered any choices about:

1. Which treatments or clinical services you received?

2. When you were treated?

3. Where you were treated?

4. Who treated you?

5. Which organisation treated you?

- (a) Was it important to you, whether the organisation actually providing your case was owned by the NHS or a private organisation?

6. How your condition might be treated?

7. If you were not in your own home, any optional 'support' or 'hotel' services (e.g. meals, meal times, access to 'phone or TV)?

8. When you were discharged or transferred (to another service or back home)?

9. Any other aspects of these services?

10. Do the above choices matter to you as a patient?
 - (a) Which ones especially?
 - i. Why? / Why not?
 - (b) Would you prefer someone else to make any of those decisions for you?

Experience of Care

For the healthcare you received, what was your opinion of:

1. Travel times and convenience of access to the surgery and/or hospital?

2. Waiting times: were you kept waiting for
 - (a) GP, nurse or other health worker to visit you at home?
 - (b) Consultations, once you had arrived at the surgery and/or hospital?

3. Staff knowledge of your health and circumstances?

[Prompts: Did they seem to know what your current health problem was and its background? Did they seem to have your health record to hand? Did you need to explain things again that you had already explained to other health staff?]

4. Staff respect for you (e.g. when they talked to you; or during physical examinations)?

(a) Did they seem kind, compassionate?

5. Confidentiality of personal information (e.g. being able to have conversations with health care staff without other people overhearing)?

6. Your opportunity to be involved as much as you wanted in deciding about your health care?

(a) Which aspect(s) of your care did you most want to be involved in deciding about?

7. Your freedom to discuss other treatment options or care regimes if you wanted?

8. Whether communication to you was clear. This means

(a) having the health care staff explain things in a way you can understand?

(b) having enough time to ask questions if you didn't understand something?

(c) Feeling able to say everything you thought was important?

9. The surroundings i.e.

(a) enough space, seating and fresh air in the waiting rooms, examination rooms and hospital wards?

(b) having clean premises (including clean toilets)?

10. If you were in hospital, contact with the outside world? This means

- (a) family and friends were allowed to visit you as much as you wanted?
- (b) being able to keep in contact with family and friends?
- (c) Having information about what is happening outside the hospital (e.g. about you family, the news in general)?

11. Was there anything else about your experience of health care that you would like to comment on?

Changes in services

1. If you have used these services before, did you notice any changes in these services the last/current time you used them?

2. What changes were they?

[Prompts: Where the service was given? Which kinds of health professionals you saw? What information you were given? Change in the organisation providing the service?]

3. What is your opinion of these changes?

[Prompts: More/less convenient to you? Harder/easier to access? Harder/easier to understand?]

Other Aspects

1. What would you do differently if you had to go through this again?

(a) What advice would you offer a friend in the same situation?

2. Is there any other important aspect about your care in the last three months which we have not yet asked about?

Personal characteristics

Can I finish by asking you a few questions about yourself?

1. How old are you?

2. Do you live alone?

3. What was your occupation before you retired?

4. Are you receiving any support from social services?

5. Do you have the use of a computer?

6. What is your ethnic group?

[Interviewer: add gender and postcode.]

Appendix 3: The study areas

Local Health Economy 1

Six of our 15 providers were based within one local health economy (LHE) (defined here as a clinical senate) and its two constituent sustainability and transformation partnerships (STP1).

STP1

Our first five providers were located in an STP with a population of over two million. It has a complex geography with substantial urban settlements contrasting with large rural areas interspersed with market towns and villages.

Our study area (part of the STP) covered one county and two unitary authorities. The former has a population of 1.34 million, defined as ageing¹ but affluent (it is amongst the least deprived upper tier authorities in England)². The two medium-sized cities in contrast are relatively deprived (in or around the top 25% of most deprived local authorities); one is growing rapidly, the other ageing, with both having affordability problems when it comes to local housing. The delivery of social and domiciliary care was seen to be a particular issue in the county whilst two local trusts (one acute and one CHS) were under particular scrutiny because of performance. This was seen to impact upon the system as a whole.

The STP covers seven clinical commissioning groups (CCGs). These were assessed by NHS England as ranging from good to inadequate, with the majority considered to require improvement. NHS England is also a major commissioner in the area. Our footprint included four Hospital (Foundation) Trusts³ providing acute secondary care; two NHS mental health/ community service Trusts and a further NHS Trust providing ambulance and NHS111 services. Other organisations providing care in the area included hospital and community/mental health trusts in adjoining counties and a corporate provider. There are two vanguards in the STP; a multi-specialty community provider (MSCP) which now covers most of the CCGs in the county and a local PACs vanguard; some of our study organisations were engaged with one or the other.

Our research focused on four of these providers, operating from 5 sites. The purchase of these services involved 11 CCGs (some from outside the STP) of which four were studied. It was notable that two of these CCGs commission services from 4 of our 5 studied providers in this STP, with a further three commissioning services from three providers and four from two. There is thus a fairly strong network of association/joint working. A further three CCGs were

¹19% of the population is aged over 75 compared to 7% nationally

²Upper tier average rank of average IMD score DCLG 2015 (2015 English Indices of Deprivation)

³NHS Trusts are taken here to include Trusts and Foundation Trusts

associates to one of our studied contracts only. Across the county as a whole there is projected funding gap of c.£700m over the next five years.

CS1: Hospital orthopaedics and ophthalmology: Corporate for profit

This corporate hospital orthopaedics and ophthalmology (HO&O) provider has been in operation for decade (having been subject to an early change in ownership). It is small in size offering both hospital orthopaedics and more recently ophthalmology to the surrounding city and environs (875k pop within 30 minute drive time) on an outpatient/day surgery basis. This is by far the smallest of the hospital orthopaedic case studies (Figure 1) and, unlike the other orthopaedic providers, hip and knee arthroplasties were not provided to NHS patients in 2014/15 (the last year for which HES data are available). Its contract value is also proportionally small (which was seen to be reflected in the degree of support drawn down from the CSU)⁴. Few medical staff are employed directly. At its last CQC inspection it was rated good. Its website stresses the availability of free NHS healthcare, short waiting times and zero cases of hospital acquired MRSA. The Corporation also operates a divisional structure with clear reporting lines.

The ISTC is commissioned by 3 CCGs (Figures 37 & 38) who have a compact in place for support functions and risk sharing. The contract had recently been re-procured on a 5+2 year basis. The lead (with whom good relations were reported) and the associates were all classified as requiring improvement. Innovation was felt to be directed primarily by the lead CCG (it is coterminous with the unitary authority and together they operate an Integrated Commissioning Unit (ICU) with the CCG's accountable officer also head of adult social care).

The ISTC had reportedly taken a long time to embed, relatively few referrals are still received via choose and book and collaboration is limited. It is, however, increasingly taking transferred activity from the local acute trust (not studied but experiencing significant problems relating to urgent care) to avoid breaches elsewhere in the system.

As illustrated in Figures 6 and 9-10, this provider commands only a very small share of local orthopaedic and ophthalmic episodes in a local market which, relative to other providers of orthopaedic and ophthalmic services, is relatively concentrated. The 30-minute drive-time Herfindahl-Hirschman Index (HHI) for orthopaedic activity is 0.26 (Figure 6), whilst for ophthalmic activity it is, at 0.39, the highest of all our case studies (Figure 9). This is a small provider in a market dominated by a small number of other providers and is notable, relative to other case-study hospitals, that most patients are drawn from a very limited area (Figures 11 and 14-

⁴Over £10 million

15). In 2014/15 the mean travel time for orthopaedic and ophthalmic episodes was 13 and 16 minutes respectively.

As illustrated by Figure 31, this provider serves a socially-mixed 30-minute drive-time catchment area and, though fewer patients are from more deprived communities, there is little evidence of a strong bias in the socio-economic background of patients receiving orthopaedic or ophthalmic treatments.

CS2: Hospital orthopaedics and ophthalmology: Corporate for profit

This corporate HO&O is under the same ownership as CS1. It has been in operation for nearly a decade (again having been subject to an early change in ownership). It is relatively small in size (with some 200 staff on a central city location) and offers outpatient, day case and inpatient HO&O services, including a number of more complex operations. The 30-minute drive-time population is, at 765k people, small relative to HO&O providers generally, though average compared to the other HO&O case studies (Figures 1-5). Its market position is unexceptional (Figures 6-9). It undertakes 16% of all orthopaedic and ophthalmic episodes provided for patients living within its 30 minute drive-time catchment area, and market concentration for orthopaedic and ophthalmic activity is relatively low with HHI scores of 0.15 and 0.23 respectively. Patients are largely drawn from the local area, with average travel times for orthopaedic and ophthalmic procedures being 15 and 12 minutes respectively.

This provider is unusual in that across orthopaedic and ophthalmic activity generally, as well as specifically with respect to hip and knee arthroplasties and cataract operations, the socio-economic profile of patients is more deprived than would be expected given the characteristics of the local area (Figure 32). For instance, although only 29% of the local (i.e. 30 minute drive-time) population lives in LSOAs classified as being in the worst 2 deprivation quintiles – and 29% of all orthopaedic patients from the local area live in such LSOAs – no less than 51% of orthopaedic patients treated at this provider come from these more deprived LSOAs. Uniquely among the non-NHS HO&O case studies, in other words, something of a ‘pro-poor’ selection bias appears to be operating here.

Most consultants working here are employed by the local NHS HO&O Trust (CS13), but orthopaedic surgeons are directly employed and ophthalmologists recruited from Chambers. At its last CQC inspection it was rated good (with care outstanding) and its website emphasises free, high quality healthcare for NHS patients (with instructions on how to gain referral), 100% patient satisfaction and cleanliness and short waiting times. As with CS1 there is a clear hierarchy of governance.

The ISTC is commissioned by 4 CCGs, although 75%-80% of orthopaedic and ophthalmic episodes were commissioned by just one CCG in 2014/15 (Figures 37 & 38). The lead CCG (responsible for about two thirds of contractual activity) was assessed formally as good and was described by the provider as strong and supportive, with the two seen as working together. As with CS1 there is an ICU in place between the lead CCG and the City Council. It is headed by the lead CCG's Director of Quality and Integration and Chief Nurse (a joint LA/CCG appointment). The CSU manages the ISTC contract on behalf of all four CCGs; this had recently been re-procured on a 5+2 year basis.

The ISTC had placed considerable emphasis on building a good reputation locally with commissioners (and GPs) and felt its role was now recognised with formal engagement around care pathways, which was helping breakdown barriers locally. At the same time the CCG was seeking better delineation between the types of patients (specific HRGs) seen in the acute and ISTC settings.

CS13: NHS Trust Hospital orthopaedics and ophthalmology

This is a very large NHS Foundation Trust with over 10,000 staff (recruitment and retention was an issue) and an income of £600/£700 million. It operates from a dated estate on a congested site in a city location but, at the time of study, was undertaking a refurbishment programme.

The Trust provides services to some 1.9 million people living in the city and the surrounding county, plus specialist services such as neurosciences, cardiac services and children's intensive care to more than 3.7 million people in the surrounding region. With high orthopaedic and ophthalmic throughput (including large numbers of hip and knee arthroplasties and cataract procedures (369, 436 and 2786 respectively in 2014/15)) and a 30-minute drive-time population of only 711k (Figures 1-5), patients are necessarily drawn from a wide area. As illustrated by Figures 11-15, average travel times are 29 minutes for orthopaedic procedures (23 minutes for hip and knee arthroplasties specifically) and 23 minutes for ophthalmic procedures (21 minutes for cataract operations). A significant tail of patients are drawn from over an hour's travel distance away from the provider site.

In terms of local market share, CS13 is the major local provider of elective inpatient care across both orthopaedics and ophthalmology, though it is not overly dominant and market concentration is relatively low. The provider undertakes 28% of all local (i.e. within 30 minute drive-time) elective orthopaedic episodes (24% of hip & knee arthroplasties) and 38% of all elective ophthalmic episodes (37% of cataract operations). The HHI score for all orthopaedic episodes within the 30-minute drive-time catchment area is only 0.14 and for ophthalmology the HHI score is 0.22. The implication is that this provider is operating in a relatively competitive local environment.

CS13 is also a major centre for teaching and research in association with the local University. It was assessed as requiring improvement at the most recent CQC inspection.

Demand on services from older people is rising as a result of both numbers and complexity. Ophthalmology services, for example, were growing 10% year on year reflecting advancements in eye care. Both ophthalmology and orthopaedics include complex presentations reflecting the Trust's specialist status.

The Trust is working to a deficit and the need to deliver the Cost Improvement Programme (CIP) was seen to focus attention not only on financial targets and performance but also joint working and new models of care. The trust only offers acute rehabilitation, meaning close relationships to the NHS CH Trust (CS15).

The Trust is commissioned on an annual basis by 11 CCGs although, as illustrated by Figures 37 & 38, two commissioners (a city and district CCG respectively) dominate and act as leads. One of these CCGs is rated good (see CS2 above), whilst the other is rated as requiring improvement. Commissioning was seen by some as having led to a competitive culture (with some perceiving the Trust to be predatory) and a lack of strategic vision. The Trust also saw some commissioners becoming increasingly aggressive in its attempt to control costs.

CS15: NHS Trust Community Health Services

This large CHS Foundation Trust was of relatively recent formation (having been the subject of two mergers) and delivered some services well beyond the studied STP. In common with CS13 above this expansion had earned it a somewhat predatory reputation.

It employed over 7,500 staff, organised into four localities and five divisions: integrated community services (covering CHS for adults and older people); mental health services; learning disabilities services; social care services; and children's services. The wide ranging portfolio meant a number of different CQC inspections. Those relating to CH inpatient services for example were rated good, whilst those relating to CHS for adults, end of life care and urgent care all required improvement. A number of serious incidents had also had an impact on morale and reputation, with the current service model and culture coming under internal and external scrutiny.

The Trust is part of a partnership project across health and social care which has resulted in a frailty model for older people. A number of innovations have followed the local MCP Vanguard, which is increasing partnership and locality working and stressing the integration of health and social care.

The size and geographical extent of the organisation means 6 CCGs commission the community services for adults and older people; these take the form of 5 separate contracts with the CCGs

assessed as ranging from good to inadequate. This burden of separate contracts and monitoring had in itself led to some strained relationships with commissioners and reduced the ability to act strategically. Contracts were only infrequently the subject of a competitive tendering process (reportedly only used if providers were unwilling or unable to reach a satisfactory solution).

The population served by this CHS is largely notable for the fact that its constituent GPs (n=171) cover the full range of health needs – a measured using practice-level QOF prevalence rates for CHD, hypertension, diabetes, COPD and cancer (Figures 39-43). The case study's overall prevalence rate for each of these conditions lies very close to the average for England as a whole.

CS24: GP Out-of-Hours Service: Social Enterprise

This is a single-site social enterprise providing GP out of hours' services through two operational arms with a combined operating budget of around £5 million. Both operational arms (which together extend across part of three counties) had their origins in GP co-operatives (established in the 1990s), a heritage which was felt still to determine its ethos of care. The arms share triage facilities whilst having a distinct GP population and separate clinics.

Our studied arm served a practice population of around 200,000 with a primary care centre co-located with the emergency department of a local acute hospital. Access is triaged by NHS111, which is provided by a local NHS ambulance Trust. This was seen to affect brand awareness. The studied arm also provides an in-hours 'Front Door' service at the same hospital in which its OOH clinic is located. This is triaged by the acute provider and can potentially divert a substantial proportion of patients from A&E. Unlike the other operational arm it does not fall in a vanguard area.

The organisation felt it had been well supported by local GPs until recently but now felt itself under operational pressure, particularly filling the clinical rota, where the workforce crisis was documented as a corporate, clinical and system risk (with attached financial penalties). Shifts are filled by both GPs and nurse practitioners. It is governed by a management council supported by a committee structure which includes a small Management Executive

Services for the two arms are contracted separately, both contracts having been retendered on a 3+2 basis in the last two years. This, together with the national review of urgent care, led to further operational uncertainty. The studied arm was commissioned by one CCG (assessed as inadequate and described variously as challenged and in flux) the other led by a CCG assessed as good.

Financial pressures had meant the organisation had not sought funding for any new initiatives recently.

The 20 GP practices served by this OOH service exhibit relatively low prevalence rates for CHD, hypertension, diabetes, COPD and cancer (Figures 39-43), reflecting the high IMD2015 score (i.e. little deprivation) for the catchment population (Figure 45).

STP 2

The second (smaller) STP covered in this LHE has a population of over 750,000, comprising one (largely rural) county council and two urban unitary authorities. One of these unitaries is a medium-sized city with above average levels of deprivation, the other a large town with below average levels of deprivation. The STP as a whole has an older than average population with a growing number of elderly.

One CCG commissions services from across the STP (including three district general hospitals, one community and mental health provider and an ambulance trust) and is contiguous with its boundaries. This CCG also purchases hospital services from our studied NHS acute hospital (CS13). A frail elderly pathway is a priority. Despite this, there was felt to be an uneven geography of service provision within the studied out of hours' sector.

CS16: NHS Trust GP Out-of-Hours Service

This is an NHS Foundation Trust (Ambulance Trust) providing ambulance services, NHS111 services and GP out of hours' services in a number of different geographical areas. It merged with a neighbouring ambulance Trust in the recent past meaning it operates on a regional basis. In our studied site the organisation is contracted to provide all three elements of the emergency/ urgent care service (999/111/OOH). This provides an integrated service (including triage) but also one where the size of the core (999) business contrasts markedly with the size of the OOH budget and where the county-wide service studied is but a small part (16%) of the organisation's budget. The service has not been re-tendered since 2004.

Core services are offered from a clinical hub. There is also a single point of access contract in the studied county (supporting healthcare professionals to access community services and avoid admission). Hub functions include call handling, triage, advice, filtering, signposting, call allocation and dispatch – these were expected to develop further. Patients able to attend a clinic can be seen at

one of five or six nurse-led treatment centres and the service will accept patients from A&E on an informal basis if they have capacity.

As with CS24, GPs and nurses are employed on a sessional basis but the provider can also draw on specialist paramedics who are directly employed. Levels of local engagement were reportedly good leading to few problems with unfilled shifts.

The large CCG (both in population and financial terms) was assured as good and was described as very supportive and understanding. As with CS24, however, frequent conference calls were held with the provider at times of peak pressure which was seen to impose a burden on the service. Responses have included changes in the call disposition over the peak period, redirection of calls to community pharmacists and inviting the provider to attend escalation group meetings, ensuring urgent care is linked into the wider local health economy.

The 98 GP practices served by this OOH service exhibit relatively high prevalence rates for CHD, hypertension, and cancer, though rates for diabetes and COPD are distributed around the national average (Figures 39-43). This pattern of health needs reflects the fact that, although the population-weighted IMD2015 score is below average, the population served by CS16 is somewhat older than average (Figure 45).

Local Health Economy 2

A further four of our 15 providers were based within a second local health economy adjacent to the first LHE. This area focus encompassed a further three CCGs, one of which acted as lead or sole CCG for three of the four providers. It has been assessed by NHS England as inadequate.

STP 3

This third STP again consists of a county and two urban unitary authorities. It is covered by two CCGs, one very large (comprising two cities and an extensive, predominantly rural, hinterland), the other a multi-centre urban area with again a mainly/ largely rural hinterland. The STP as a whole has a population of 1.2 million, and includes four hospital trusts (three of which also provide CHS), a separate SE community health provider and an NHS mental health/learning disabilities trust. Other STP partners include two corporations and a social enterprise OOH provider.

This is a stressed LHE with deep-rooted, system-wide problems. The city on which our study focused is in the top quartile of deprivation nationally whilst the locality in which it is embedded

(with a total population of over 300,000) is like many of our study areas older than average. Without change it will be over £500,000 in debt by 2020/21. Here there is an Integrated Health and Wellbeing Board and integrated commissioning with the city council.

CS9: Hospital Orthopaedics: Voluntary not-for-Profit

This is a not-for-profit (charitable) provider whose local offer includes hospital orthopaedics. This is a relatively small provider in an environment with few alternative providers. It serves a local (30min drive time) population of just 363k people and has a relatively small case load (Figures 1-3). It takes a relatively small market share of local orthopaedic procedures generally (13%) and of hip and knee arthroplasties (16% and 17% respectively). With few other local independent or NHS providers of orthopaedic services the 30min drive time HHI scores are relatively high (>0.31; Figures 6-8). Patients do, however, tend to come from further afield than average (Figures 11-13). It is owned by the same organisation as CS10 and, importantly, it not only offers services to non-NHS patients but these non-NHS (insured and private) patients also provide the most important part (over two-thirds) of the revenue. Such patients are able to gain more rapid access to treatment and care (with the CCG reportedly stipulating wait to treatment time for NHS patients).

As illustrated by Figure 33, LSOAs are distributed broadly equally across all five deprivation quintiles, albeit with slightly fewer from the least deprived IMD2015 quintile. This pattern is largely reflected in the distribution of patients receiving orthopaedic care, although CS09 itself takes a larger than expected proportion of people from the least deprived LSOAs and smaller than expected proportion from the most deprived LSOAs.

At the time of interview the organisation (which has many hospitals nationally with reportedly very different personalities) had recently undergone a re-organisation with a change in personnel, structure and strategy at the corporate level. There was a suggestion that this would result in a stronger corporate identity. The case mix meanwhile is determined locally with the studied hospital marketing itself as a centre of excellence for orthopaedic surgery (this is its most important single offer, accounting for perhaps a third of the business).

In common with the ISTCs, this is a low risk hospital with no emergency or high dependency care, so patients with multiple health problems are not considered for treatment. It was rated as requiring improvement in the latest CQC report this is qualified on its website, which affords prominence to the provider's performance against PROMs data for hip and knee replacements. It directly employs about 160 contracted staff locally with consultants, again as with the ISTCs, employed under

licence to practice arrangements. It includes a small local management team reporting through a regional and corporate structure.

Effectively, two CCGs (a lead and a material associate; see Figure 37) commission the NHS activity on an annual (relatively small) contract. Both are subject to turnaround directives, which were felt to produce a transactional emphasis. Relationships with the lead CCG were, nevertheless, described as generally quite open and quite mutual, with all commissioning activity dealt with in a quarterly meeting.

VS23: Community Health Service: Social Enterprise

This social enterprise CHS (a community interest company limited by guarantee) was previously a provider arm of the PCT. Its geographical remit for adults with complex needs has recently been extended, prompted in part by the commissioner's desire for parity of service across the locality. It also provides not just integrated physical and mental health (inpatient and community-based), but also social care (although physical and mental health and urgent care continue to be commissioned separately) and some specialist services (such as CAMHS) for those living in adjoining administrations. There is a combined health and social care budget.

It is thus large for a social enterprise, covering two primarily rural districts as well as a medium sized city core and employing over 2,500 people. Yet, with an annual contract of c£100 million, it describes itself as a relatively small care provider compared to the statutory bodies. Most (c. two-thirds) of the organisation's activity remains focused on its original city core where, as illustrated by Figures 39-43, the majority of GP practices served have higher than average QOF prevalence rates for CHD, hypertension, COPD and cancer. Diabetes, however, is slightly less prevalent than the national average. This generally slightly higher than average health burden reflects the fact that the population is both slightly more deprived than average (population-weighted IMD2015 = 22.3 against a national average of 21.8) and slightly older than average (see Figure 44). The proportion of people reporting 'bad' or 'very bad' general health in the 2011 Census (at 6%) is slightly worse than the national average (5.5%) and is worse than any of the other case studies (Figure 44).

The organisation directly employs most staff, including catering and cleaning staff; recruitment and retention are nevertheless an issue. The board structure was described as similar to a **company board structure**, including executive directors and non-executive directors. It suggested much of the time was spent responding to pressures in the local health and social care system, particularly those in the acute hospital, it thus seeks to be a 'system leader', trying to provide community-based

alternatives. This was supported by membership of the local health and well-being board. It was rated good at its last CQC inspection.

It is commissioned for 4+2 years primarily by one CCG, noted above as subject to a turnaround directive. Both the physical and mental health contracts had been the subject of competitive tender. Provider/commissioner relations were however felt to be subject to negotiation and the CCG was felt to be supportive of innovation. The diverse nature of its provision still means this CCG only accounts for c60% of its business (the local authority being the second largest commissioner), followed by NHS England.

CS31: Community Health Service: Professional Partnership

In meetings with the CCG and local providers it was obvious that emphasis was being placed on developing an orthopaedics pathway in the community. Our definition of community health services did not originally include MSK services but Laing Buisson's 2015 Primary Care and Out of Hospital Services report suggested '*pathway contracts along the lines of recent musculoskeletal contracts, with substantial elements of community health activity*' were likely to become increasingly common alongside straightforward tenders of community health services en bloc⁵.

This small case-study (contract value less than £100,000 and serving just 3 practice populations) allowed us to interrogate one of the few areas where patient choice might be emerging in community health services (acting as an alternative to hospital orthopaedics) whilst also enabling us to talk to a professional partnership offering emergent CHS. The focus was a capitated budget practice providing MSK services in the community as part of a new pathway to reduce elective hospital care.

The professional partnership at its centre was formed as the result of a formal GP merger across four sites. Its services were rated as good at the the last CQC inspection. Community MSK and dermatology services were available to the practice population only, with expansion predicted as a result of further mergers. Prime Minister's Challenge funding had been important both in piloting specific projects and encouraging a positive attitude to change and development more generally, whilst primary care at home funding had also just been awarded at the time of interview.

Good relations were reported with the same CCG as in cases studies 9 and 23 above, which was seen as a collaborator, although it was felt the financial pressures it was under were constraining further innovative work. The MSK service, following a 12-month pilot, is now offered on a two-year block contract. It is subject to light touch management because of its small size.

5. HSJ 21.1.15.

As illustrated by Figures 39-44, the population served by this small CHS is unexceptional. The three practice populations covered have, on average, slightly worse than average QOF prevalence rates for CHD, hypertension, COPD and cancer, but a slightly lower than average diabetes prevalence. As illustrated by Figure 44, the population-weighted IMD2015 score is low (11.5 against a national average of 21.8), but the age profile is older than average (with 26% of the local population aged 60plus against a national average of 23%). It is the oldest of the CHS case-study providers, and has the smallest non-white population (comprising an unusually low 1.2% of the total population).

STP 4

With a combined population of c.870, 000, this STP covers three unitary authorities and three coterminous CCGs. It is a largely affluent area, where the population is growing and where the standard of health and care services compares well to other areas of England. It includes three (geographically peripheral) hospital foundation trusts, a mental health trust and an ambulance trust; CHS are provided by a number of organisations, including the hospital trusts.

CS8: GP Out-of-Hours Service: Ex-proprietary

The CCG covers a population of 470,000 and is largely rural in composition. 56 practices are served by the OOH service and these, as shown in Figures 39-43, have QOF prevalence rates that cluster around the national average for CHD, diabetes and COPD. Hypertension tends to be more prevalent than average, and QOF prevalence rates for cancer are high (3.1% against a national average rate of 2.5%). The population-weighted deprivation score is relatively low (IMD2015 = 13.5 against a national average of 21.8), but the population served by this OOH provider is otherwise unexceptional (Figure 45).

This provider was originally identified as a proprietary provider of GP Out of Hours Services having been founded by the then CEO a decade or so earlier. It had previously been a GP co-operative. Interviews revealed, however, that it should now be more correctly classified as a corporate provider. In effect, however, its local identity has remained that of a place-based small company, with a small on-site management team (supported by an advisory board) taking executive decisions.

It directly employs nearly 300 staff having extended both its geographical and operational remit to include broader responsibilities within the field of urgent care, to include the provision of a clinical

management hub/single point of access for health care professionals and the provision of telecare and telehealth services. It also offers an urgent care at home /crisis response service providing integrated rapid health and social care for service users in crisis at home and manages a number of community intermediate care beds. Most of these contracts expire (at different points) in 2018. Their range means this provider has a large (for sector) budget of over £8million.

The OOH service operates from five primary care centres (six at weekends) each staffed by a GP and a nurse practitioner covering the county as a whole. Like all the other OOH providers it also offers home visits and self-care advice. In an effort to increase resilience, like CS16, it also utilises paramedics to carry out a proportion of domiciliary visits and works in partnership with other organisations (including a project with the ambulance service to reduce admissions after a fall and initiating a regional OOH Quality Group). Sessional employees (mostly GPs are also employed primarily for the OOH service), with nurse practitioners employed directly.

Calls are triaged by NHS111 (usually with a disposition assigned), the NHS111 service being offered by another corporation. Activity levels were seen as going up across the board but particularly the demand for home visits as patients' needs become more complex and they can't get in to clinics easily. The provider was rated as outstanding at its last CQC inspection.

Relationships with the CCG were considered good; it was supportive of the integration agenda and was seen to play a part in both monitoring and shaping the services provided. It is also assessed formally as good. The local authority is also a significant commissioner, alongside the CCG.

Local Health Economy 3

The third LHE also has a boundary in common with LHE1, with our study encompassing three case-study sites and 13 CCGs, only two of whom commission more than one of our case-study providers in this LHE (case studies 3&4) but a further two also commission a studied provider in LHE1 (13 & 24).

STP 5

This STP covers a densely populated part of the country adjoining a major conurbation with clinical, operational and commercial relationships extending across these boundaries. It has a population of 850,000 people with a combined health revenue allocation of £1 billion. Like many of our study areas it has a relatively mature population with a larger than average proportion aged over

75. People in our particular study enjoy better health than much of Britain and live longer than the national average. Care is commissioned and delivered by multiple organisations. The STP includes three acute hospitals, two community health providers (one corporate, one social enterprise), a mental health trust, an ambulance trust and three CCGs. The main hospital serving our studied population has experienced a sustained failure to meet the 4-hour A&E waiting target; there have also been quality and contractual issue with the ambulance trust.

CS3: Community Health Service: Corporate for profit

The corporation provides adult and community services provider across the county and some 145 GP practices are served. As illustrated by Figures 39-43, QOF prevalence rates for these practices are distributed across the full spectrum of values for hypertension and cancer, but are skewed towards the lower end for CHD, diabetes and COPD. The 2011 census records that the population served by this CHS provider has higher than average rates of owner occupation and better than average general health. The population-weighted deprivation score is very low (IMD2015 = 9.6 against a national average of 21.8).

Services provided by this CHS case-study include: (adult) district/community nursing; community hospitals/scheduled care; and rapid response together with community therapies and stroke. It thus covers a broad spectrum of services across a wide geographical area. It was noted that over time patients were presenting with more complex needs, assessments were taking longer and expectations were higher. During 2013/14, all the provider's community hospitals met CQC's standards and the inspection reports showed a 'high level of satisfaction and positive feedback' from patients.

Innovations had focused on whole-system working, including care coordination centres and admission avoidance, and mobile working. The provider was party, for example to joint working groups on system resilience and frailty. Locally 8% of the budget is spent on CHS.

Most staff are employed directly (many having been TUPE'd from a previous provider on NHS terms and conditions) with recruitment described as difficult due to the high cost of living locally and a shortage of qualified staff. Support for the local business unit (and monitoring), was provided by the corporation but operational matters were dealt with locally.

The CH services were contracted by four local CCGs, with the lead commissioner (assessed as good), holding the head (block) contract on behalf of the other CCGs locally. The four-year contract totaled c£85 million per annum and was described by commissioners as currently complex and disjointed (being the subject of local variation particularly around integration). There had also been

some difficult provider/commissioner relationships at the outset. It was the subject of re-tender at the time of interview (with two CCGs negotiating a standalone year contract (to enable re-alignment) and two going for re-procurement). Overall, it was felt change was often addressed via joint working rather than provider or commissioner alone.

CS4: GP Out-of-Hours Service: Corporate for profit

This corporate GP out of hours' service (which had previously existed as a GP co-operative and then NFP) is owned by the same corporation as the two studied ISTCs, with quality assurance and performance monitored nationally. Its website jointly brands the service with the NHS. The organisation also provides the 111 service in partnership with an NHS Trust; this is able to book patients directly to appointments at the relevant out of hours' primary care clinic reportedly improving patient experience.

This OOH service covers about 800,000 patients across 103 practices, the majority of which report lower than average QOF prevalence rates for CHD, diabetes and COPD (Figures 39,41 & 42). Practice-level QOF prevalence rates for hypertension and cancer are distributed more evenly around the national average (Figures 40 & 43). The area served is the least deprived of all the OOH and CHS study site areas (population-weighted IMD2015 = 9.2 against a national average of 21.8).

The OOH runs from seven (rented) clinics, in common with the other studied OOH services there are no walk-in centres. One of these is in a GP surgery (with a pharmacy on site); two are in acute and four in community hospitals. On weekday evenings there is also a dedicated GP in one of the acute hospitals who (similar to CS24 and informally 16) is there to take referrals from the A&E department, a similar arrangement but without the dedicated OOH GP exists at the second acute hospital with a primary care clinic. The OOH service can in turn refer on to A&E.

The provider employs one GP directly, the remainder are self-employed or agency staff (advanced nurse practitioners (variously employed as bank staff, on contracted hours or as agency staff) and pharmacists are also deployed. There were problems filling shifts with indemnity and the demands of the 'day job' important contributory factors. It was also looking to develop an integrated clinical hub (with inter alia 111 and integrated urgent care in the same building). The OOH service has recently been assessed by the CQC as good on all five quality domains.

The service (in place for three years) is commissioned by three CCGs, the lead being assessed as good but pressures on the latter were seen to have resulted in limited engagement. A number of joint innovations had also had to be abandoned reportedly because of financial pressures. The local

CCGs have now joined together to procure a joint NHS111/OOH service across the county following NHS England's Integrated Care Guidance.

STP 6

This larger than average STP crosses a county boundary and covers an ageing and relatively wealthy population of 1.7million people. The area includes four hospital trusts, two mental health foundation trusts, two community health trusts, one SE CHS and an ambulance trust, together with a SE OOH and eight CCGs. The STP reports significant financial challenges across the LHE most notably across two hospital trusts, the ambulance trust and two CCGs.

CS25: Hospital Orthopaedics: Voluntary not-for-profit

For long this has been a single site, single speciality organisation. It now operates from two hospital and three outreach sites but still primarily offers hospital elective orthopaedic services from one centre, together with more preventative MSK services and physiotherapy. It is also party to two (five-year) MSK Partnerships run as a joint venture company and involving the provider, a social enterprise, and two NHS Trusts with the aim of reducing elective admissions. The contract with the lead commissioner for the HO&O service amounts to 1% of the CCG's annual spend whilst the MSK partnership accounts for 16% of its spend. Charitable status and an operating surplus were seen as key to the centre's diversification.

Although an independent hospital (there is an executive team and board of directors), the majority of work has traditionally been done for the NHS. Patients at the main hospital site, however, tended (it was suggested) to be self-selecting: middle class, articulate and familiar with the choice agenda. This is clearly supported by HES data, which highlights the rather unusual characteristics of this HO&O provider. It serves a relatively small 'local' catchment population (212k within a 30 minute drive) but a large number of operations are carried out (910 and 925 hip and knee arthroplasties respectively in 2014/15, and 4397 orthopaedic episodes in all) (Figures 1-3). Most patients therefore travel some distance to attend this HO&O provider, with a mean travel time of 37 minutes for all orthopaedic procedures and 44 minutes for hip and knee arthroplasties. Nearly three-quarters of patients receiving hip or knee arthroplasties were from outside a 30 minute drive-time catchment area, which is far more than at any of our other HO&O providers (Figures 11-13).

This HO&O dominates its local provider environment (Figures 6-8), with a 57% and 58% share of all hip and knee arthroplasties for people living in the local area (i.e. within 30 minutes drive-time).

The 30 minute drive-time market concentration score (HHI) is also relatively high, at 0.37 for both hip and knee arthroplasties. Its influence clearly extends well beyond the 30 minute drive-time catchment area, undertaking 18% and 17% of all hip and knee arthroplasties within a 60 minute drive catchment area. Most notable, however, is the socio-economically skewed cohort of patients attending this HO&O provider (Figures 21-23), although this appears to be entirely due to the relatively affluent nature of the local population (Figure 36).

Most staff (except consultants) are directly employed with in-house training having been developed to provide new skills such as extended scope practitioners. There are also about 100 volunteers working with the provider.

The large number of commissioners involved (Figure 37) reflects the geographical spread of patients, proximity to a county boundary and recent restructuring of CCGs (now increasingly working through discrete contracts rather than through a lead commissioner). As a result there are now four separate quarterly contract meetings (involving 8 commissioners for the HO&O services) with further contract meeting for the MSK partnership (introducing another three distinct CCGs into the equation). The observed lead was assessed as good but the key contact was with the CSU.

Outliers

STP 7

Our case-study area was located in a conurbation with a population of 1.4 million, nearly half of whom live in the most deprived areas of England, with consequent poor health and well-being. It includes three acute trusts, two mental health NHS Trusts (one of which also provides community health services), a combined acute and community health trust, a CHS Trust an Ambulance Trust and 4 CCGs.

CS10: Hospital Orthopaedics and Ophthalmology: Voluntary not-for-profit

Our study area was one of five distinct local communities within the STP with a population of over 250,000. 1.5 million people live within a 30-minute drive-time of the HO&O provider (the largest 'catchment area' amongst our case studies) although the number of orthopaedic and ophthalmic episodes is relatively modest (Figure 1-6). The vast majority of patients are drawn from the local (30 minute drive-time) area (Figures 11-15) and most patients travel only short distances (the mean travel time for elective orthopaedic and ophthalmic episodes is 11 and 15 minutes respectively (Figures 11-15)). There is only one other local independent HO&O undertaking orthopaedic and ophthalmic procedures, but there are 8 NHS hospitals undertaking orthopaedic procedures (7 of

which provide hip and knee arthroplasties) and 9 NHS hospitals undertaking ophthalmic procedures (of which 7 provide cataract operations). This HO&O thus occupies a relatively minor position in a relatively 'open' market environment; it has a '30-minute catchment area' market share of just 5% for orthopaedic procedures and 6% for ophthalmic procedures (although 9% for cataract operations specifically). HHI scores are low (and the lowest experienced by any of our case-study hospitals) at 0.09 for orthopaedics and 0.14 for ophthalmic procedures.

The city has marked health inequalities, and the 30-minute travel-time catchment area has the highest proportion of people in the two most deprived IMD2015 quintiles (60% against an expected 40%) of all our HO&O providers (Figure 27). Interestingly, this is not reflected in the deprivation profile of patients from the catchment area actually receiving orthopaedic or ophthalmic procedures, either at any HO&O provider or at CS10. Indeed, Figure 34 suggests that processes of social selection significantly influence who receives orthopaedic and ophthalmic treatments at this HO&O provider.

We focused on a multi-site NFP (with the same parent organisation as CS9) in order to provide an insight into hospital ophthalmology services, CS9 having withdrawn from this sector of the market.

Case mix/service viability was again considered to be a local decision with HO&O the two main strands in the NHS Payer groups. Ophthalmology was an area that this provider wanted to grow and they were thus exploring different practices and outreach services in order to increase throughput. The hospital directly employs about 120 staff. These are supplemented by bank staff who account for c18-20% of the labour force. Consultants are employed under practicing privileges.

As with CS9, considerable emphasis was placed on its private status and the importance of non-NHS patients (c.80% of activity). This site had received a good CQC report and was named as a top performing hospital in the most recent NHS Partners Network (NHSPN) Report on Independent sector providers caring for NHS patients. Patient Reported Outcome Measures (PROMs) also show the hospital scoring highly.

A single commissioner dominates (Figures 37-38) and it is assessed as outstanding. There are also four associates to the contract (which is moving from annual to bi-annual renewal). The senior management team engaged primarily with the local CSU with the independent nature of the provider seen to pose some challenges in terms of relationships including limited autonomy in responding to emerging markets or consultant availability.

The STP in which the final case-study was located was the largest studied with a population of over 2.5 million, nearly a third of whom live in the most deprived areas in the country. It includes 12 CCGs and 20 providers (together with 9 local authorities). Its size alone means it covers a very diverse area, including urban areas with poor levels of health and significant service and financial challenges.

CS20: GP Out-of-Hours Co-operative

Our studied provider was a co-operative OOH servicing a patient population of over 200,000 in 36 GPs dispersed across a large town. It serves a relatively old population with higher than average levels of reported poor health and high levels of deprivation (Figure 45). With a population-weighted IMD2015 score of 29.8 (against a national average of 21.8) this is the most deprived population covered by our CHS or OOH case studies. This is reflected in generally high practice-level QOF prevalence rates for CHD, hypertension, diabetes, COPD and cancer. Most practices have rates higher than the national average and, overall, there is clearly a high local burden of ill-health.

The OOH service had originated in the 1980s following identification of a need for a co-operative approach to managing out of hours' calls. From the outset it was run as a non-profit making, subscription service, with members recouping some monies from their earnings from the rota. Since 2004 it has run as an opt-in service, with all but a very few local practices participating (and subject to SLAs). It is now run as a limited not for profit company with the shareholders being GP practices (and shares dependent on practice size). It is run by two salaried directors together with an elected committee of local GPs.

As well as providing a GP out of hours service the provider offers a number of other in hours services including: an acute visiting service (AVS); daily children's clinics; a single point of access for health professionals for urgent care; GP Admissions; and call handling for district Nurses and dental services. Calls come direct to the out of hours service rather than being semi-triaged by NHS111. Patients are seen either at the clinic (purchased to provide the out of hours service in 2011) or at a surgery in a pharmacy in another part of the town.

Both the AVS and children's clinics were rated as outstanding by the CQC, which also rated the organisation as outstanding for clinical effectiveness. Despite local ownership recruitment and retention was an issue (attributed in part to an ageing GP Population) and the provider also employs ANPs and locums on a sessional basis..

As the provider is owned by its member practices it does not need to retender for its core services every three or five years. It does however have a contract with the local CCG for those practices who have opted out and for the additional services outlined above, many of which are funded from winter pressure monies. The CCG was assessed as inadequate (and is subject to a turnaround action plan). This financial stress had affected services but the relationship seemed resilient.

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Hospital Provider Case Studies in Context: Catchment populations and elective inpatient activity

Analysis of drive-times from patients' LSOAs to all significant (>50 elective episodes in 2014/15) providers of hospital orthopaedic and ophthalmic (HO&O) services enables us to define how many people live (in mid-2013) within 30 minutes of each HO&O provider in England. This provides a useful measure of the size of each provider's local catchment population, and this is compared with each provider's throughput (in terms of elective episodes, 2014/15). The case-study hospitals are highlighted in graphs which cover (1) all elective orthopaedic procedures, (2) hip arthroplasties, (3) knee arthroplasties, (4) all ophthalmic procedures, and (5) cataract operations.

None of the case studies are extreme outliers in terms of catchment population or scale of activity, although CS25 (voluntary not-for-profit) is a nationally significant provider of hip and knee arthroplasties, whilst CS13 (NHS Trust) is a large provider of ophthalmology generally, and cataract operations specifically.

Figure 3: Population and episodes: providers of elective orthopaedic services, 2014/15

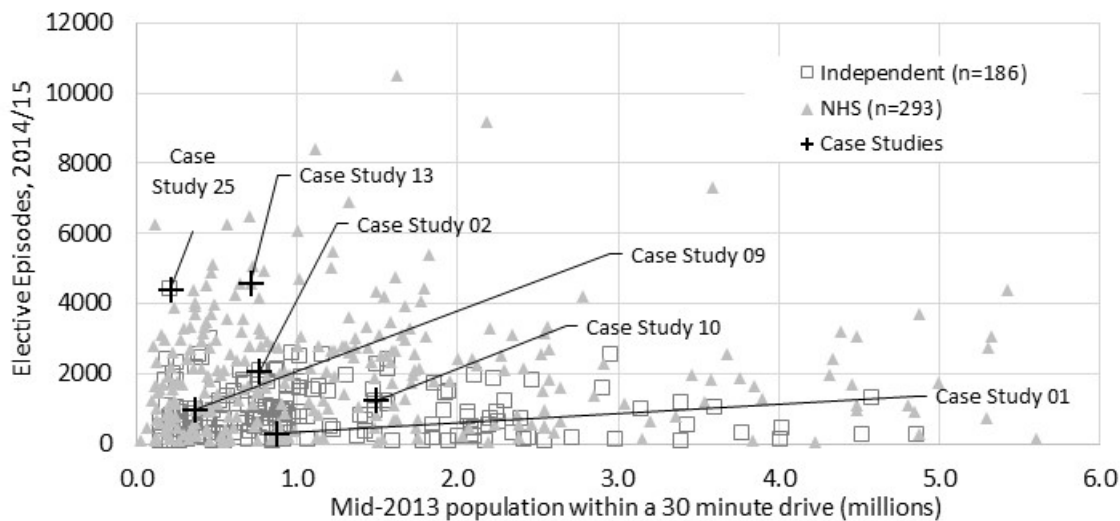


Figure 4: Population and episodes: providers of hip arthroplasties, 2014/15

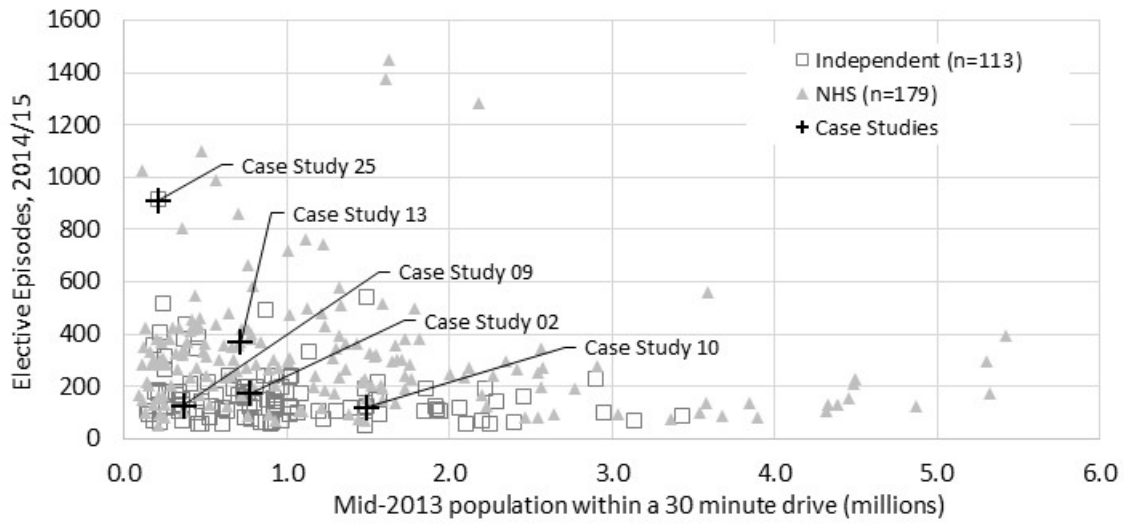


Figure 5: Population and episodes: providers of knee arthroplasties, 2014/15

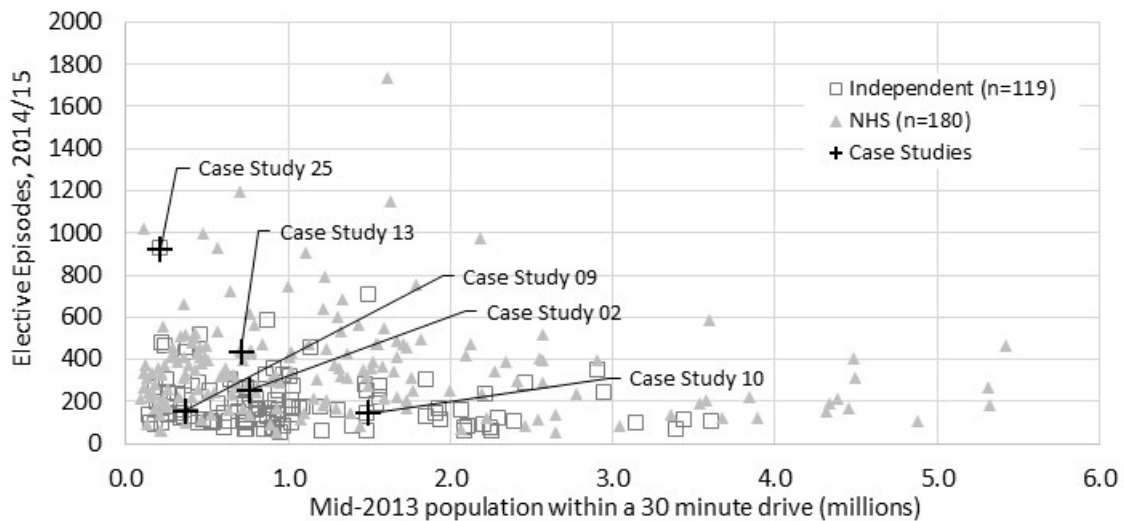


Figure 6: Population and episodes: providers of elective ophthalmic episodes, 2014/15

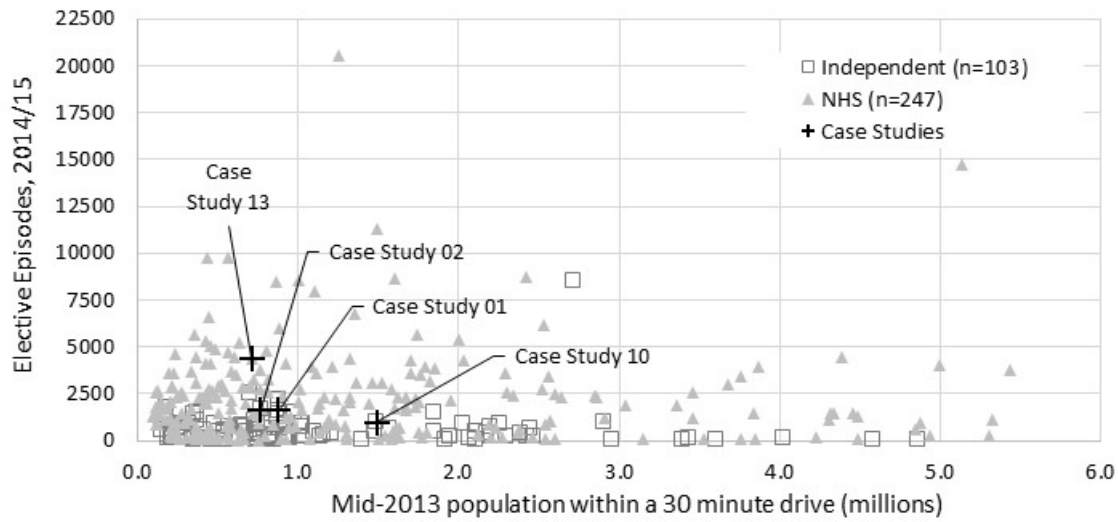
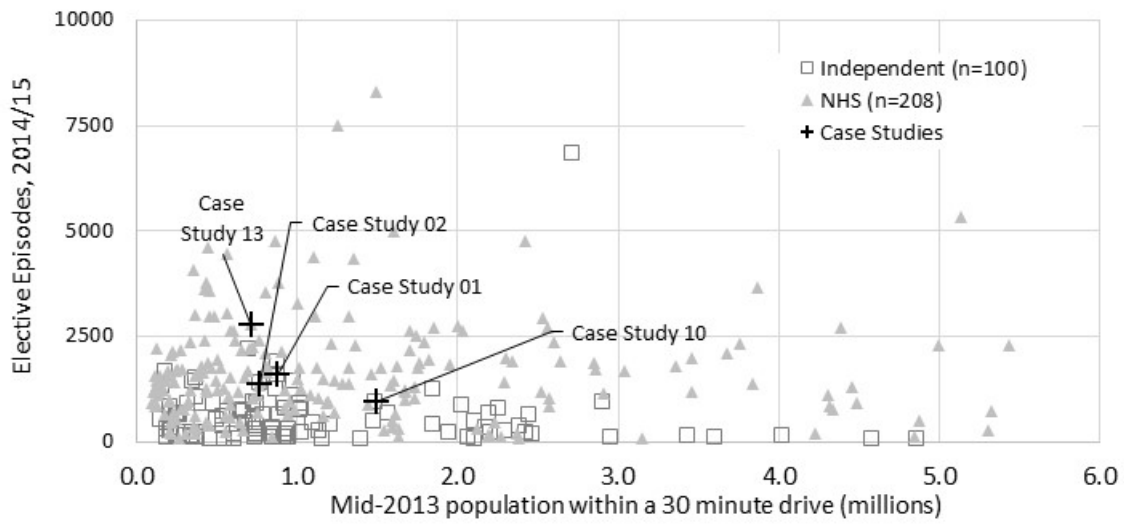


Figure 7: Population and episodes: providers of elective cataract surgery, 2014/15

Hospital provider case studies in context: market environments

The ‘market environments’ within which HO&O providers operate are here measured relative to each providers’ 30-minute drive-time catchment area. The following figures describe (a) how many alternative independent and NHS HO&O providers are to be found within each provider’s 30 minute catchment area, and (b) each provider’s % market share of all relevant episodes within the 30 minute drive time catchment area plotted against the Herfindahl-Hirschman Index (HHI) for that catchment area. A large HHI value indicates a monopolistic market environment, whilst low HHI values point to a large number of small providers.

The case-study hospitals are highlighted in these graphs which plot all significant (i.e. >50 episodes in 2014/15) providers of 1) all elective orthopaedic procedures, (2) hip arthroplasties, (3) knee arthroplasties, (4) all ophthalmic procedures, and (5) cataract operations. The case studies cover a useful range of market environments.

Figure 8: Market context: providers of elective orthopaedic episodes, 2014/15

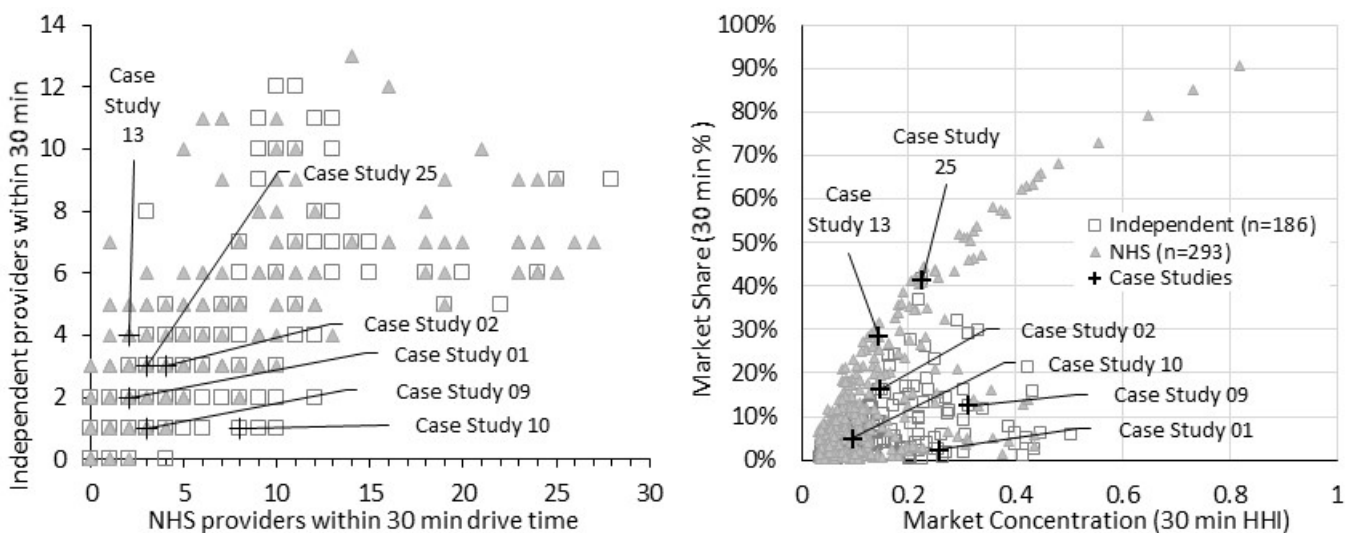


Figure 9: Market context: providers of hip arthroplasties, 2014/15

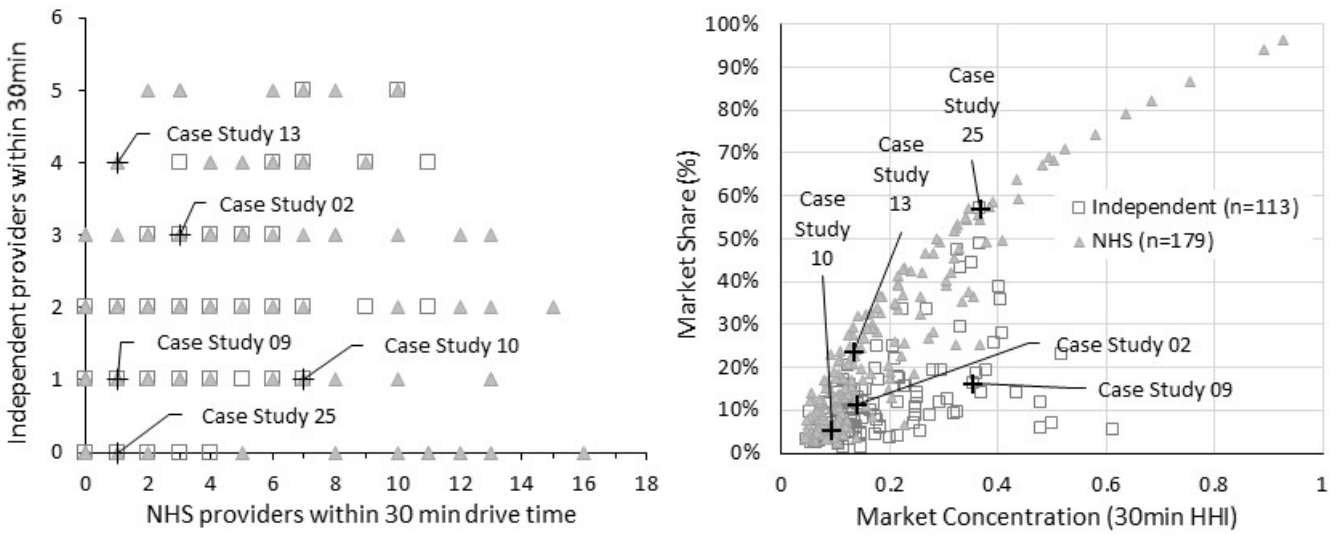


Figure 10: Market context: providers of knee arthroplasties, 2014/15

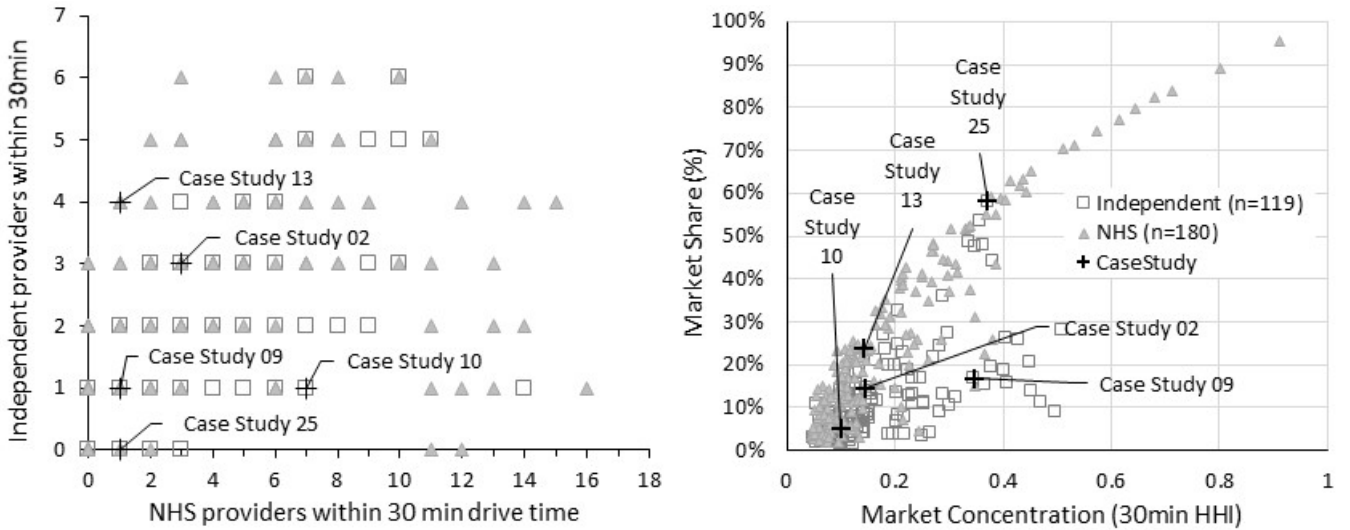


Figure 11: Market context: providers of elective ophthalmic episodes, 2014/15

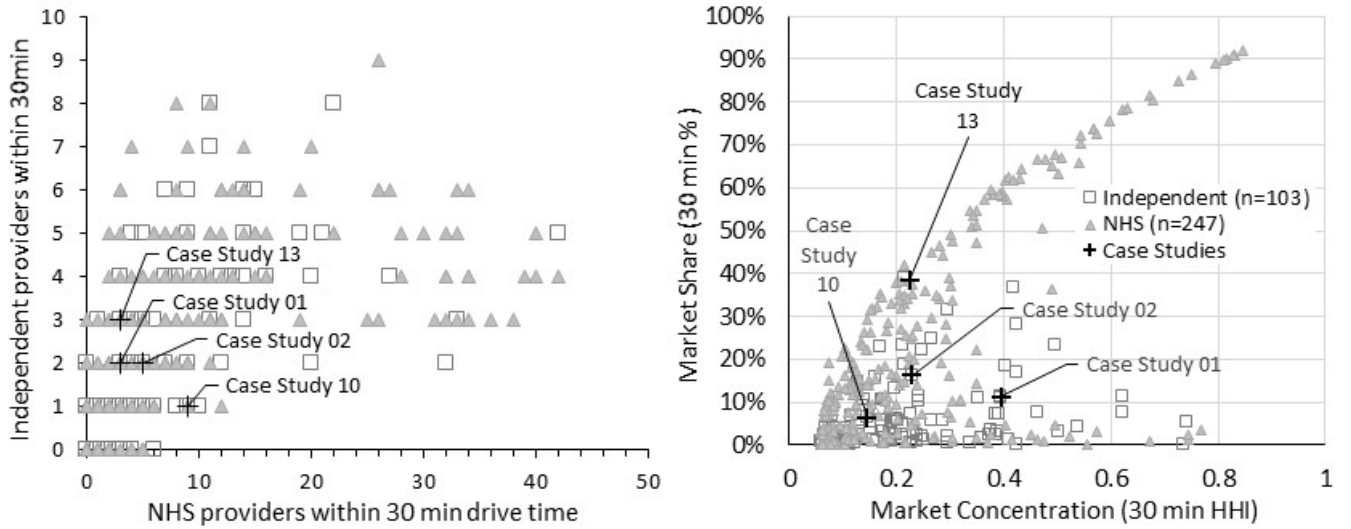
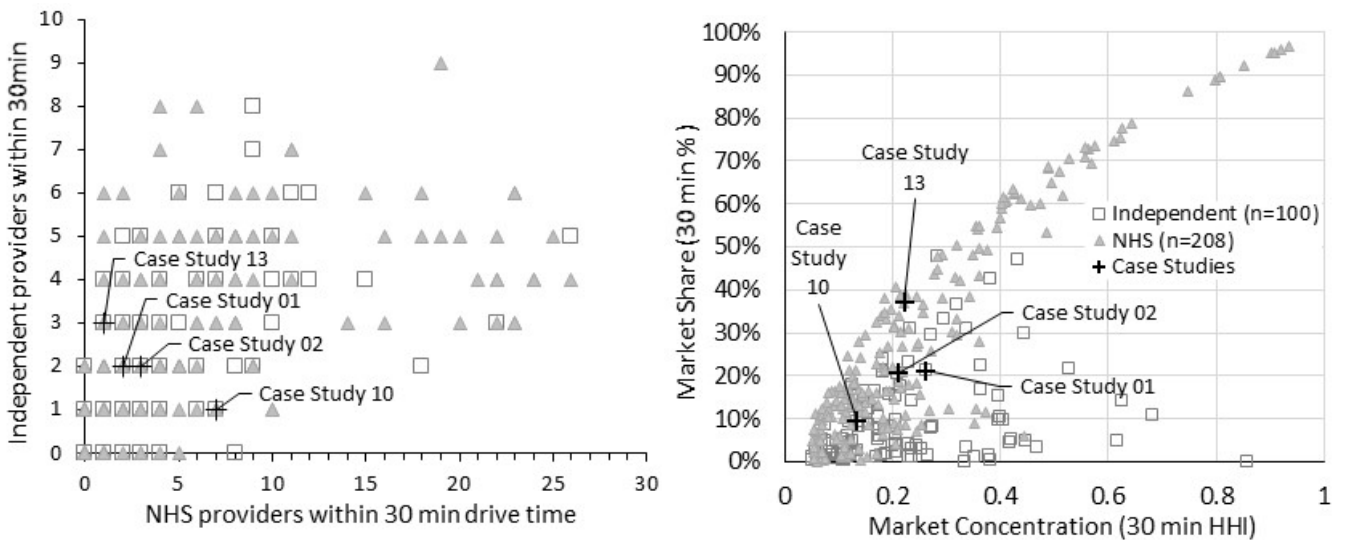


Figure 12: Market context: providers of elective cataract surgery, 2014/15



Hospital provider case studies: Patient drive times for elective procedures

Although a 30 minute drive time serves as a useful benchmark for describing the catchment area around HO&O providers, in fact different providers tend to draw patients from varying distances. The following graphs illustrate the different ‘travel time’ profiles for patients attending the HO&O case-study providers. Thus case studies 01, 02 and, in particular, CS10 predominately draw patients from their immediate localities, whereas case studies 09, 13 and, in particular, CS25 draw patients from much further afield. The travel time profiles are reflected by the average (mean) travel times incurred by patients attending each HO&O provider, which range from 11 minutes (for all orthopaedic procedures at CS10) through to 44 minutes (for hip and knee arthroplasties at CS25).

Figure 13: Patient drive times for elective orthopaedic procedures, 2014/15

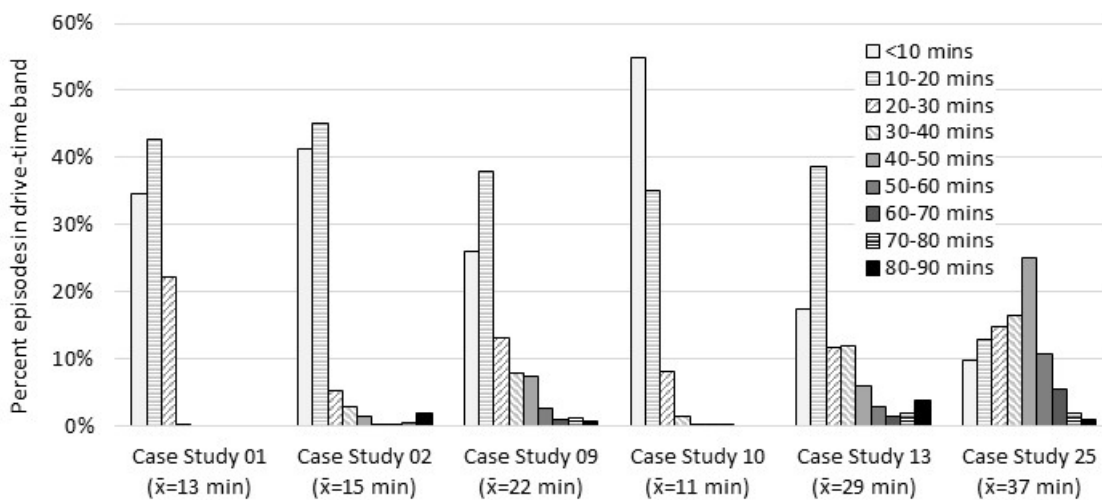


Figure 14: Patient drive times for hip arthroplasties, 2014/15

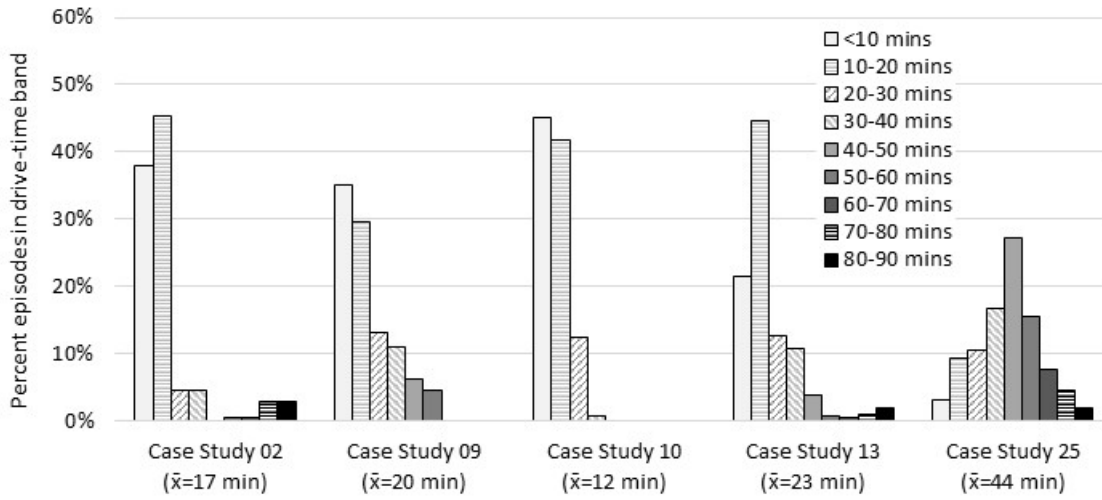


Figure 15: Patient drive times for knee arthroplasties, 2014/15

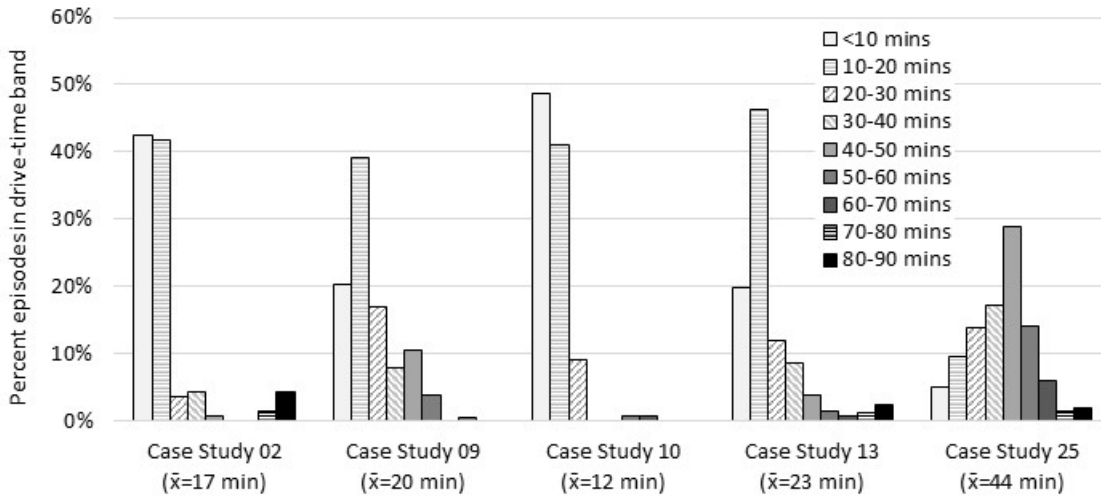


Figure 16: Patient drive times for elective ophthalmic procedures, 2014/15

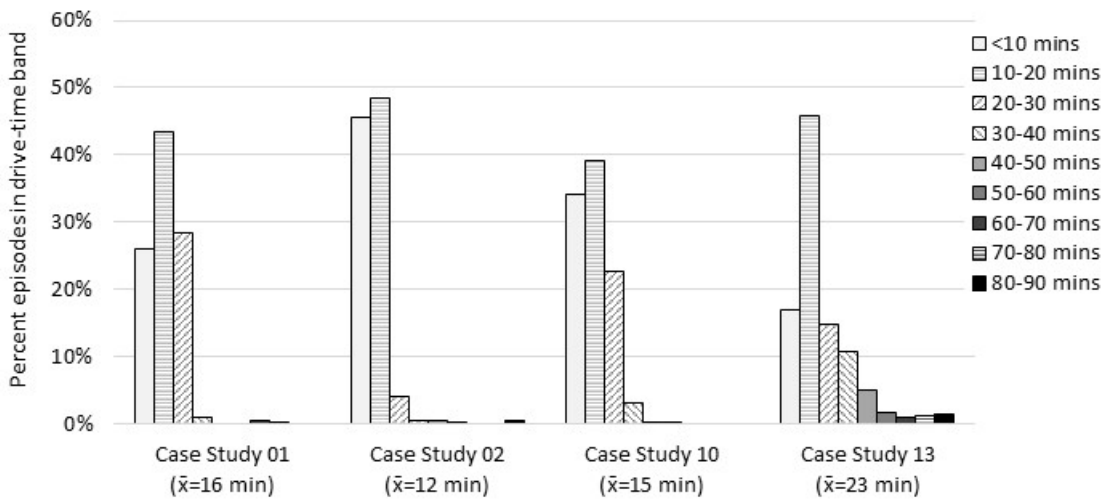
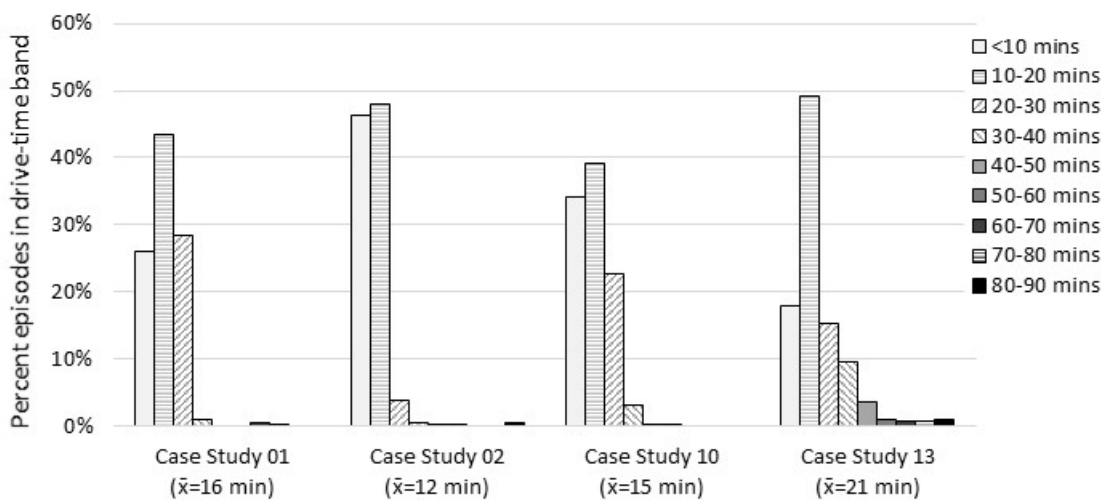


Figure 17: Patient drive times for cataract surgery, 2014/15



Hospital provider case studies: Patient age profiles

The following five graphs plot the age profiles (and average ages) of patients attending the case-study hospitals. Patient ages are recorded for almost all (>99%) HES episodes.

Age profiles vary between providers partly in response to the characteristics of local areas (see Figure 26 below) and partly due to case mix. The latter particularly affects the profiles for ‘all elective orthopaedic procedures’ (Figure 16) and ‘all elective ophthalmic procedures’ (Figure 19) as these comprise a diverse range of operations. case-study13 (an NHS Trust hospital), for instance, deals with a much larger proportion of young patients, in contrast to the broadly similar set of age profiles for the remaining case studies, all of which are independent hospitals.

Figure 18: Patient age profiles for elective orthopaedic procedures, 2014/15

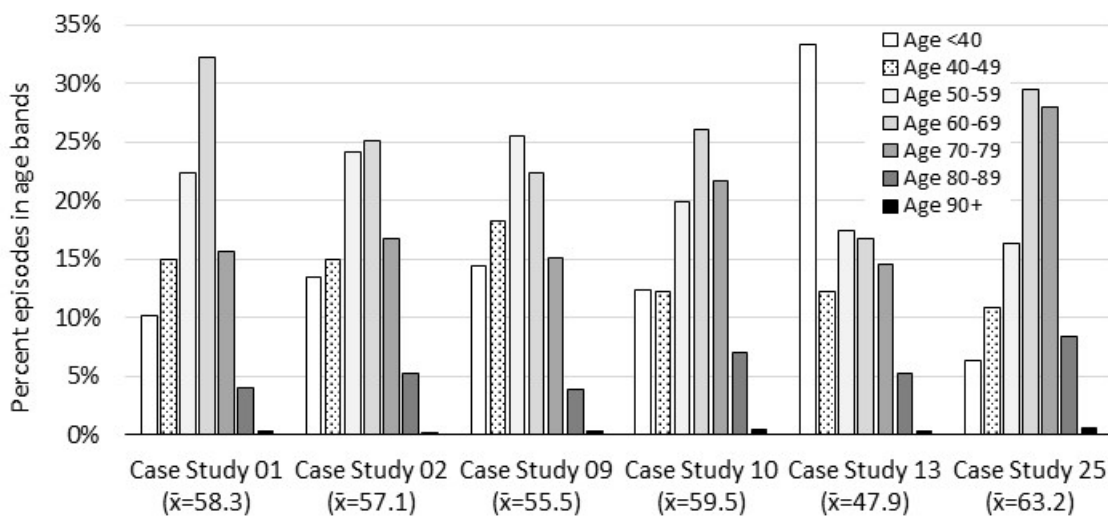


Figure 19: Patient age profiles for hip arthroplasties, 2014/15

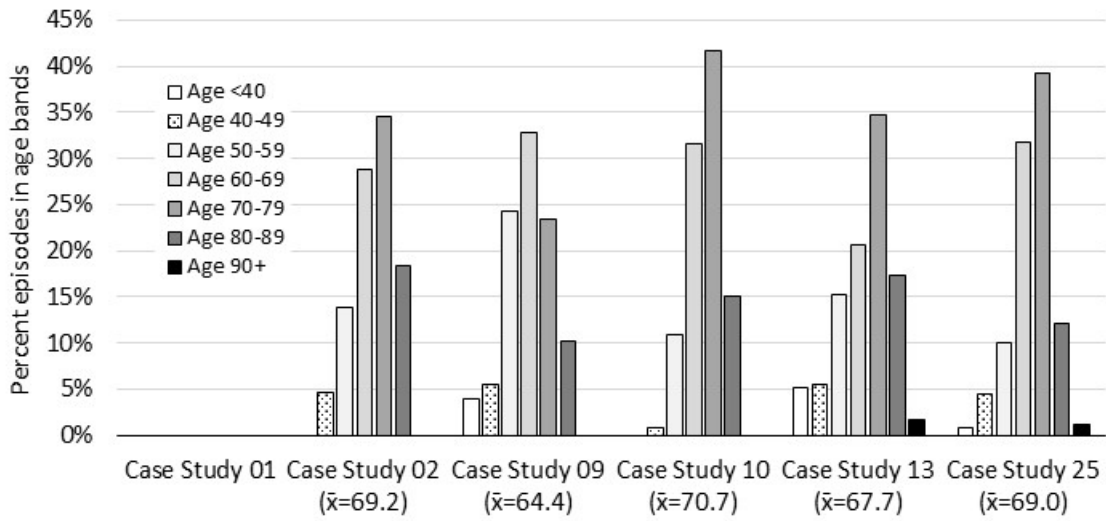


Figure 20: Patient age profiles for knee arthroplasties, 2014/15

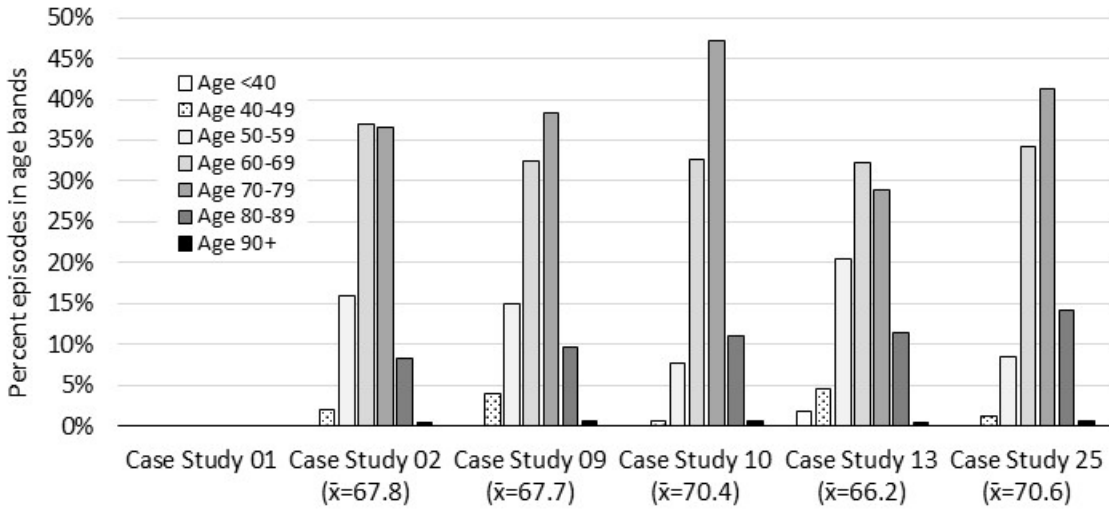


Figure 21: Patient age profiles for elective ophthalmic procedures, 2014/15

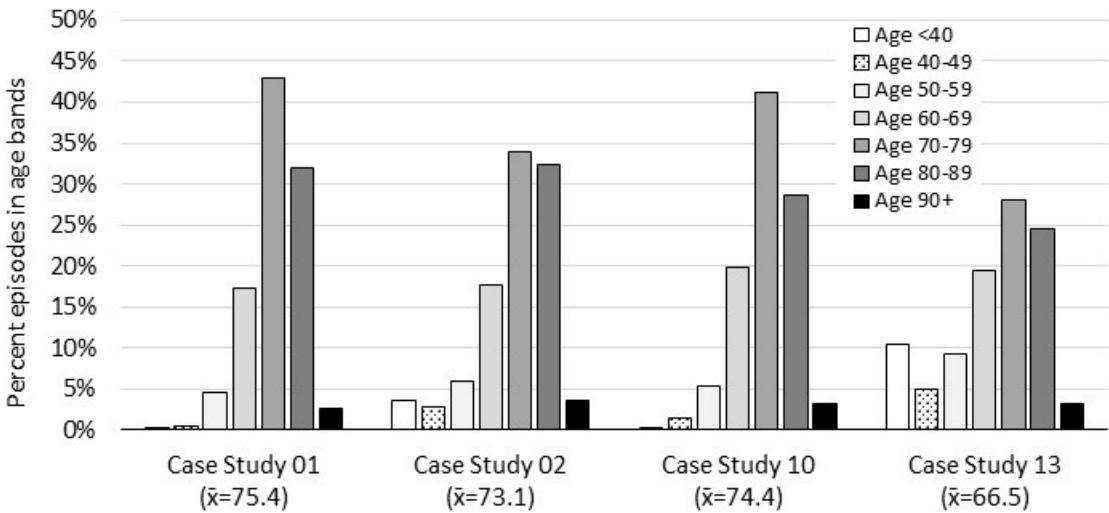
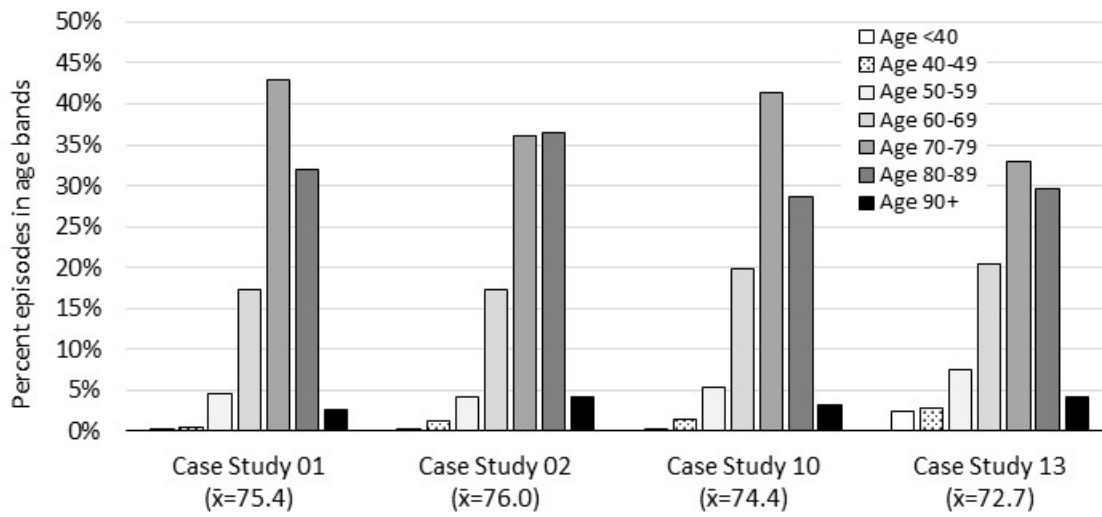


Figure 22: Patient age profiles for cataract surgery, 2014/15



Hospital provider case studies: Deprivation profiles of patients' home localities

Hospital Episode Statistics (HES) include the Lower Super Output Area (LSOA) in which patients live and this can be linked to LSOA-level Index of Multiple Deprivation Scores (<http://bit.ly/1Vr5M7O>) to derive measures of the socio-economic background of the patients being treated at the HO&O case-study providers.

The following graphs show the percent of hospital episodes associated with patients living in LSOAs categorised in five deprivation quintiles from 'least deprived' to most 'deprived'. Patients from the most deprived LSOAs tend to be under-represented, particularly with respect to hip and knee arthroplasties and cataract operations (other than at CS02, a corporate for profit provider). The 'pro-affluent' bias is particularly pronounced with respect to CS25, a voluntary not-for-profit provider. As illustrated in Figures 32-37 below, this bias may largely reflect the characteristics of local populations rather than processes of selection.

Figure 23: Patient deprivation profiles for elective orthopaedic procedures, 2014/15

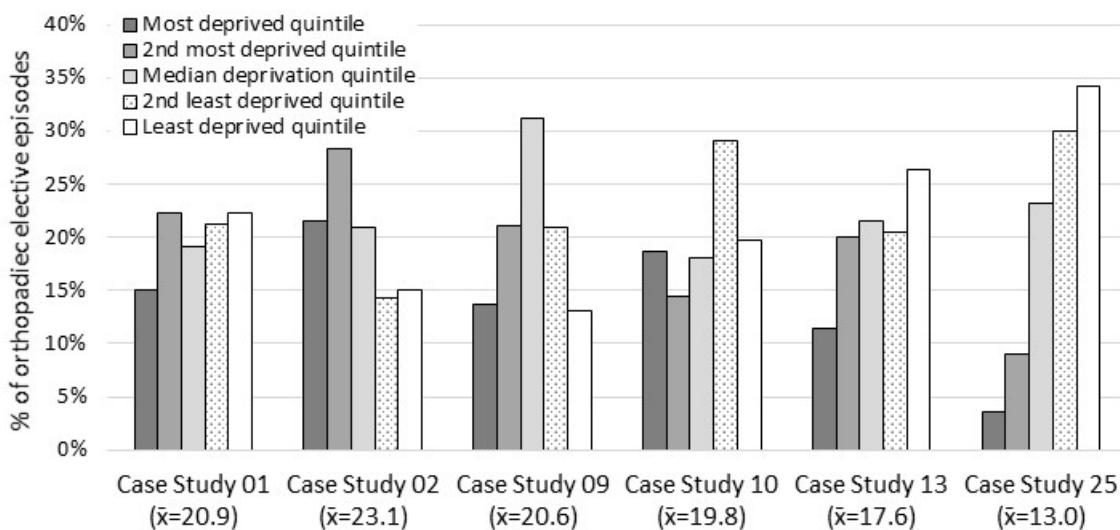


Figure 24: Patient deprivation profiles for hip arthroplasties, 2014/15

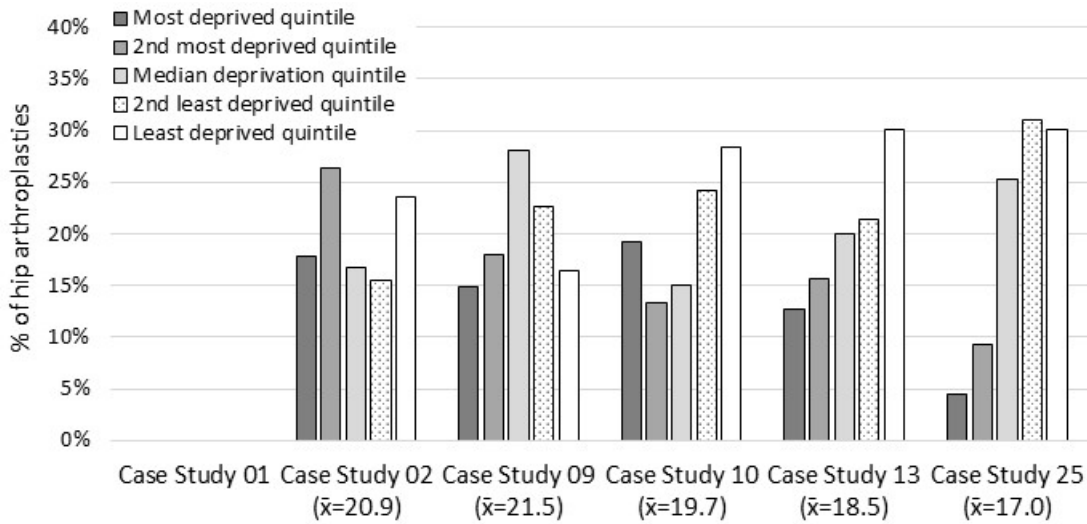


Figure 25: Patient deprivation profiles for knee arthroplasties, 2014/15

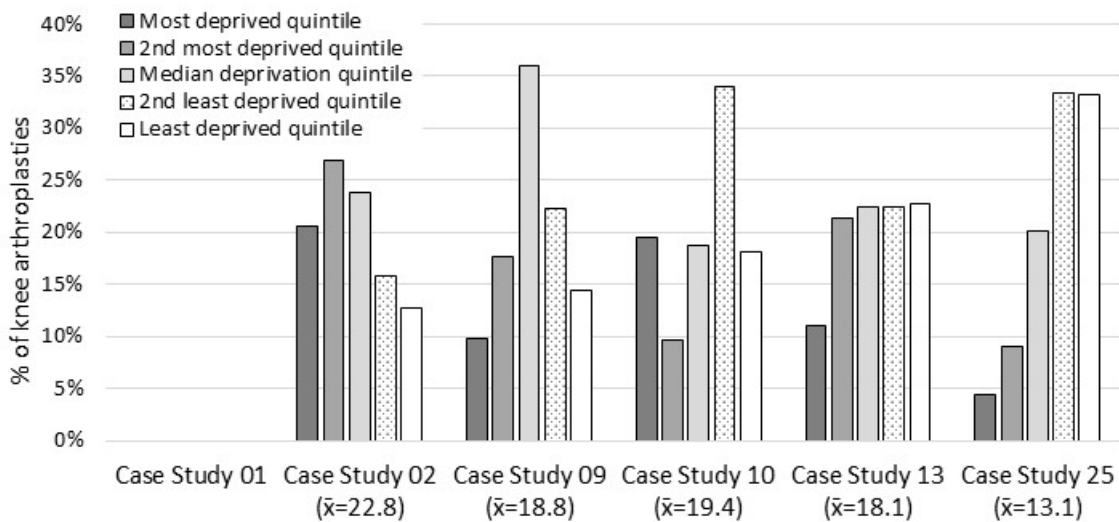


Figure 26: Patient deprivation profiles for elective ophthalmic procedures, 2014/15

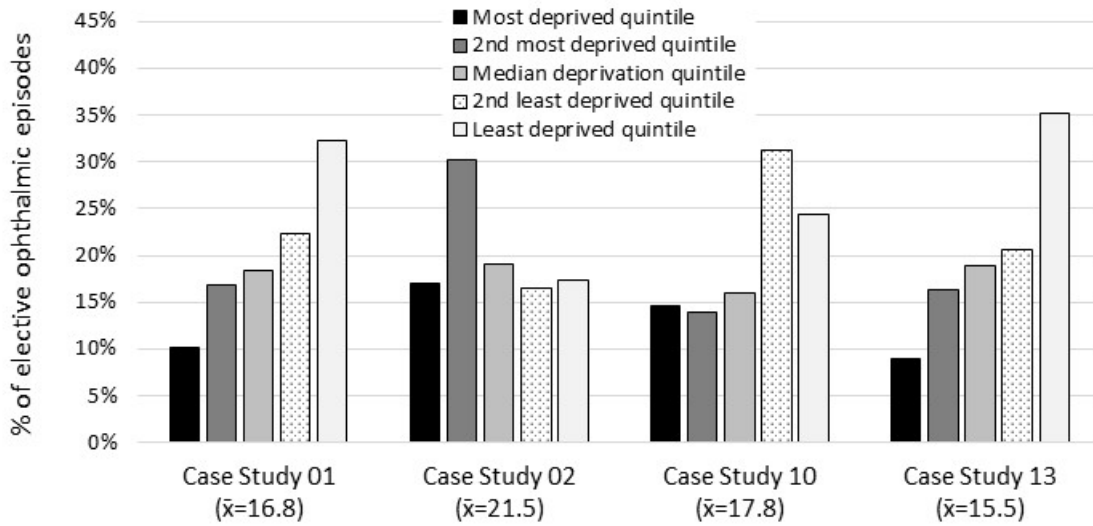
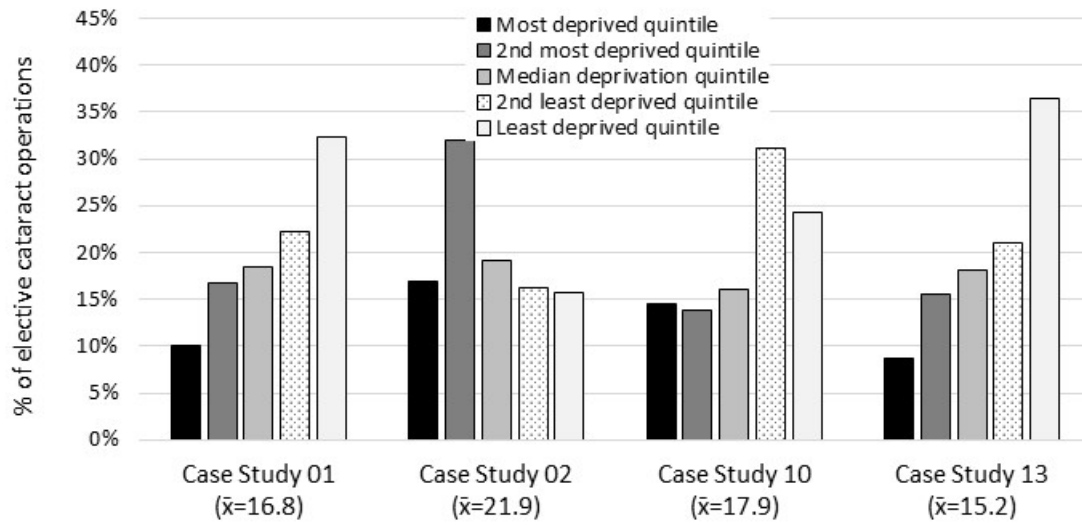


Figure 27: Patient deprivation profiles for elective cataract surgery, 2014/15



Hospital provider case studies: Socio-demographic profiles of catchment areas

Again using 30 minute drive-time catchment areas around each case-study hospital, the following graphs describe the socio-demographic characteristics of the populations served by those providers. The final column in each graph refers to the overall English population. Demographic data are drawn from ONS mid-year population estimates for 2013 (<http://bit.ly/2hkV0a6>); other graphs are based on 2011 census data (<https://www.nomisweb.co.uk/census/2011>) and the 2015 Index of Multiple Deprivation (<http://bit.ly/1Vr5M7O>). A useful description of the National Statistics Socio-economic Classification (NS-SeC) can be found at <http://bit.ly/22QWQBD>.

All case-study catchment areas have slightly younger than average age profiles (Figure 26), very similar and very average General Health profiles (Figure 28), and a slightly lower than average proportion of owner occupiers (Figure 30). As illustrated by Figure 27, the case-study providers cover a range of different populations in terms of deprivation (IMD2015); from CS25 (and to a lesser extent CS13) serving catchment areas with very few deprived LSOAs through to CS10 serving more than its fair share of deprived LSOAs.

Figure 28: Catchment area age profiles (2013 mid-year estimates)

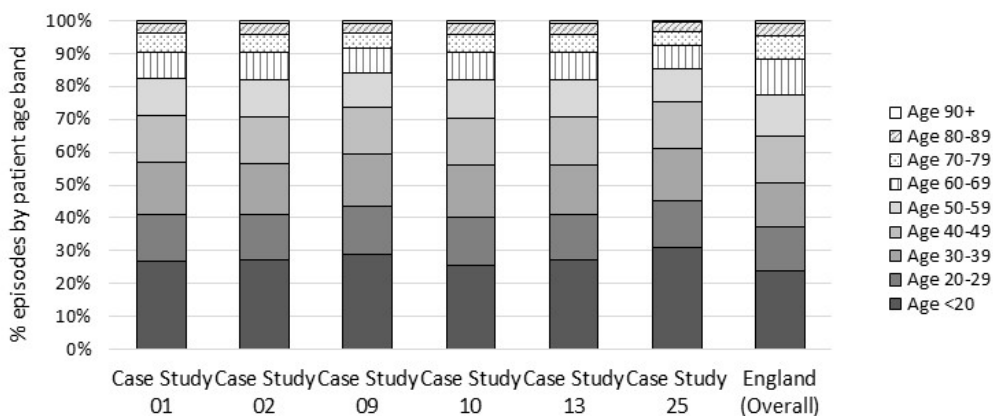


Figure 29: Catchment area deprivation profiles (IMD2015 quintiles)

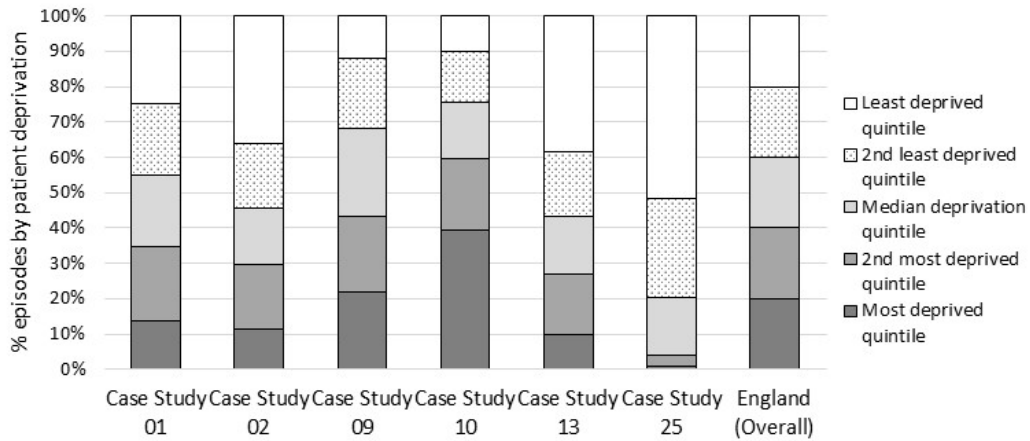


Figure 30: Catchment area socio-economic classification (NS-SeC) profiles (2011 Census)

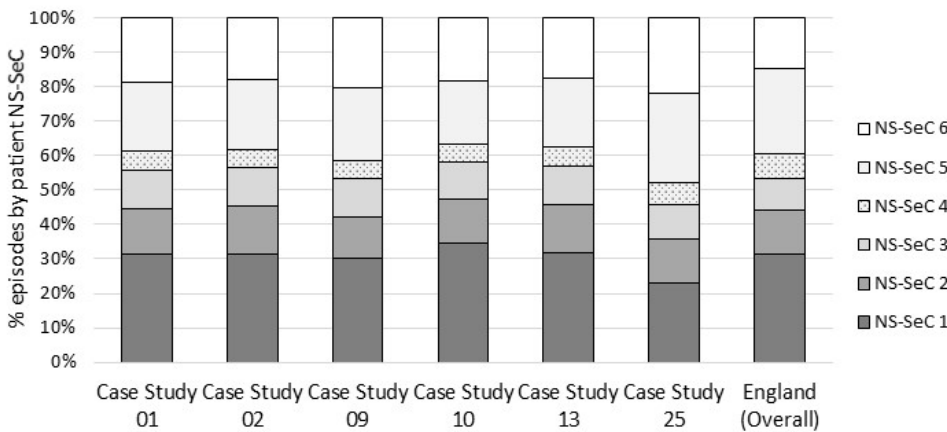


Figure 31: Catchment area general health status profiles (2011 Census)

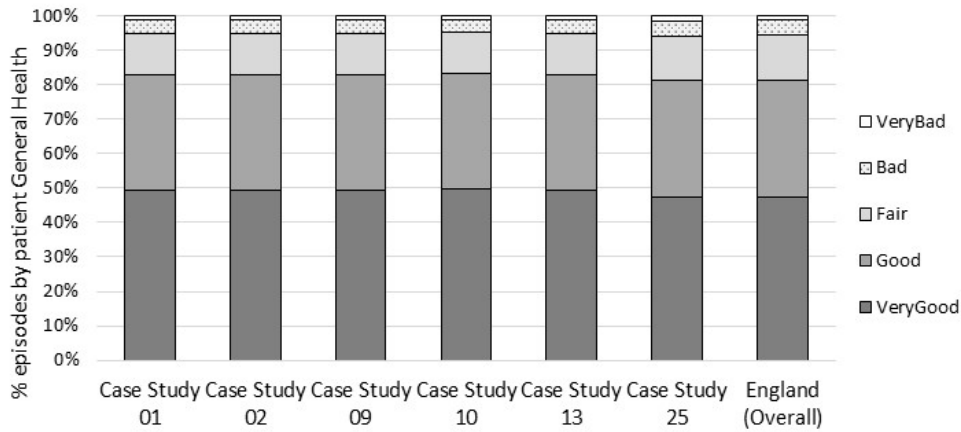
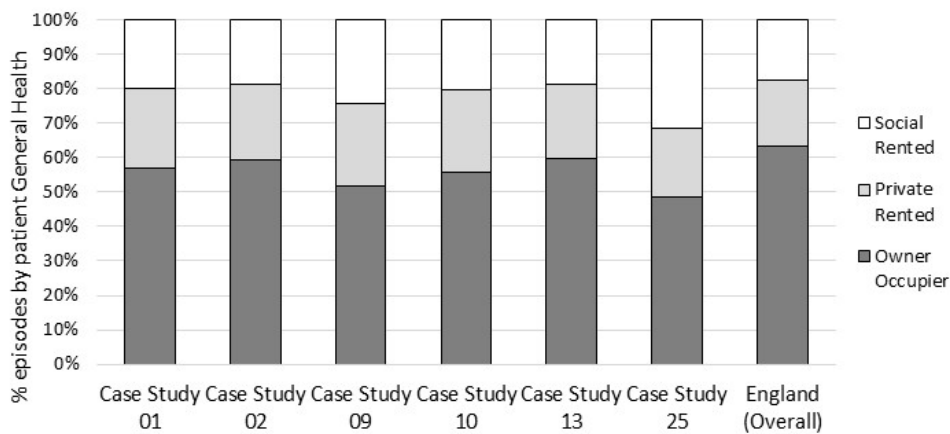


Figure 32: Catchment area household tenure profiles (2011 Census)

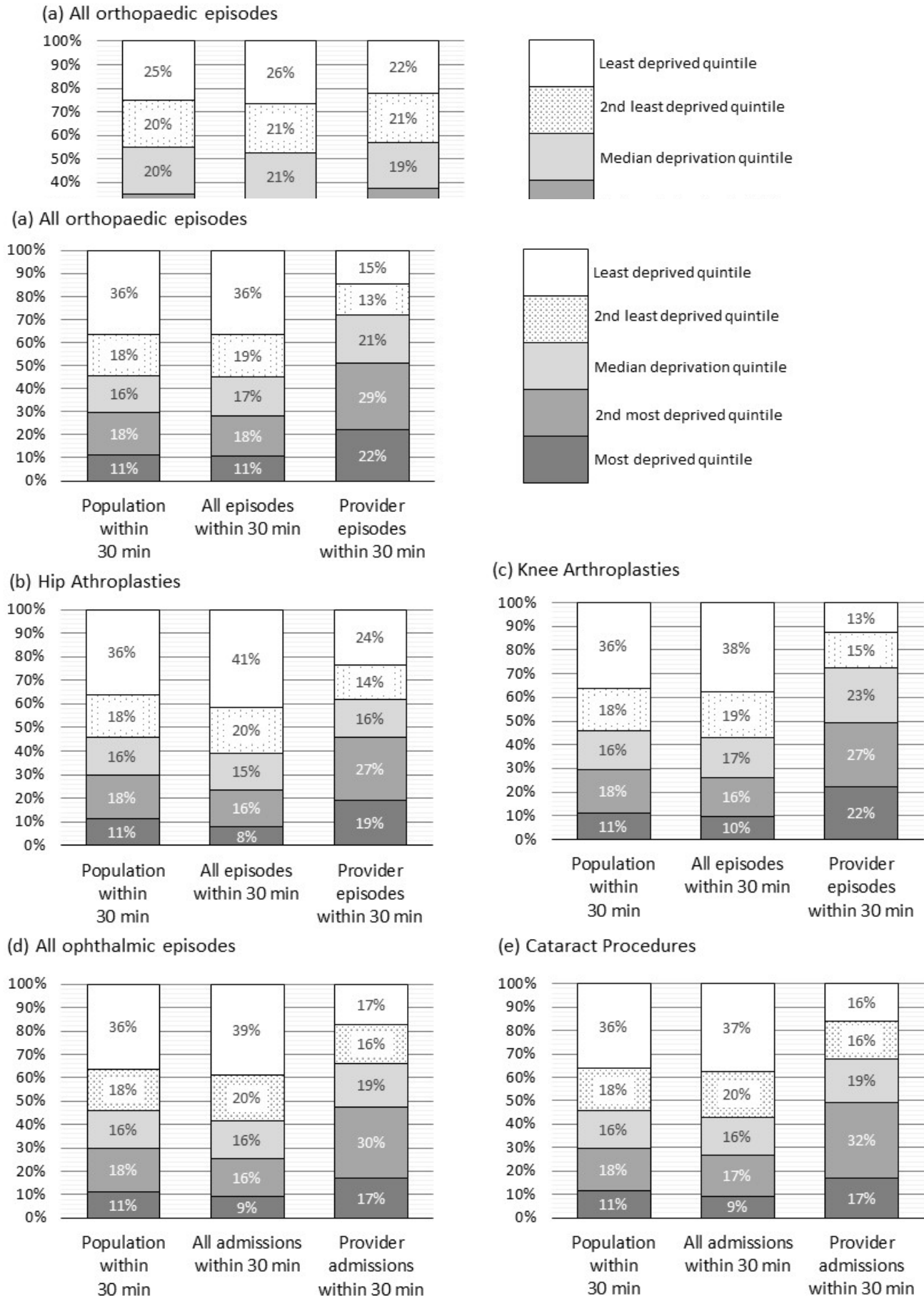


Hospital provider case studies: Geographic- and social-selection of patients

The following graphs show the socio-economic profiles (in terms of IMD2015) of (i) people living within the 30 minute drive time catchment area around CS1, (ii) all patients from within that catchment area receiving treatment (at any provider), and (iii) patients from within that catchment area receiving treatment at CS1. The graphs serve to illustrate any socio-economic bias in patients treated by the provider, and the extent to which this reflects the nature of the local population.

Nationally 20% of the population will fall into each deprivation quintile, and to that extent CS1 serves a slightly less deprived than average population. This is broadly reflected in the distribution of local patients receiving orthopaedic treatments, but there does appear to be some degree of 'social' selection with respect to ophthalmic treatments both generally and at CS1.

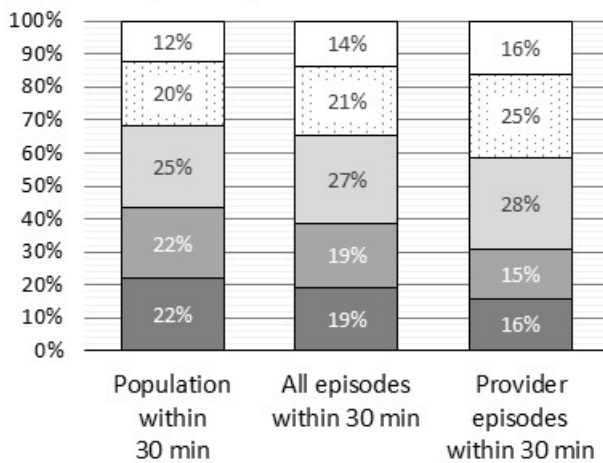
Figure 33: Deprivation (IMD2015) quintile of patients (i) in catchment area population, (ii) in catchment area & being treated at any provider, and (iii) in catchment area and being treated at case-study 1



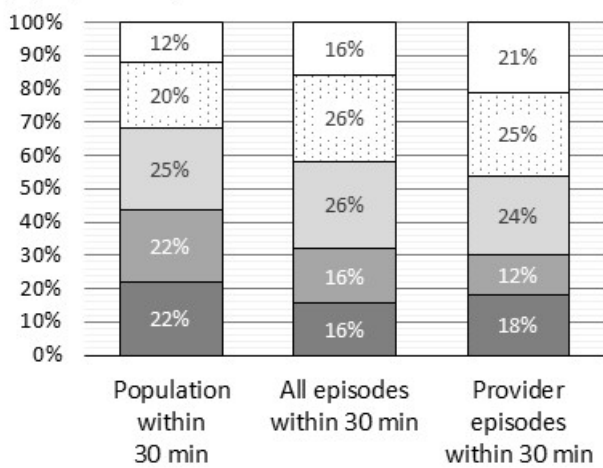
CS2 serves a significantly less deprived than average catchment area and this is broadly reflected in terms of patients being treated across all treatment categories. CS2 itself, unusually for an independent provider, serves a more deprived cohort of patients than might be expected given the character of the local population.

Figure 35: Deprivation (IMD2015) quintile of patients (i) in catchment area population, (ii) in catchment area & being treated at any provider, and (iii) in catchment area and being treated at case-study 9

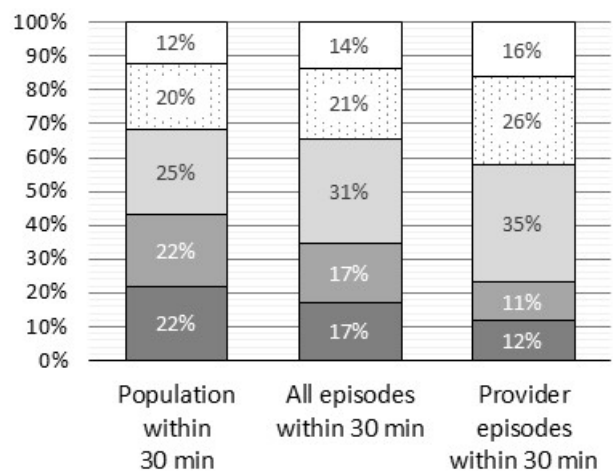
(a) All orthopaedic episodes



(b) Hip Arthroplasties



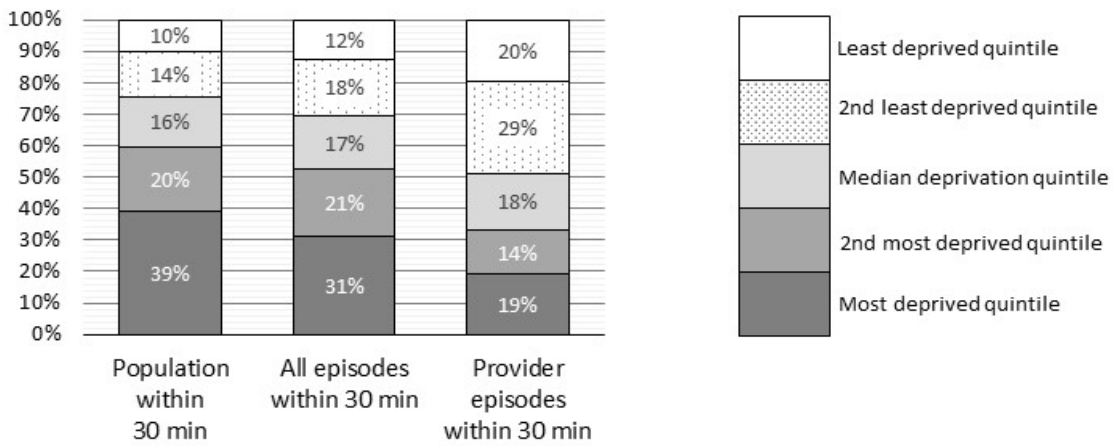
(c) Knee Arthroplasties



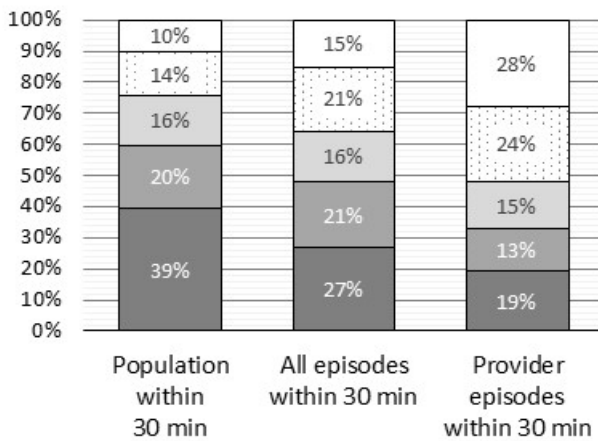
CS9 serves a slightly more deprived than average catchment area, but some degree of social selection appears to be operating (particularly with respect to hip and knee arthroplasties) resulting in a slight 'pro-affluent' cohort of patients being treated, both across all providers and at CS9 in particular. This is most strongly marked with respect to the provision of knee arthroplasties. For instance, although an above-expected 44% of people in the local 30-minute catchment area live in LSOAs in the two most deprived IMD2015 quintiles, 34% of patients receiving knee arthroplasties generally, and only 23% of patients at case-study09, are from such LSOAs.

Figure 36: Deprivation (IMD2015) quintile of patients (i) in catchment area population, (ii) in catchment area & being treated at any provider, and (iii) in catchment area and being treated at case-study 10

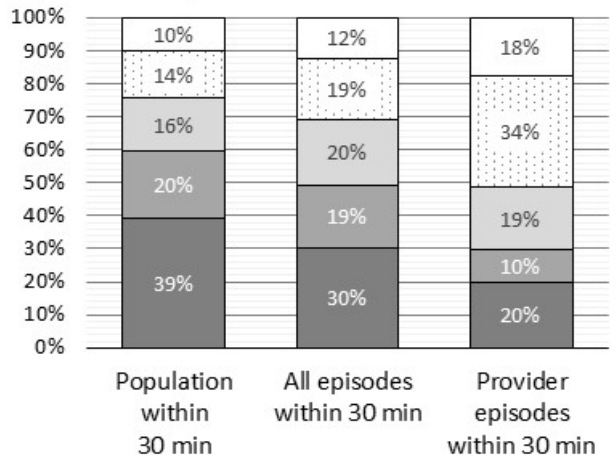
(a) All orthopaedic episodes



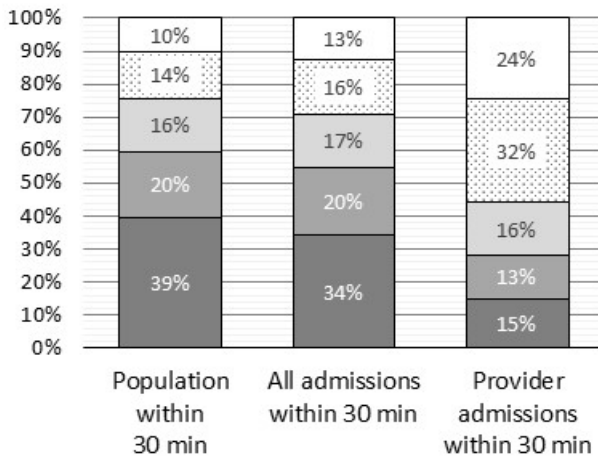
(b) Hip Arthroplasties



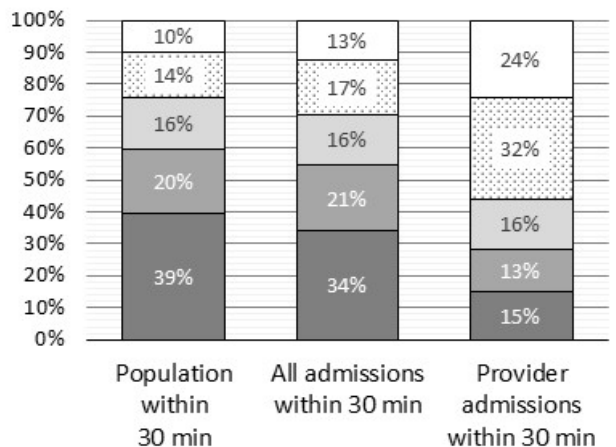
(c) Knee Arthroplasties



(d) All ophthalmic episodes



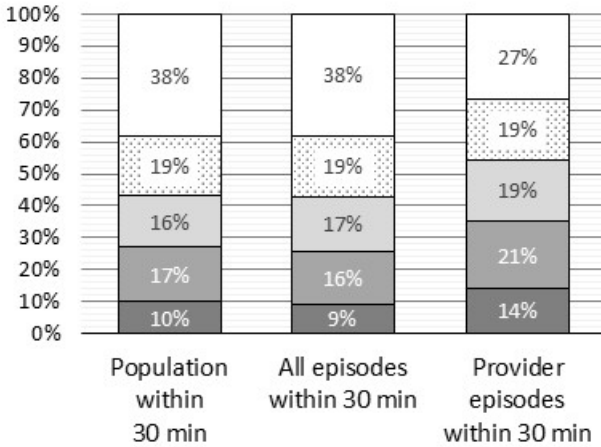
(e) Cataract Procedures



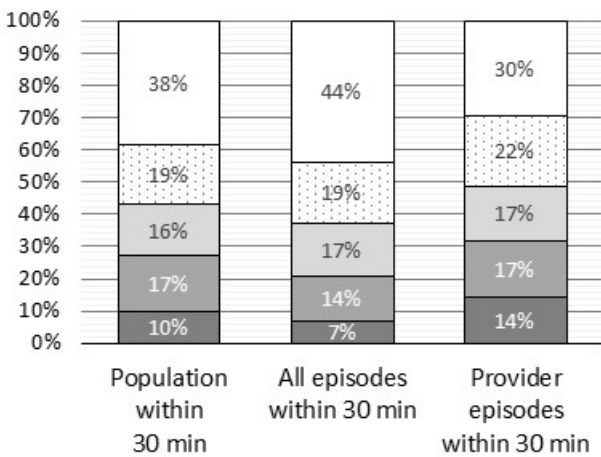
CS10 serves a significantly more deprived than average catchment area, but some degree of social selection the operates across all treatment groups, culminating in a distinctly 'pro-affluent' cohort of patients being treated at case-study10. This appears to be particularly pronounced with respect to ophthalmic (and specifically cataract) treatments.

Figure37: Deprivation (IMD2015) quintile of patients (i) in catchment area population, (ii) in catchment area & being treated at any provider, and (iii) in catchment area and being treated at case-study 13

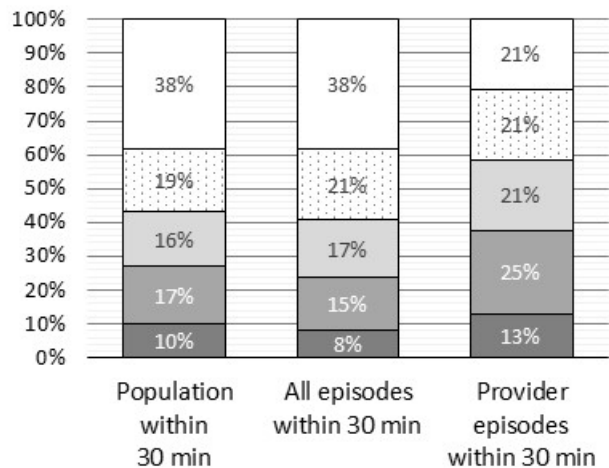
(a) All orthopaedic episodes



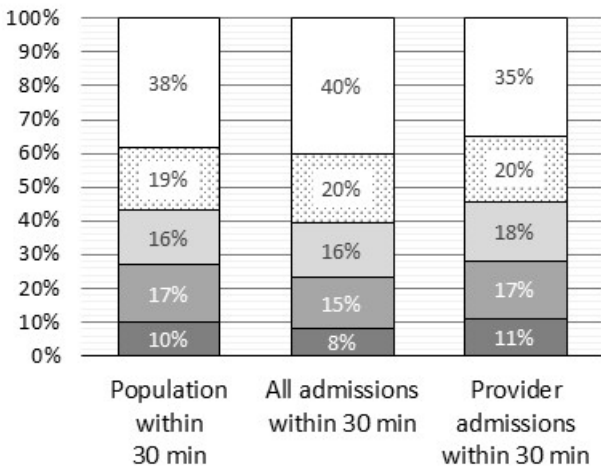
(b) Hip Arthroplasties



(c) Knee Arthroplasties



(d) All ophthalmic episodes



(e) Cataract Procedures

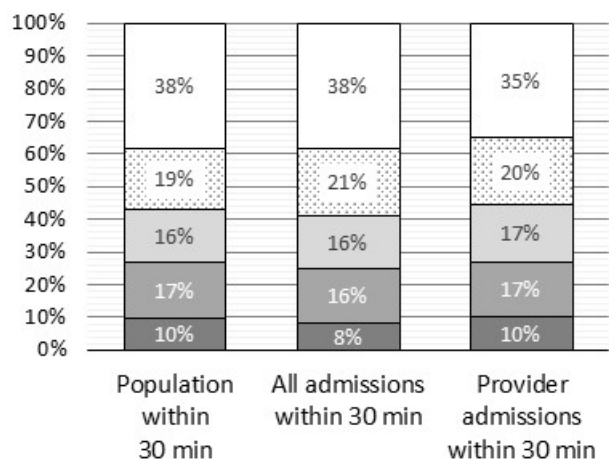
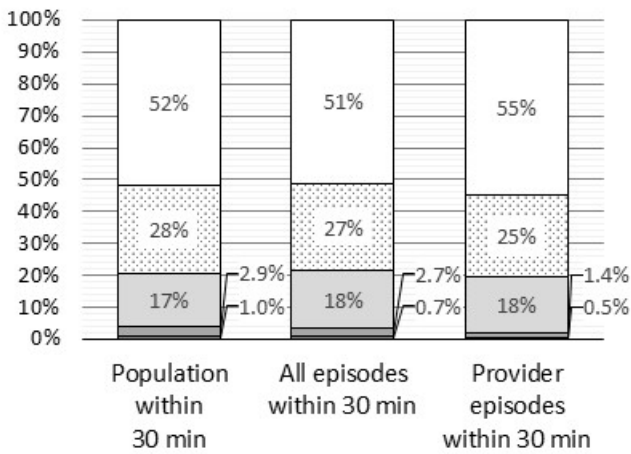
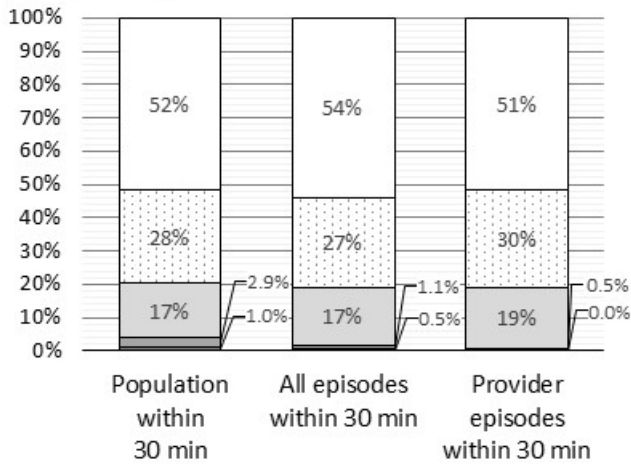


Figure 38: Deprivation (IMD2015) quintile of patients (i) in catchment area population, (ii) in catchment area & being treated at any provider, and (iii) in catchment area and being treated at case-study 25

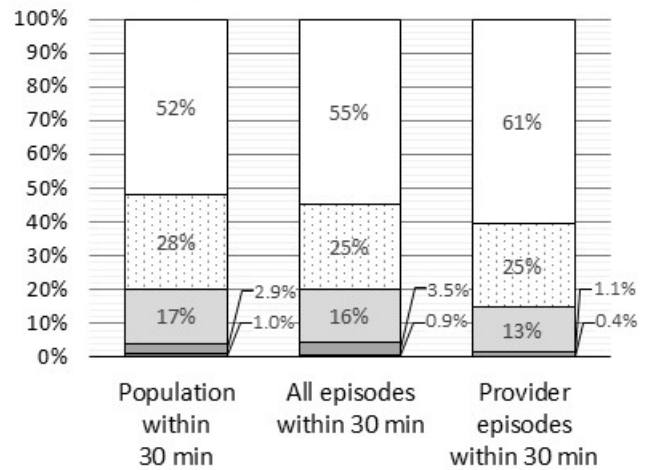
(a) All orthopaedic episodes



(b) Hip Arthroplasties



(c) Knee Arthroplasties



CS25 serves a uniquely affluent '30-minute drive-time' catchment area, with very few LSOAs falling into the two most deprived IMD2015 quintiles. With respect to orthopaedics generally and hip arthroplasties specifically, the profile of patients treated, either at any provider or specifically at CS25, closely reflects the underlying population characteristics. With respect to knee arthroplasties the strong geographic bias appears to be reinforced by social selection, such that only 1.5% of patients treated at CS25 live in the 40% most deprived LSOAs.

Hospital provider case studies: Commissioner profiles

The following charts are based on HES data for 2014/15 and show the proportion of orthopaedic (Figure 37) and ophthalmic (Figure 38) episodes at each case-study hospital commissioned by different CCGs. The pattern of commissioning varies from a single dominant CCG with few other commissioners (e.g. CS2,9,10), through a more even split between a small number of CCGs (e.g. CS1), to the involvement of many CCGs (e.g. CS25).

Figure 40: Commissioners of Orthopaedic Procedures at case-study hospitals

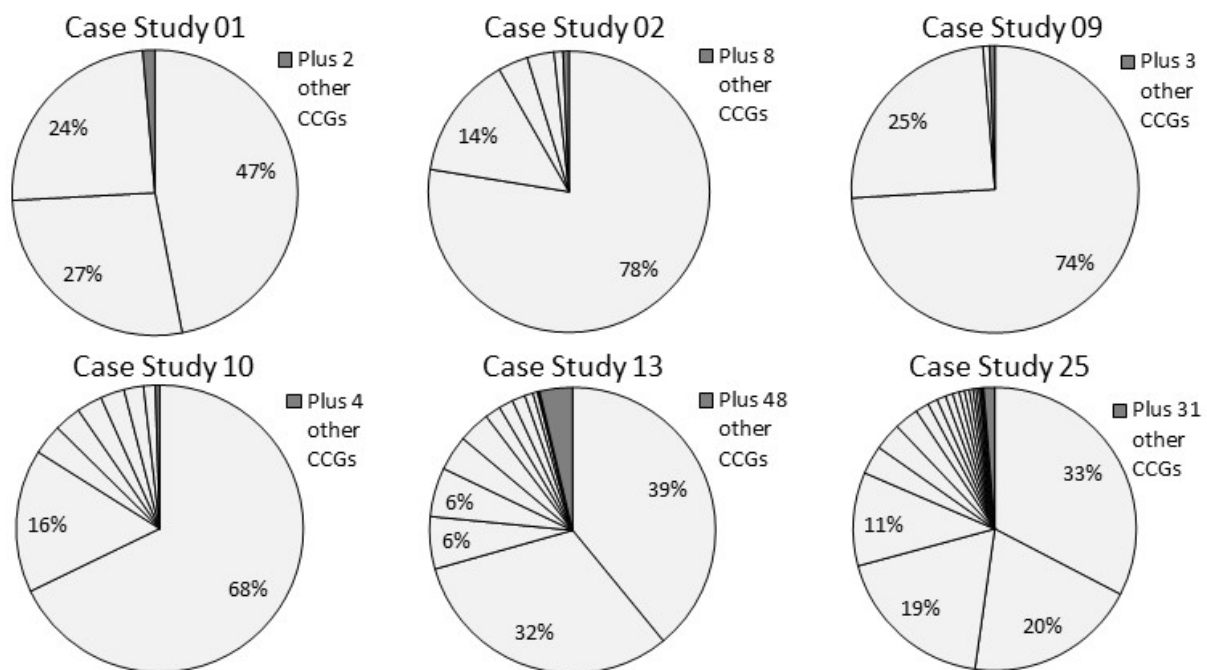
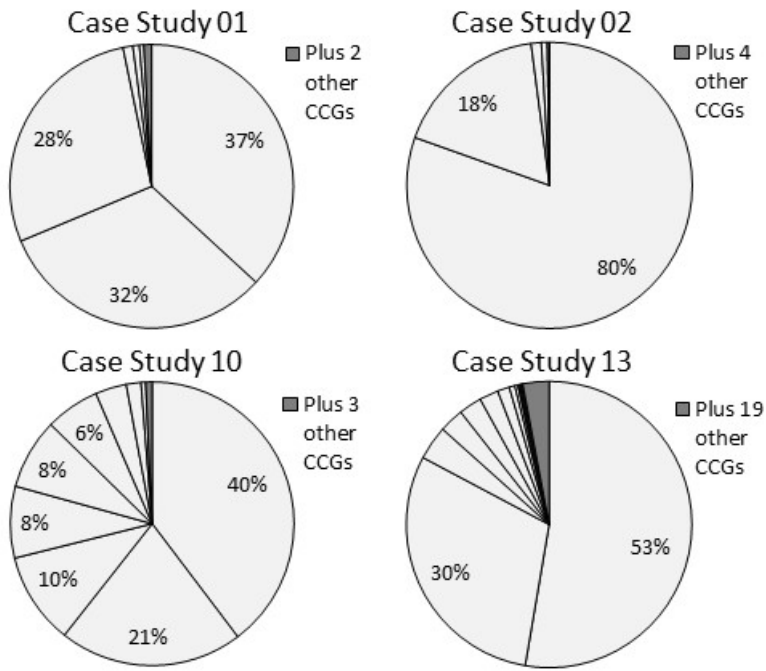


Figure 41: Commissioners of Ophthalmic Procedures at case-study hospitals



OOH & CHS case studies in context: GP health profiles

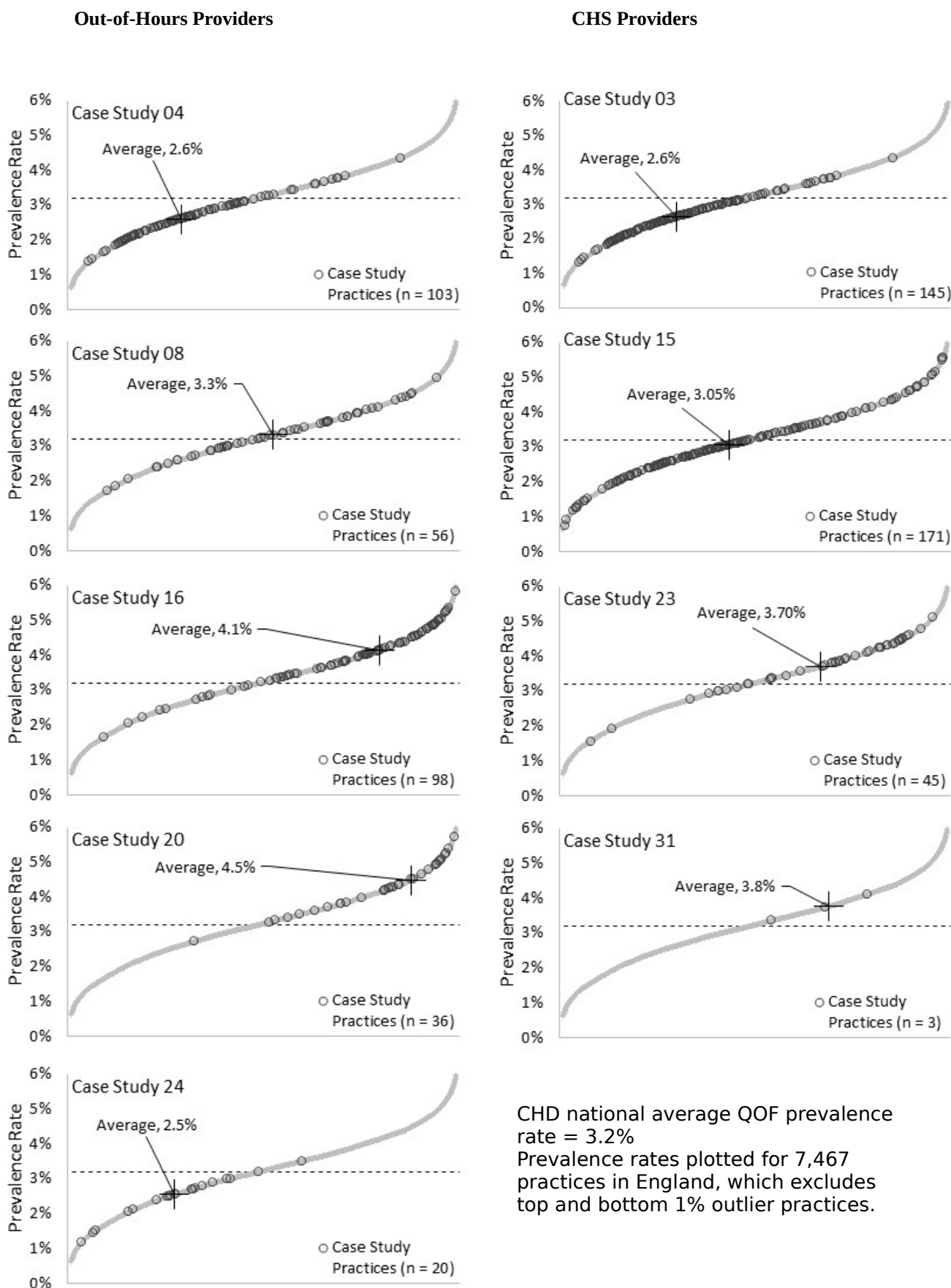
Figures 39-43 seek to utilise practice-level 2015/16 Quality and Outcomes Framework (QOF) data to capture and illustrate the relative health status of populations served by the project's Out-of-Hours (OOH) and Community Health Service (CHS) case studies. The underlying idea is that this will serve to illustrate, at least in general terms, the health burden faced by the different providers.

To that end we have used a variety of formal and informal sources to establish which General Practices are served by each OOH and CHS provider, and then highlighted those GPs in plots of the QOF prevalence of a variety of conditions at GP level (n=7467): specifically, Coronary Heart Disease (CHD), hypertension, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Cancer.

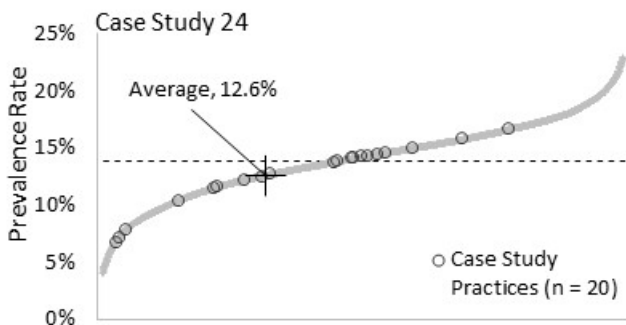
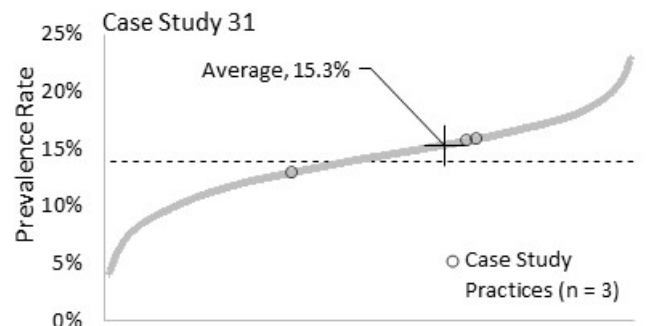
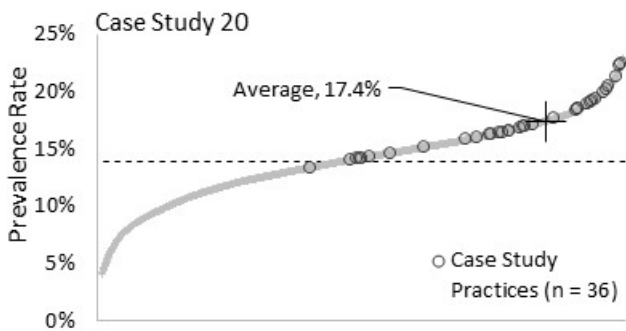
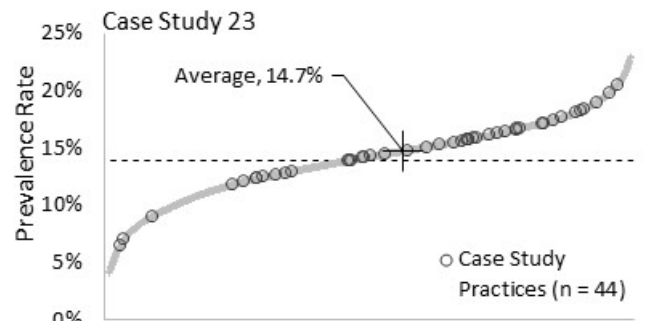
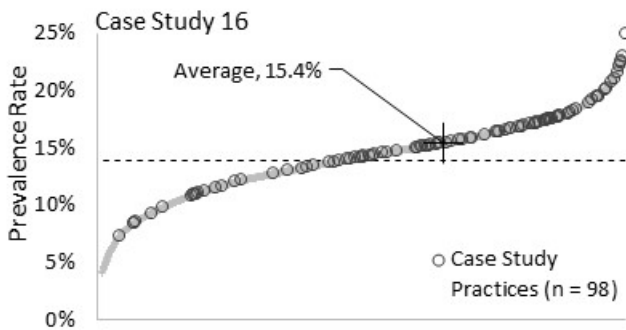
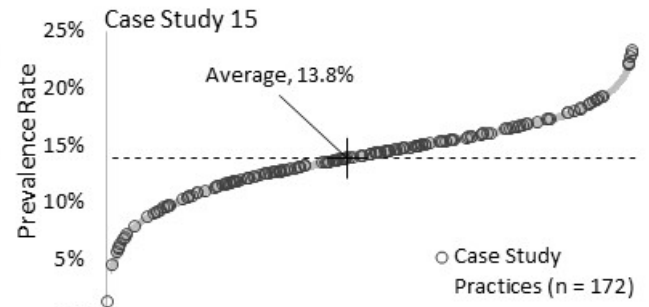
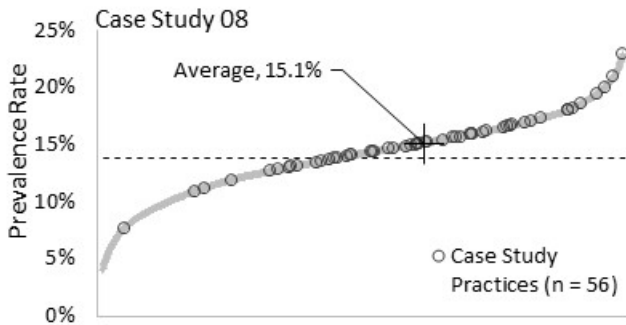
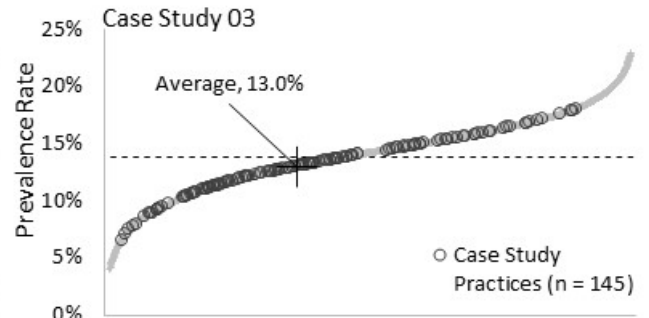
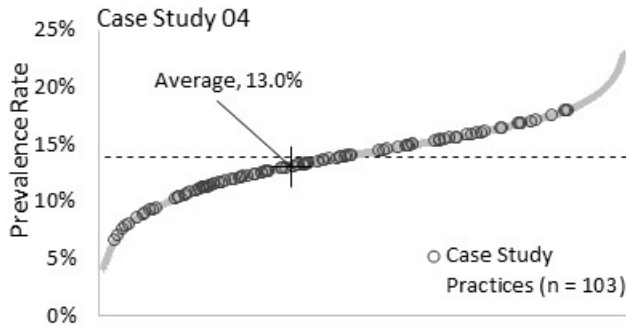
As illustrated in Figures 39-43 below, the various providers serve quite different populations, both in terms of size and health status. For instance, CS15 (an NHS Trust Community Health Service) covers a very large number of practices (n=171) which span the full range of prevalence rates. The overall prevalence rate for practices served by CS15 is, for each condition, very close to the national average.

In contrast to CS15 (which, in effect, mirrors the overall English population), CS20 (a co-operative OOH) serves some 36 GPs almost all of which suffer higher than average prevalence rates across all conditions, whereas VS24 (a social enterprise OOH) serves some 20 practices with generally lower prevalence rates. The health burden imposed on OOH services by the former population is likely to be far greater than that imposed by the latter population.

Figure 42: Coronary Heart Disease Practice-level QOF Prevalence Rates, 2015/16

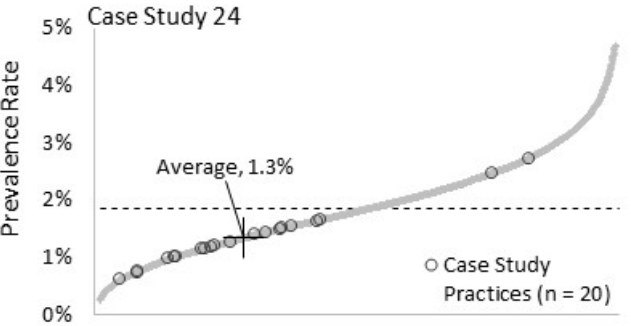
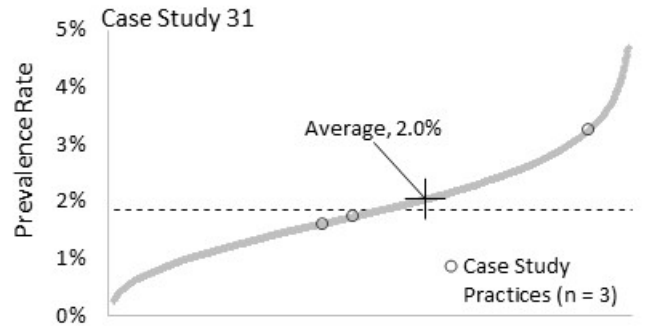
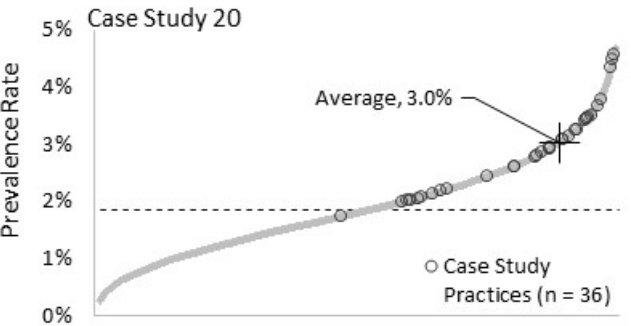
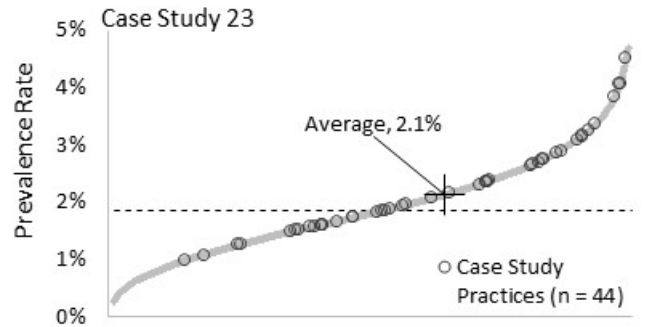
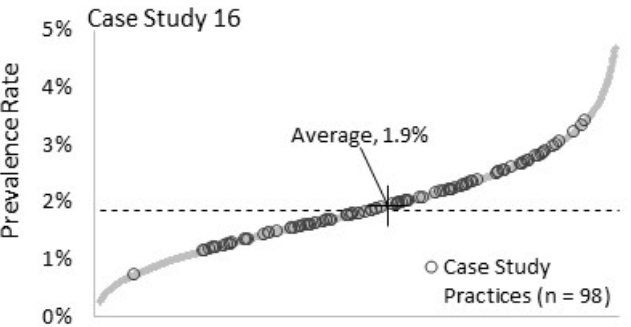
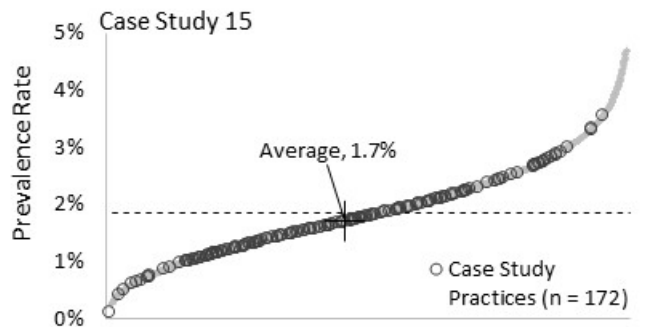
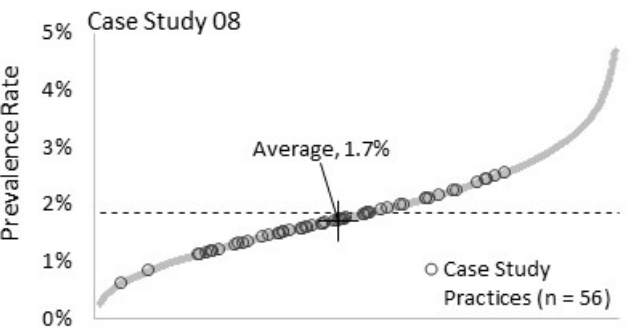
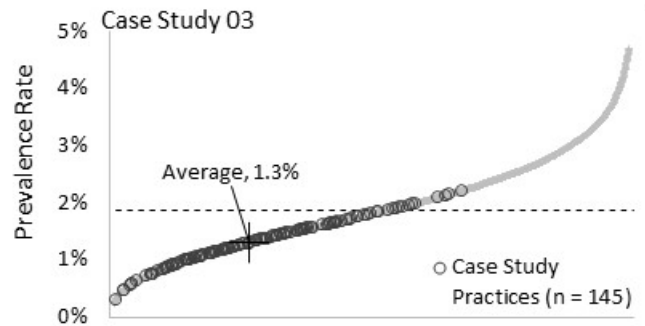
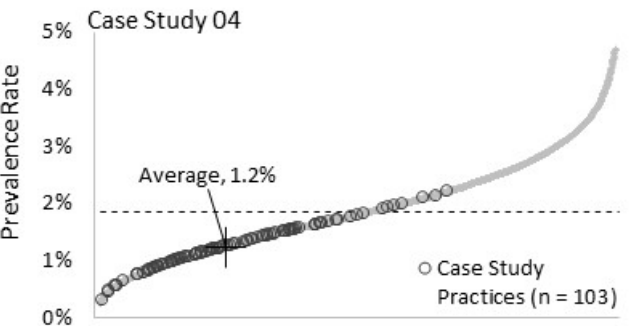
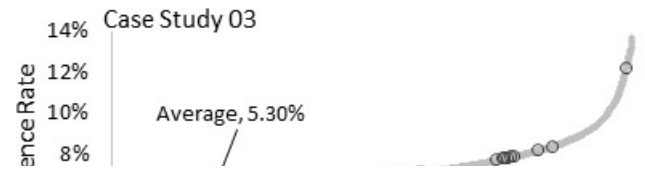
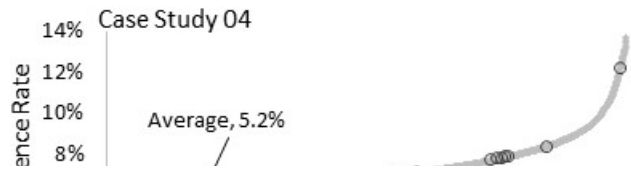


CHD national average QOF prevalence rate = 3.2%
 Prevalence rates plotted for 7,467 practices in England, which excludes top and bottom 1% outlier practices.



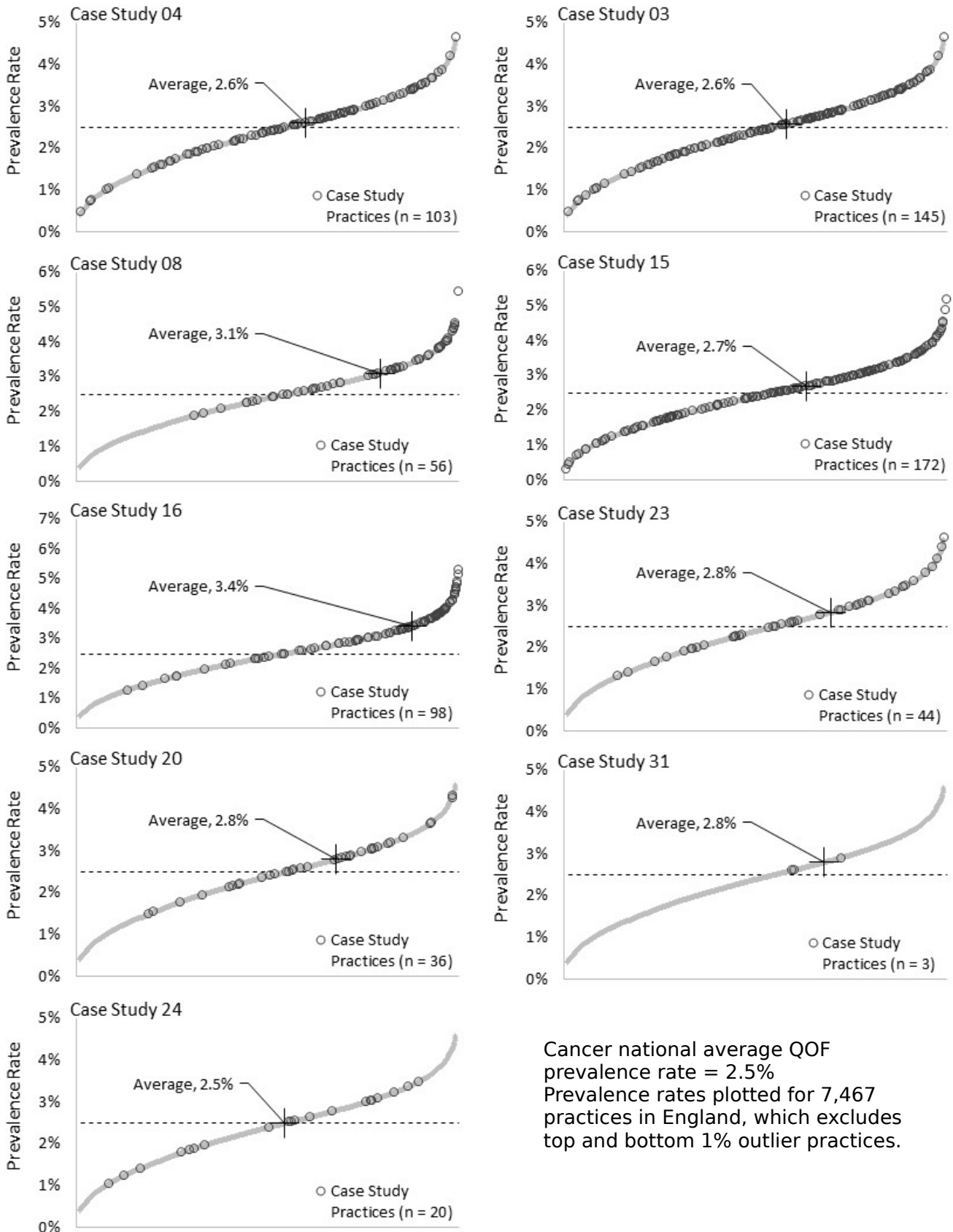
Hypertension national average QOF prevalence rate = 13.8%
Prevalence rates plotted for 7,467 practices in England, which excludes top and bottom 1% outlier practices.

F



COPD national average QOF prevalence rate = 1.9%
Prevalence rates plotted for 7,467 practices in England, which excludes top and bottom 1% outlier practices.

Figure 46: Cancer QOF Prevalence Rates



Cancer national average QOF prevalence rate = 2.5%
 Prevalence rates plotted for 7,467 practices in England, which excludes top and bottom 1% outlier practices.

CHS & OOH catchment population profiles (2011 Census)

Figures 44 and 45 bring together Census (<https://www.nomisweb.co.uk/census/2011>) and Index of Multiple Deprivation data (<http://bit.ly/1Vr5M7O>) on the populations served by the Out-of-Hours (OOH) and Community Health Service (CHS) case studies. Most providers have clearly defined areas of responsibility (usually described in terms of local authority or CCG geographies, but occasionally in terms of MSOAs and/or LSOAs) and the nature of the populations in these areas can be summarised. We have thus aggregated 2011 census and 2015 IMD data for the geographic areas served by the OOH and CHS providers so as to describe, at least in broad terms, the characteristics of the populations (and thus the nature, and possible scale, of the health burden) associated with each of those OOH and CHS providers.

As can be seen in Figures 44 and 45, the CHS and OOH case-study providers serve populations with relatively low IMD2015 scores (relative to the national average), and only the populations served by CS23 (a Social Enterprise CHS provider) and CS20 (a co-operative OOH provider) have higher than average levels of deprivation. These two providers also deal with populations with slightly greater than average proportions of people with self-reported 'bad' or 'very bad' general health. All other providers serve populations with slightly better than average general health profiles, and all case-study OOH and CHS providers deal with populations with, relative to England as a whole, a low proportion of people of non-white ethnicity.

Figure 48: CHS Providers: Socio-demographic profiles of catchment populations

