

HOW DOES PATIENT CHOICE IMPACT ON SECONDARY CARE: AN IN DEPTH  
INVESTIGATION IN A LARGE TEACHING HOSPITAL

By

BALBIR KAUR BHOGAL

A thesis submitted to the University of Birmingham for the degree of DOCTOR OF  
PHILOSOPHY

Health Services Management Centre  
University of Birmingham  
September 2014

UNIVERSITY OF  
BIRMINGHAM

**University of Birmingham Research Archive**

**e-theses repository**

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

## **Abstract**

Over recent decades health care policy in the English NHS has focused on the role of patient choice of provider as a lever for health care improvement (Mays 2010; Fotaki 2013). The thesis explores the degree to which patient choice policy has been successful in its aim. Specifically, it explores the influence that patient choice policy has on changing and shaping organisation culture in an acute hospital trust.

A qualitative case study was undertaken in a teaching hospital Trust involving interviews with 30 interviewees drawn from different levels of the hierarchy in the hospital. The study also reviewed documents to understand where PCP was positioned in the hospitals ambition. The study found that patient choice had not changed organisational behaviour in the hospital and did not have the desired impact as expected by policy makers.

The study identified that the PCP programme theory had failed to recognise the impact that the culture of an organisation has on change. The culture of the hospital was still one of 'knowing what was best for its patients' and rejecting the notion that patients wanted choice. Also, the incentives of patient choice policy were considered weak in the context of hospitals overrun with demand and competing priorities.

## Dedication

ਤੂੰ ਕਰਤਾ ਸਚਿਆਰੁ ਮੈਡਾ ਸਾਂਈ ॥

You are the Creator of everything, You are ever existent, You are my Master.

ਜੋ ਤਉ ਭਾਵੈ ਸੋਈ ਥੀਸੀ ਜੋ ਤੂੰ ਦੇਹਿ ਸੋਈ ਹਉ ਪਾਈ ॥੧॥ ਰਹਾਉ ॥

Whatever pleases You is what happens (in the world), and only what you give me is what I can get. ||1||Pause||

**Sri Guru Granth Sahib Ji (11)**

## **Acknowledgements**

I would like to thank my supervisors, Professor Russell Mannion and Dr Jo Ellins, who have spent many hours guiding me and editing the chapters that have been written. I would have struggled without their belief, support and encouragement.

Most researchers will recognise the enduring challenge that this type of study represents and without the support of loved ones it can, at times, feel unachievable. I would like to thank my family who have supported me through these times and provided me with the direction, energy and support to keep going.

## Table of Contents

|  |    |
|--|----|
| Tables and Figures .....   | 5  |
| Chapter 1 - Introduction .....   | 7  |
| 1.1 Background to the research .....   | 7  |
| 1.2 Purpose and contribution of the thesis.....  | 10 |
| 1.3 Aims and Objectives of the study .....   | 11 |
| 1.4 Outline of thesis .....  | 12 |
| Chapter 2: Patient Choice Policy – Origins and Evolution .....   | 16 |
| 2.1 Introduction .....   | 16 |
| 2.2 Choice Theory and Choice in Healthcare .....   | 17 |
| 2.3 Evolution of Health Policy in the English NHS .....  | 23 |
| 2.3.1 Pre 1990s .....  | 24 |
| 2.3.2 1990 to 2010 .....   | 27 |
| 2.3.3 from 2010 onwards.....   | 40 |
| 2.4 PCP Programme Theory and NHS response.....   | 46 |
| 2.4.1 PCP Programme Theory .....   | 46 |
| 2.4.2. How choice has been perceived by the NHS.....   | 48 |
| 2.5 Conclusion .....   | 53 |
| Chapter 3: The Impact of Patient Choice Policy (PCP) in NHS hospital trusts - A review of the evidence ..... | 56 |
| 3.1 Introduction .....   | 56 |
| 3.2 Objectives of the review .....   | 56 |
| 3.3 Methods of Review .....  | 57 |
| 3.3.1 Search strategy.....   | 57 |
| 3.3.2 Publication Language and Publication dates .....   | 57 |
| 3.3.3 Search Databases .....   | 58 |
| 3.3.4 Inclusion criteria .....   | 59 |
| 3.3.5 Exclusion criteria.....  | 59 |
| 3.3.6 Research Evidence.....   | 59 |
| 3.3.7 Key terms.....   | 60 |
| 3.3.8 Data Extraction Sheet .....  | 60 |
| 3.3.9 Search Approach.....   | 61 |
| 3.3.10 References Scanning.....  | 62 |
| 3.3.11 Quality Assessment .....  | 62 |
| 3.4 Search Results .....   | 62 |
| 3.4.1 Search Results by Database .....   | 62 |
| 3.4.2 Refining of Results .....  | 64 |
| 3.5 Review of Relevant Literature .....  | 66 |
| 3.5.1 Overview of the included studies .....   | 66 |
| 3.5.2 Research Methods .....   | 67 |
| 3.5.3 Geographical Spread.....   | 68 |
| 3.5.4 Aims of studies .....  | 68 |
| 3.6 Thematic Analysis.....   | 72 |
| 3.6.1 Do Patients Want Choice of Provider?.....  | 73 |
| 3.6.2 What Types of Patients Exercise Choice of Provider?.....   | 76 |
| 3.6.3 Is the Patient Exercising Choice of Provider? .....  | 76 |

|  |     |
|--|-----|
| 3.6.4 Are patients able to exercise choice of provider?.....   | 78  |
| 3.6.5 What factors influence patient choice of provider?.....  | 84  |
| 3.6.6 Impact of choice on providers .....  | 86  |
| 3.7 Discussion.....  | 90  |
| 3.8 Limitations of this review .....   | 93  |
| 3.9 Limitations of included studies .....  | 93  |
| 3.10 Gaps in the literature.....   | 94  |
| 3.11 Implications of the evidence on the proposed study.....   | 95  |
| Annex 3.1 – Studies categorised by theme.....  | 97  |
| Chapter 4: Understanding the culture of hospitals and cultural change.....                                     | 116 |
| 4.1 Introduction .....   | 116 |
| 4.2 Evolution of Organisation Culture theory.....  | 117 |
| 4.2.1 Origins and Development of Organisational Culture.....   | 117 |
| 4.2.2 Defining Organisational Culture .....  | 119 |
| 4.2.3 Organisational Culture – Ontological and Epistemological considerations.....                             | 120 |
| 4.2.4 A functionalist framework.....   | 121 |
| 4.2.5 Organisational Sub Culture .....   | 124 |
| 4.2.6 Organisational Culture – Stability .....   | 125 |
| 4.2.7 Measuring Organisational Culture.....  | 126 |
| 4.2.8 Summary.....   | 127 |
| 4.3 Organisational Culture Change .....  | 128 |
| 4.3.1 Defining Cultural Change.....  | 128 |
| 4.3.2 Models of Cultural Change.....   | 129 |
| 4.3.3 Problems in Implementing Change .....  | 132 |
| 4.3.4 Summary.....   | 133 |
| 4.4 How Hospitals behave .....   | 134 |
| 4.4.1 Culture and Hospitals .....  | 134 |
| 4.4.2 Changing Hospital Culture .....  | 138 |
| 4.5 Conclusion .....   | 141 |
| Chapter 5: Conceptual Framework - Patient Choice Policy and its Interaction with the<br>Hospital Culture ..... | 143 |
| 5.1 Introduction .....   | 143 |
| 5.2 Patient Choice Policy Programme Theory and Assumptions.....  | 143 |
| 5.2.1 PCP Programme theory .....   | 143 |
| 5.2.2. The assumptions underpinning PCP.....   | 146 |
| 5.3 Exploring the assumptions .....  | 151 |
| 5.3.1 Do patients behave as consumers? .....   | 151 |
| 5.3.2 Are GPs behaving as facilitators rather than decision makers?.....                                       | 152 |
| 5.3.3 Do hospitals perceive patients as consumers?.....  | 153 |
| 5.3.4 Are hospitals incentivised to change? .....  | 154 |
| 5.3.5 Does meaningful information exist to support patients making their choices?.....                         | 156 |
| 5.4 Analytical framework.....  | 158 |
| 5.4.1 Organisational Culture and Cultural Change theory and PCP .....  | 158 |
| 5.4.2 Measuring the Culture of the Hospital .....  | 164 |
| 5.5 Conclusion .....   | 166 |
| Chapter 6: Methodology .....   | 169 |
| 6.1 Introduction .....   | 169 |
| 6.2 Methodology.....   | 170 |

|  |     |
|--|-----|
| 6.2.1 Philosophical Concepts Influencing the Choice of Research Design .....                               | 170 |
| 6.2.2 Research Design .....  | 173 |
| 6.2.3. Case Study Design.....  | 175 |
| 6.2.4 Strengths and Limitations of the Case Study Approach.....  | 178 |
| 6.2.5 Justification of case study design for this study .....  | 185 |
| 6.3 Selecting the Case .....   | 186 |
| 6.3.1 Background.....  | 186 |
| 6.3.2 A description of the Case.....   | 188 |
| 6.4 Sampling .....   | 191 |
| 6.4.1 Selecting the Specialties for Study within the Case .....  | 192 |
| 6.4.2 Selecting the Individuals to Participate in the Study.....   | 195 |
| 6.5 Data Gathering .....   | 198 |
| 6.5.1 Review of documents .....  | 200 |
| 6.5.2 Interviewing.....  | 201 |
| 6.6 Methods of Data Analysis .....   | 202 |
| 6.7 Validity and Reliability .....   | 205 |
| 6.8 Reflexivity.....   | 207 |
| 6.9 Ethical Considerations.....  | 209 |
| 6.10 Summary .....   | 209 |
| Chapter 7: Understanding patient choice and the culture of the hospital.....                               | 212 |
| 7.1 Introduction .....   | 212 |
| 7.2 Case study background .....  | 213 |
| 7.2.1 Context to the Case Study .....  | 213 |
| 7.2.2 Data Sample.....   | 213 |
| 7.2.3 Data Analysis.....   | 215 |
| 7.3 Views and Perceptions of Patient Choice.....   | 215 |
| 7.3.1 Patient Choice of Provider and Appointment.....  | 215 |
| 7.3.2 Patient involvement in health care.....  | 219 |
| 7.3.3 PCP and Service Quality .....  | 224 |
| 7.4 Organisational Behaviour .....   | 229 |
| 7.4.1 Describing the Culture of the Organisation .....   | 229 |
| 7.4.2 Organisational Cultural Change .....   | 238 |
| 7.5 Summary of findings.....   | 245 |
| Chapter 8: Exploring how the Hospital has perceived PCP .....  | 247 |
| 8.1 Introduction .....   | 247 |
| 8.2 Organisational Factors and Processes Mediating the Impact of PCP .....                                 | 248 |
| 8.2.1 The role of GP in facilitating PCP.....  | 248 |
| 8.2.2 Patient as a Consumer.....   | 251 |
| 8.2.3. The Incentives for Hospitals to Change .....  | 261 |
| 8.2.4 Meaningful information to support patients making their choices.....                                 | 267 |
| 8.3 Impact of Organisational Factors on Intended Outcome of PCP.....                                       | 270 |
| 8.4 Unintended Consequences of PCP .....   | 277 |
| 8.5 Summary of Findings.....   | 282 |
| Chapter 9: Discussion and Analysis of Findings.....  | 284 |
| 9.1 Introduction .....   | 284 |
| 9.2 Restatement of the research questions and an outline of the programme theory<br>underpinning PCP. .... | 285 |
| 9.3 Headline findings from the study .....   | 287 |



|   |     |
|---|-----|
| 9.3.1 Mapping the empirical findings to the research questions .....            | 287 |
| 9.3.2 Views and perceptions of PCP .....  | 291 |
| 9.3.3 Analysing the Programme Theory Assumptions.....                           | 292 |
| 9.4 Understanding the hospitals response to PCP .....                           | 301 |
| 9.5 Summary.....  | 313 |
| Chapter 10: Conclusion .....  | 316 |
| 10.1 Introduction .....   | 316 |
| 10.2 Overview of research and summary of key findings .....                     | 316 |
| 10.3 Research contribution.....   | 320 |
| 10.4 Limitations of the Study .....   | 321 |
| 10.5 Implications for future research .....                                     | 322 |
| 10.5.1 Recommendations for future research .....                                | 322 |
| 10.5.2 Recommendations for policy.....  | 323 |
| Appendix 1 - Choose and Book Bookings by Specialty .....                        | 325 |
| Appendix 2 - Percentage of patients offered choice by SHA, surveys to date..... | 329 |
| Appendix 3 – Documents Reviewed .....   | 330 |
| Appendix 4 – Information for Participants.....                                  | 331 |
| Appendix 5 – Topic Guide .....  | 333 |
| Appendix 6 - Research Questions .....   | 337 |
| Appendix 7 - Attributes of Interviewees .....                                   | 338 |
| Bibliography .....  | 340 |

## Tables and Figures

| Name       | Description   | Page |
|------------|---|------|
| Figure 2.1 | Overview of System Reform Mechanisms  | 39   |
| Table 2.2  | Evolution of Patient Choice Policy  | 44   |
| Figure 3.1 | Description of Search Databases   | 58   |
| Figure 3.2 | Search steps  | 61   |
| Figure 3.3 | Results by Database Search  | 63   |
| Figure 3.4 | Results of Abstracts  | 65   |
| Figure 3.5 | Studies by Year of Publication  | 66   |
| Figure 3.6 | Studies by method type  | 68   |
| Figure 3.7 | Studies by Aim of Research  | 69   |
| Figure 4.1 | The three levels of the Schein Model  | 122  |
| Figure 5.1 | Conceptual Framework – Exploring the Impact of Patient Choice Policy in an NHS Hospital | 163  |
| Figure 5.2 | Competing Values Framework Model  | 166  |
| Table 6.1  | Situations and Relevant Research Methods  | 174  |
| Table 6.2  | Research Questions  | 177  |
| Table 6.3  | Examples of Inductive Case Study Research   | 182  |
| Table 6.4  | National Choose and Book referral rates by Specialty                                    | 193  |
| Table 6.5  | Trust Local Choose and Book Referral Rates by Specialty                                 | 194  |
| Table 6.6  | Sample Selection and Criteria for Selection   | 196  |
| Table 6.7  | Participants by role by department  | 198  |

|             |   |     |
|-------------|---|-----|
| Table 6.8   | Sources of evidence and their strengths and weaknesses                    | 198 |
| Figure 6.9  | Five Stages of Analysis in the Framework Analysis Approach                | 203 |
| Figure 6.10 | Outline of Research Case Study and core components of study               | 210 |
| Table 7.1   | Staff Interviewees  | 214 |
| Table 7.2   | Hospital Goals  | 216 |
| Table 7.3   | Changing Culture of Hospital  | 244 |
| Table 8.1   | Research Questions  | 247 |
| Table 9.1   | Research Questions  | 285 |
| Table 9.2   | Mapping of the empirical research findings against the research questions | 288 |
| Figure 9.3  | Hospital leadership behaviours  | 304 |

## **Chapter 1 - Introduction**

### **1.1 Background to the research**

The English NHS is a publicly funded health service established in 1948 which is free at the point of use (Cooper et al 2011). Traditionally, patients have had little choice over where they received care. Recent health care policy has shown an increased focus on the role of patient choice of provider in health care delivery (Mays 2010, Fotaki 2013) and has concentrated on the role of individual choice as a means to improve the quality and efficiency of health care services (Le Grand 2007). There are a range of perspectives on the role of patient choice in the delivery of health care; this ranges from viewing choice as a good with its own intrinsic value whilst some view it as a transfer of responsibility to patients in an attempt to reduce health care costs (Lawton and Armitage 2012).

The introduction of choice in public services is part of a wider modernisation agenda of public services in the UK and elsewhere designed to challenge the power of professionals, drive quality improvement and improve the responsiveness of services to users (Peckham et al 2011). Patient Choice Policy (PCP) is firmly rooted in neo-classical economics and is based on the notion that individuals make choices that are in their best interests (Fotaki 2011). PCP, in the English NHS, is designed to offer patients a choice of hospitals at the point that they are referred for treatment. The rationale driving patient choice is based on the assumption that health care consumers use information to make choices and that this will incentivise providers to

focus their attention on improving the performance and the quality of services that they provide (Fotaki 2013). The proposition of policy makers is that choice-based reforms will create sharper financial incentives for hospitals in markets where choice is feasible (Cooper et al 2011).

PCP in the English NHS was shaped by the findings from the Patient Choice Pilots conducted in London in 2002 (Dawson et al 2006). The pilots revealed that when patients are offered a choice of an alternative provider that they exercise this choice. The pilot studies offered choice to those patients that had waited for a number of months for treatment. The subsequent policy that emerged offered patients a choice of hospital at the point of referral. A number of concerns have been raised regarding the introduction of PCP, in particular, the impact on the equity of services (Appleby et al 2003, Fotaki 2014). Another criticism was that the lower socioeconomic groups would not have equal access to information or that they would have difficulty in assimilating information (Besley and Ghatak 2003).

The introduction of patient choice in health care prompts the need for cultural change in provider organisations, which have traditionally been paternalistic in nature with health care professionals determining what is 'right' for the patient (Lawton and Armitage 2012). Given this perspective it has been argued perhaps patients would not want to exercise choice, however, the empirical research has found that choice is important to patients but that GPs often fail to prioritise choice (Dixon et al 2010). Patients tend to rely on informal information from personal experience, the advice of friends and family or the GP's advice when making choices. Only a small proportion of patients use the formal information on the quality of services to inform their choices (Dixon et al 2010). Magee et al (2003) found that patients tend to distrust

information available from official sources. The study reported that patients felt that the positive aspects of hospital performance would be exaggerated and that the information was biased.

Despite the concerns around equity of access and service provision, there is no evidence to suggest that PCP has affected equity of service provision (Dixon and Le Grand 2006; Fotaki et al 2005). The empirical research also found little evidence to suggest that PCP has improved the efficiency of service provision (Dixon et al 2010; Peckham et al 2011; Fotaki 2014).

Much of the empirical research on PCP has focused on the relationship between the patient and primary care. A limited number of studies have focused on PCP and the impact that it has had on secondary care providers. These studies have found that PCP has had a limited impact on improvements in quality and service efficiency in hospitals (Dixon et al 2010, Peckham 2011). The literature does not offer much explanation of the limited response from hospitals or indeed why for many hospitals patient choice is of limited significance (Dixon et al 2010). This thesis originates in the context of the debate around PCP as a lever for quality improvement and service efficiency in hospitals, and PCP as a sharper financial incentive for hospitals.

## **1.2 Purpose and contribution of the thesis**

The aim of this thesis is to explore the impact of PCP on hospital behaviour. Specifically, it addresses how understanding the way in which organisational culture and cultural change can influence how PCP is implemented.

There are a range of theories available that can be used to understand how hospitals behave and to reveal how PCP has impacted on hospital behaviour. Schein's theory of culture (1990) proposes that three levels of culture exist within an organisation. Schein's model suggest that an organisation can aspire to achieve a set of values and beliefs which may differ from those that employees within the organisation actually experience on a day to day basis. There are a range of different cultures found within hospitals (Martin 1992). A number of professional groups from managers, doctors, nurses, therapists, porters, cleaners and any other professional groups whilst brought together to support health care delivery each have their own sense of professional identity and purpose (Scott et al 2003). This mosaic of sub cultures is likely to influence the way in which PCP is perceived and therefore, may affect its influence on hospital behaviour.

This study constructs a conceptual framework derived from a reading of the organisational behaviour literature and explores what light it sheds on the principles underpinning PCP. The original contribution of this thesis is the interaction of these

two bodies of literature and what this reveals on the impact of PCP in hospitals. The study is important as it will enable a deeper exploration of PCP within the hospital and will disclose the factors that affect the hospital response to PCP.

In summary, the thesis seeks to understand PCP from the perspective of its impact on organisational behaviour in an NHS hospital environment. Given that PCP was intended to stimulate hospitals to act by improving quality and cost effectiveness, the thesis seeks to explore whether the stimulus has succeeded and how hospital behaviour has changed in response.

### **1.3 Aims and Objectives of the study**

The overall aim of this study is to explore the influence of PCP on organisational behaviour in an NHS teaching hospital with a particular focus on how PCP has shaped organisational culture and cultural change. This broad aim is explored through the following supporting research questions;

1. How is PCP viewed by different staff groups within the organisation?
2. How has the organisation's culture changed in response to PCP?
3. What organisational factors and processes mediate the impact of PCP within the hospital and how and how does this align with the intended outcomes assumed by policy makers?



## **1.4 Outline of thesis**

The thesis is organised into ten chapters;

Chapter 2 examines health policy in the English NHS and in particular focusses on the evolution of PCP. The chapter explores Choice theory and sets out the rationale underpinning PCP. The programme theory underpinning PCP is also examined with the final section considering how the NHS has implemented PCP.

A detailed review of the empirical literature is undertaken in Chapter 3. The literature review examines four key areas: the empirical evidence relating to whether patients want choice; the barriers that may exist when patients try to exercise choice; the factors that influence patient choice; and finally, the impact that patient choice has had on provider behaviour. The review of the empirical research finds that whilst patient choice is important to patients there are a number of barriers to effective patient choice. Patients express their desire to exercise in choice but in practice choices are often made with or by the GP. There remains a concern whether the information available supports patients in exercising choice. The response from providers to PCP has been limited with little evidence to support improvements in the quality of service or service efficiency.

Chapter 4 provides a critical review of organisational culture and cultural change theory. It outlines the evolution of organisation culture as an academic area of study over time. The chapter explores the different perspectives on organisation culture

and the different theories of organisational culture change. The chapter also explores the culture of hospitals and how implementing change in hospitals can be challenging.

The conceptual framework derived and used in the study is set out in Chapter 5. This chapter seeks an integration of the organisation culture and cultural change theory literature and the programme theory of PCP and in doing so develops a conceptual framework for the empirical study. The study uses the lens of organisation culture and cultural theory to explore PCP in the context of a hospital. This chapter shows how PCP policy makers have made a number of assumptions about the way in which the policy will be implemented, but has not given due consideration to the hospital as a complex organisation. The chapter proposes that the PCP is naïve in its assumptions and that the culture of hospitals and cultural change are factors in the way that PCP will be received by the organisation. This chapter outlines a number of theories that will be used as lenses from which to explore the impact of PCP in the hospital.

The research design used in the empirical phase of the study is outlined in Chapter 6. This methodology is designed around three key research questions derived from the analytical framework. The methods used to collect the data are described in addition to the process of data coding, theming and analysis.

Chapter 7 sets out the findings from the study in relation to the way in which the hospital has viewed PCP and the different meanings associated with patient choice. The chapter explores the culture of the organisation and how it has changed over a number of years. The study reveals a historical hierarchical corporate culture that has prevented the hospital in developing its culture and driving forward innovation. Whilst change in culture is reported by many it is difficult to attribute the change to PCP.

The organisational factors and processes that mediate the impact of PCP within the hospital and how these align with the intended outcomes assumed by policy makers are examined in Chapter 8. This chapter explores whether change has occurred as a result of the introduction of PCP. The chapter reveals many organisational factors and processes that could mediate the impact of PCP but in practice little has changed in the hospital as a direct response to PCP. The corporate teams focus on relationships with GPs and commissioners rather than the patient. The role of that patient as a consumer is not being experienced in the hospital. The findings reveal how the hospital is focused on the loyalty of its patients and is convinced that patients want local service provision and do not want to travel. This belief has driven many within the hospital to not perceive PCP as a threat. Despite patients being seen to choose alternative providers the hospital does not turn its attention to PCP as it does not perceive the change to de-stabilise the hospital.

Chapter 9 undertakes a detailed discussion of the findings of the study and synthesises the findings with the broader theoretical and empirical literature. The chapter describes the importance of recognising context when exploring change and

policy implementation. The programme theory sets out a number of assumptions on how PCP will work in practice but fails to acknowledge many factors. Existing relationships between the patients, GPs and the hospital where trust has been established is largely ignored. The threat of losing patients and closing feels like a remote reality in an environment where there are too many patients to see, patients have to wait for treatment and hospitals feel overworked. This oversight contributes to the policy not producing the outcomes as intended by policy makers.

Chapter 10 sets out the overall conclusions of the study and discusses the research and policy implications arising from the research. The study aligns with previous research in this area that has found PCP not to be a lever for service improvement as intended. A number of policy and practice recommendations are made with regard to PCP in the hospital context and sets out an agenda for further research in this area,

## **Chapter 2: Patient Choice Policy – Origins and Evolution**

### **2.1 Introduction**

Patient Choice Policy (PCP) forms part of a set of inter-related changes introduced in the NHS by a range of governments, with the aim of enhancing the quality and efficiency of health care services (Mays and Tan 2012). PCP specifically sets out to offer patients choice of provider in the secondary care setting. To understand the potential influence of PCP it is important to consider the theoretical context of choice per se and how this has been applied to health care. In addition to understanding the theories that influence PCP, it is also important to consider the evolution of health policy and how PCP has emerged.

This chapter serves a number of purposes; it aims to explore the concept of choice and outlines different theories that have been used to frame the concept. This reflects the challenges associated with choice as a concept and how it has been interpreted in different ways. The chapter then aims to understand how choice in health care contexts may be understood. The chapter also describes the evolution of PCP within the English NHS and highlights the supporting reforms and policies that have been implemented alongside it. The final section outlines the programme theory that underpins PCP and also, considers how the NHS has responded to PCP. The chapter aims to set the scene of PCP from both a policy and theoretical basis.

## 2.2 Choice Theory and Choice in Healthcare

Choice has been explored from a range of different standpoints including philosophical, religious, political and economic perspectives and has been widely debated in the academic literature (Ross 2008). Fotaki et al (2005) propose that;

“Choice is a many sided, diffuse and value-laden concept. Any use of the term choice invokes assumptions about the following, who chooses? By what process do they choose? What scope do they have for choice? What do they choose? What effects does their choice have?”

(Fotaki et al 2005 p 26)

The different theories that have been used to frame the concept of choice fall into three broad categories: normative, descriptive and mixed (Dillon 1998). First, normative models of choice focus on articulating what people should do. Second, descriptive models which seek to understand what people actually do and third, mixed models which describe what people should do and what they can do. Normative theories of choice fall within the domain of moral philosophy. For example Rawls' Theory of Justice (Rawls 1971) interprets choice as the manifestation of personal autonomy. He proposes that justice revolves around the adaptation of two fundamental principles of justice which, in turn, guarantee a just and morally acceptable society. The first principle guarantees the right of each person to have the most extensive basic liberty compatible with the liberty of others. The second

principle states that social and economic positions are to be to everyone's advantage and open to all. Rawls' suggests that individuals exist in a 'veil of ignorance' which is described as the procedure for reasoning used when an individual reflects on his/her own preferences. He proposes that individuals will make choices that are based on equal liberty. This normative model of choice views the individual choices as exercised in the context that is good for them and also, one which does not disadvantage others.

Descriptive theories of choice are based on findings of empirical work in real world settings. For example, prospect theory developed by Kahneman and Tversky (1979) explores the decision making process used by individuals when making choices. They identify a range of concepts including 'mental short cuts and rules of thumb' that individuals use when making decisions. Prospect theory acknowledges that individual's previous experiences influence the choices that they make. Tversky and Kahneman also found that the way in which information is presented can change the decisions made (Tversky and Kahneman 1983). McNeill et al (1982) found that when their participants were presented with information about cancer treatments, their preferences for treatment were influenced by the way in which the outcomes were framed. The concept of framing is, therefore, important as it identifies not just the need for information to support choice but the importance of how information is presented.

Mixed models of choice theory can be found in neo-classical microeconomic theory. The neo-classical economic perspective of choice theory proposes that choice and competition are not only desirable in public services but are essential in making services both responsive and efficient (Le Grand 2006). Neo-classical

microeconomics has consumer choice theory at its core. Here choice is achieved through the development of the active informed consumer who assumes the role of a knowledgeable agent (Fotaki et al 2005). The assumptions on which the mixed theories preside are that consumers are 'utility maximisers' and that their decisions will be based upon the maximisation of benefits over costs (Kirzener 1973). Neo-classical economics is also based on the assumption that individuals are motivated by personal gain, including financial incentives and opportunities to make profit.

Rational choice theory views social interaction as a form of rational social exchange, modelled on economic behaviour. The theory assumes that individuals act rationally in their own interests and that people will calculate the likely costs and benefits of any action before deciding which course to take (Green 2002). Predicated on the notion that all social action is rationally motivated, the theory views the individual as being motivated by wants or goals that express their preferences. Individuals are required to anticipate the outcomes of alternative courses of action and calculate for themselves what will be best for them. The theory proposes that the individual will choose the alternative that is likely to yield them the greatest level of satisfaction (Heath 1976, Coleman 1973). These theories assume that appropriate information is the necessary pre-condition for effective choice to be made (Lunt et al 1996).

Neo-classical theory has been criticised for a number of reasons, including failing to recognise the limitations and imperfections of the human mind. In particular this includes the difficulty of processing a large amount of information needed to make optimal choices (Kahneman and Tversky 1979). Keen (2001) argues that millions of pieces of information would be required to select a single item from a supermarket shelf if the choice was to be based on perfect information. Furthermore, critics of



rational choice theory argue that if there is no other option than to select the rational course of action then this suggests perhaps that there is no choice at all (Hay 2004). The theory assumes the need for 'perfect information' to exercise choice, in practice this can create such a vast amount of information that it would become impossible for individuals to process (Keen 2001). The theory has also been criticised for prejudging the meaning of rationality, assuming that individuals act under free will and do not attempt to explore the conditions under which rational choices are likely (Green and Shapiro 1994).

The definition of 'rational choice' is also problematic;

“What does it mean to say that a choice is rational? In rational choice theory it means only that an agent's choices reflect the most preferred feasible alternative implied by preferences that are complete and transitive (that is, choices reflect utility maximization).”

(Green 2002 p4)

Acknowledging the criticisms associated with the neo-classical theory a further evolution of behavioural economics is the introduction of the concept of bounded rationality (Simon 1956). Simon suggested that individuals do not seek out the one utility maximising choice from the many that are available but instead settle for a choice that is 'good enough' to meet pre-defined levels of satisfaction. The bounded rationality of individuals, based upon their knowledge of probabilities and value systems, therefore allows them to create rough and ready rules of thumb or

heuristics. An example of this is where an individual bases a choice on a previous experience of a similar situation rather than on new information.

Further criticisms of rational choice theory relate to the fact that individuals' preferences may not always be known, nor are they always stable (Zaller and Feldman 1992). The instability in preferences relates to situational factors. Choices made by individuals will be affected by a range of situational factors and not just their own preferences. An example of this may be people who need to travel as part of their work. They may prefer a specific mode of travel but their choices will be affected by the time of travel, destination and modes available at that point in time. In this case preferences are influenced by the situation. Finally, concentrating on such a narrow definition of 'rationality' does not allow for full exploration of choices which are made rationally that do not maximise utility, or explore those utility maximising actions that are based on irrational choices.

In response to the rational neoclassical choice view of individuals, behavioural economists have proposed alternative approaches to understanding human choice behaviour. A recent example is 'Nudge', which has been influenced by recent public policy in the UK (Thaler and Sunstein 2008). A nudge is described as;

“... any aspect of the choice architecture that alters people's behaviour in a predictable way without forbidding any options or significantly changing their economic incentives. To count as a mere nudge, the intervention must be

easy and cheap to avoid. Nudges are not mandates. Putting the fruit at eye level counts as a nudge. Banning junk food does not.”

(Thaler and Sunstein 2008)

Nudge breaks the link between thought and action and suggests that individual's choices are as likely to be based on habit as they are based on pre-planned option review. It recognises that individuals regularly seek to make decisions in supposedly 'rational' ways, but that powerful contextual factors and the tendency to 'default' to the status quo option can open up a gap between intended and actual behaviour. A 'nudge' prompts choice without getting individuals to evaluate all options available. This presents an alternative perspective to the rational neoclassical view of choice.

The theory is not without criticism though. It has been described by some as paternalistic intervention from the state resulting in the manipulation of the behaviour of individuals (Oliver and Brown 2010). Others have suggested that although Nudge has impacted on mainly minor problems there is a challenge as to whether it can be scaled to macro public policy level (Chakraborty 2010).

This section has shown that choice theory has developed from a range of different disciplines and sought to explore the factors that influence individual action. So, what role can choice play in health care? There are potentially a number of choice options for patients within the health care setting. The range of options includes;

“Choice of treatment (what)

Choice of individual health professional (who)

Choice of appointment time/date (when)

Choice of which provider (where).”

(Dixon et al 2010, p3)

Recent health policy has focussed on the latter two types of choice, encouraging patients to choose where and when they wish to be treated. The next section will describe the evolution of health policy in the English NHS and explore the choice theories that have influenced it.

### **2.3 Evolution of Health Policy in the English NHS**

This section considers how PCP has emerged through broader NHS reform, exploring three chronological eras: pre 1990s, post 1990s to 2010 and 2010 onwards. The purpose of this section is to understand how health policy has evolved over time and the factors that have influenced its development.

### **2.3.1 Pre 1990s**

The NHS was created in 1948 with the aim of providing a comprehensive service funded by general taxation, available to all and free at the time of need. The service was based on recommendations from the 1942 Beveridge report which called for a state welfare system. The report proposed that a nationalised health service could help combat want, disease, ignorance, squalor and idleness (Tweddell 2008). In its first year the NHS cost £248m to run, almost £140m more than had been originally estimated (Klein 1995). This provided an early indication that funding of the NHS was likely to be a problem for Government to fund adequately.

Patient choice of secondary care provider was not an explicit component of the NHS during its early years but patient choice existed from the outset (Greener et al 2006).

Health policy during these early years concentrated on structural change and reform as a means of improving the delivery of services. Following the implementation of the Hospital Plan another key structural change of the NHS was introduced in 1974 – the NHS Re-organisation Act. The reforms aimed to deliver three key objectives (Leathard 2000):

- Provide unified health services delivered through each area health authority
- Align health services to other government services to enable services to be delivered effectively

- Improve the management of health care through multidisciplinary teams with medical, nursing, financial and administrative teams delivering health care through 'consensus management'.

There were a number of factors that were problematic with the new structure which affected the delivery of the other two objectives. A key criticism of the 1974 reorganisation was that the number of layers of administration that had been introduced caused unnecessary levels of bureaucracy. The calm that it had set out to achieve had not been realised through the structure (Leathard 2000).

Following criticism of the structural reform of 1974 policy makers turned their focus away from the structural changes and re-organisations shifted the emphasis of health care towards the needs of patients. The Government White Paper, 'Putting Patients First' (1979) aimed to simplify health care delivery and bring its focus to patient care. As part of a newly formed conservative government under the leadership of Margaret Thatcher, this era of change was set in a political context focused on managing spending within public services. The political environment in the 1980s was one of privatisation. Margaret Thatcher had been elected to power in 1979 and brought with her a manifesto that sought to improve efficiency in public services through the introduction of competition and market forces. During this period there was a move to encourage the role of the private sector within health services. Not only did this fit with the 'New Right Ideology' of increased competition and choice within the health care sector but it was assumed that the private sector could be used to relieve the pressure on the NHS.

Although prior to the 1990s the opportunity for patients to exercise choice existed it was limited and in real terms there was little expectation that patients would actually exercise choice (Greener et al 2006). Access to private hospitals had also been available to patients but this had previously been limited to those that could afford to pay (Klein 1995). Therefore, although patients could exercise choice for many years this was not a realistic expectation or a requirement in the health care delivery process and was certainly not viewed as a vehicle to improve the responsiveness of health care providers. From 1946 until the late 1980s health care policy made little or no reference to patient choice (Greener et al 2006). Health policy during this era of the NHS was focused on the provision of welfare services to the population. The patient's role in this early phase was that of a 'patient' in the traditional sense, with decision-making authority firmly located with clinical professionals. Evolving health policy at this time concentrated on establishing organisations and structures that would facilitate the delivery of service. As the years progressed, the cost of service provision and the need for the NHS to demonstrate value for money became increasingly more important. During this era of health policy, whilst the patient had not yet been conceived of as a consumer by the end of this period, pro-market principles and competition were being introduced. Business principles within the NHS were emerging and the role of the patient as a customer was being introduced. The health policy during this era had shifted from focusing on the way in which organisations were structured to deliver care to a focus on those that were receiving health care.

### ***2.3.2 1990 to 2010***

#### *Working for Patients - 1989*

The White Paper 'Working for Patients' (1989) introduced patient choice as part of wider quasi-market reforms into healthcare (Ferlie 1994). The case for change was made by the Thatcher government with the argument that the NHS had become a 'bottomless financial pit' (Thatcher 1993) and therefore reform was required to contain rising costs. The basis of the reform saw the introduction of a split between purchasers and providers of care. Commonly known as the introduction of the purchaser/provider split, this change also saw the introduction of a state financed internal market whose purpose was to support efficient service delivery.

The introduction GP 'fundholding' saw GP practices for the first time holding their own budgets, as long as they met agreed criteria. They could then use their funds buy services for their patients from hospitals and compete with other practices for patients. Any savings generated from their budgets could be re-invested back into the GP fundholding practice. (Leathard 2000)

Klein (1995) described the changes that emerged in the 1990's as a transformation of the patient into a 'consumer', at least in terms of health policy discourse. He also suggested that the purchaser provider split created an opportunity for purchasers to challenge the demands for extra resources from providers. This was achieved through requiring providers to illustrate how they were contributing to improving the health of the wider population. From the 1990s onwards health policy introduced a



new discourse into health care provision of markets, competition and consumerism (Powell 1997). GPs and community services were required to explore health promotion opportunities and alternatives to hospital referral. This model marked a challenge to the position of power that hospitals had traditionally held in the healthcare system. Traditionally, health care provision had been centred on hospital and specialist care. This change began to shift the focus towards primary care in which purchasers and GPs needed to understand the wider health needs of the population and consider how this could be improved.

#### *Introduction of the Patient's Charter*

The introduction of the Patient's Charter was a key development in this era (Department of Health, 1991). The charter outlined a range of 'rights' that patients would have in relation to health care delivery. From the perspective of hospitals, the reform of the 1990s started to challenge 40 years of dominance they held within the NHS as monopoly service providers in the health care system (Klein 1996). This could be viewed as another important milestone which introduced the concept of service standards to patients and signalled an increased role for patients. Although consumerism and markets were a key feature of health policy of this time it has been widely acknowledged that 'the market' did not operate on the basis of traditional neo-classical principles (Klein 1995). In particular, although patients as consumers were provided information in reality they only had limited choices and alternatives to the 'usual care' option of the local provider were very restricted (unless that individual was able to access alternatives through private health insurance). This resulted in

patients having very little influence and therefore limited impact upon the 'market' (Klein 1995). The Patients Charter may have been designed to empower the patient but the reality was that not much else had changed to enable this.

#### *NHS: A Service with Ambitions - 1996*

Patient choice as a concept continued to appear in health policy throughout the 1990s. The White Paper, 'NHS: A Service with Ambitions' (1996) focused on patient choice and highlighted the provision of information that would support patients' ability to make choices (Greener et al 2006). There was recognition that choice should also cover choices regarding healthy lifestyles and that choice was not merely limited to decisions about treatment.

*"A service responsive to the needs and wishes of patients is one where patients are fully involved in their health and health care. Knowledge about health, illness, symptoms and treatment gives people more control over their circumstances, and helps them access and use services effectively. People need good quality information:*

- *on how to stay healthy and choose healthy options;*
- *when symptoms appear or in an emergency, to know what actions to take to help themselves, and whether, when and how to seek help;*
- *If a condition is diagnosed, to understand the implications and to take part in decisions about treatment and care.*

(Department of Health, 1996 Section 1)

The desire for patients to be more involved in health care was apparent. Policy makers recognised that information was required to support patients making choices and that without it patient choice in health care would be difficult. This White Paper set out an ambition which would see patients taking a far more active role in health care.

*The New NHS: Modern and Dependable - 1997*

The New Labour government came into power in 1997 and published their White Paper, 'The New NHS: Modern and Dependable' (1997). This policy outlined the plan to abolish the internal market but proposed that the purchaser/provider split would be retained. Despite the government's claim that the market had been abolished, in fact several 'market-like' elements remained (Powell 1997). Although not explicit in its references to patient choice, health policy was unequivocal in its support of the patient as consumer; for example:

*"Rising public expectations should be channelled into shaping services to make them more responsive to the needs and preferences of the people who use them."*

*(Department of Health 1997 section 3)*

Improving the quality and efficiency of the NHS were increasingly the grounds on which the case for reform was made. It was proposed that change would principally

be delivered through the introduction of performance measures that would be set against standards of quality and efficiency.

Health policy was characterised at this time by the goal of achieving responsiveness through consumerism (Greener et al 2006), but until the early 2000s it was NHS purchasers who were seen to be playing the role of consumer, not patients themselves. It was assumed that through the channels of the internal market, purchasers would contract with hospitals which would meet the needs and preferences of consumers. This was expected to incentivise less responsive hospitals to raise their standards to ensure that they continued to attract patients. The terms 'customer' and 'consumer' were becoming more widely used in the health care. The use of these terms within health care was contentious as it opened the debate of health care as a market good versus health care as a service good (Mahon et al in Robinson and Le Grand 1994), one that continues to the present day. Despite the challenges, patient as consumer would soon become an important feature of future health policy reform. Whilst it is beyond the scope of this thesis to engage in the debate surrounding patient consumer it is important to recognise that this is widely contested. It is relevant to acknowledge given the market requirement for PCP to be effective. From a very early stage the ability for patients to act as consumers has been contested.

## *NHS Plan 2000*

The NHS plan (2000) set out a 10 year strategy to improve the NHS. The need for improvement was principally justified by reference to long waiting lists and the related problem of inefficient use of capacity (for example it was reported that 98% of population lived within 1 hours travel time of 100 available and unoccupied NHS beds, 76% within 500). The service was also described as being unresponsive to patients' needs and wants and poor on innovation. Tony Blair's health advisor, Julian Le Grand, remarked that only the educated middle classes were able to exercise choice, presented as clear evidence of inequity within the NHS. Part of the problem, he concluded, was that the health service was dominated by monopoly of provision (Le Grand 2003).

The introduction of the NHS Plan (Department of Health, 2000) continued to reinforce the importance of consumerism within the NHS. The document emphasised the rights of patients to choose their GP and make informed choices in their healthcare more generally. A significant contributor to the shaping of PCP was the introduction of the first patient choice pilots in July 2002 (Department of Health 2001). The scheme was designed to offer patients that were waiting for elective treatment the opportunity to be treated at an alternative provider if they were likely to wait greater than 6 months for treatment. The choice pilots took place in London across the specialties of Ophthalmology, Orthopaedics and General Surgery. Choices were supported and facilitated by Patient Care Advisors, who would contact patients, provide relevant information and discuss the options available. The options consisted of alternative hospitals, independent treatment centres and the private sector. The

pilots provided evidence that choice reduced overall waiting times for patients waiting to be treated. They also found that there was a convergence of waiting times across the city of London, reducing the gap between the shortest and longest waiting times (Dawson et al 2004). The positive findings from the pilots were used to evidence the success of patient choice and directly referred to in justifications for the formalisation and expansion of PCP.

#### *Formalisation of Patient Choice of Provider*

The prospect for patients to be able to have a choice of providers when being referred for treatment was formalised soon after the London Patient Choice Pilots. In July 2003, the Department of Health issued the 'Choosing a Hospital' guidance which set out the requirement for patients being referred for elective hospital treatment to be given the opportunity to select from four or five alternative providers. This would become a mandatory requirement from December 2005. The point of significance to note is that the model of choice that would be rolled out and expanded was different to the model used by the London Patient Choice pilots. Notably, the patient care adviser role was not mentioned as part of the expansion of the policy and no reference was made to the reimbursement of travel costs to the patient when choosing an alternative to their local provider- two features that were held to be critical to the uptake of choice across diverse social groups (Coulter et al 2005). The Department of Health reinforced its commitment to patient choice in health care at this point and stated that this approach would lead to a range of benefits for the patient.

“• greater involvement and control over their treatment, so that choices reflect the patients’ priorities

- faster treatment

- greater certainty over the time they will be treated

- reduced variation in standards of care, as more standardised care pathways are introduced and patients apply pressure for higher standards

- greater equality of choice for all patients”

(Department of Health 2003 p20)

The stated motivation for the reforms was to use the combination of choice and competition to create a framework and incentives for NHS to improve their responsiveness to the needs of individuals using their services. A key assumption was that the threat of losing patients to competitors would stimulate providers to consider and improve the quality of service provision (Greener et al 2006).

The notion that patient choice and competition would lever service quality was highly contested. This was based on a range of factors including the proposition that it was neither possible nor desirable for patients to act as ‘consumers’ in the purest sense, that patients did not behave in the same way as ‘consumers’ and that doctors did not behave in the same way as other institutions (Morris et al 2007).

### *National Booking System to support Choice of Provider – 2004*

As patient choice of secondary care provider was rolled out, national guidance turned attention on how choices would be facilitated and executed in practice. In 2004 'Choose and Book – Patients Choice of Hospital and Booked Appointment' was issued as further policy guidance. The guidance described the ambition to enable a patient to book their appointment at the time they had selected the hospital to be treated at. In 2006 the national Choose and Book system was launched with expectations that the system would be used to support choice and the booking of the appointment. The aim was to provide a system that not only permitted the booking of the appointment but also provided information such as waiting times and types of services by provider.

By now PCP was at the heart of health policy reform. There was a recognition that for patients to be able to fulfill the role of consumer adequately that they would need access to information (Thomson and Dixon 2004; Le Maistre et al 2006). In response to this the national NHS Choices website was launched on 1<sup>st</sup> July 2007. The website was designed to provide comprehensive information on service providers, to support patients to make choices about their health care. It was hoped that, as a 'consumer', the patient would use the information available, act in a rational way and choose the hospital that would provide the best health care (Dixon et al 2010). The scope for patient choice increased significantly in the late 2000s; initially patients were offered a choice of up to 5 local providers; from 1<sup>st</sup> April 2008, patients had 'free choice' of any provider that met NHS quality standards. Policymakers justified the extension of choice in several ways: making reference to its role in improving service quality,



through arguments about equity and invoking concepts of patient ‘autonomy’ and ‘control’:

*“Choice matters because it is at the heart of the Government’s public service reform agenda to empower patients, reduce inequalities in access to healthcare and improve health outcomes for all patients.*

*The 2003 national consultation asked health professionals, patients and the public what they actually wanted from their NHS. Recurring themes in the responses were that everyone, not just the affluent, wanted more choice about their health care. They also wanted the right information to enable them to choose and they wanted services to be shaped around their needs.*

*People’s willingness and capacity to take part in decisions about health and social care have increased, and choice should be offered to everyone, not just those who are best able to demand it. We can promote social inclusion by ensuring choice for groups who tell us it is important to them but have sometimes been denied it for a variety of reasons, including a lack of information about what is available and how to access it.”*

(Department of Health 2006 p1)

#### *Reforms related to Patient Choice Policy*

PCP was part of a wider programme of system reform of health care designed to create a health care delivery model which would behave as a market (Jones and

Mays 2009) (Figure 2.1). The core features of the market included new financial mechanisms based on activity flows and the money 'following the patient' known as Payment by Results (PbR); PbR was introduced in April 2004 as a mechanism for managing financial flows across the NHS. PbR would generate a fixed price tariff that would be based on a healthcare resource group (HRG). PbR was designed as a process that allows the 'money to follow the patient'. Coupled with patient choice, this was viewed as an incentive for providers to increase efficiency and improve the quality of services that they offered. Efficiency was expected to be achieved through providers reviewing their cost base and ensuring that tariff payments would adequately recover the required income to offset expenditure.

As part of the introduction of PCP from 2002 onwards private hospitals were encouraged to enter the NHS market and Primary Care Trusts (PCTs) were permitted to contract with both NHS and Private Providers. This plurality of provision fosters business like cultures within NHS hospitals (Brereton and Vasoodaven 2010). Another feature of the supply side reform is the commitment for all NHS hospitals to achieve Foundation Trust status. Foundation Trust status is defined as;

“Earned autonomy, or the ability to make independent governance and finance decisions as a reward for meeting certain financial management and clinical quality standards, is the incentive behind trust applications for FT status.

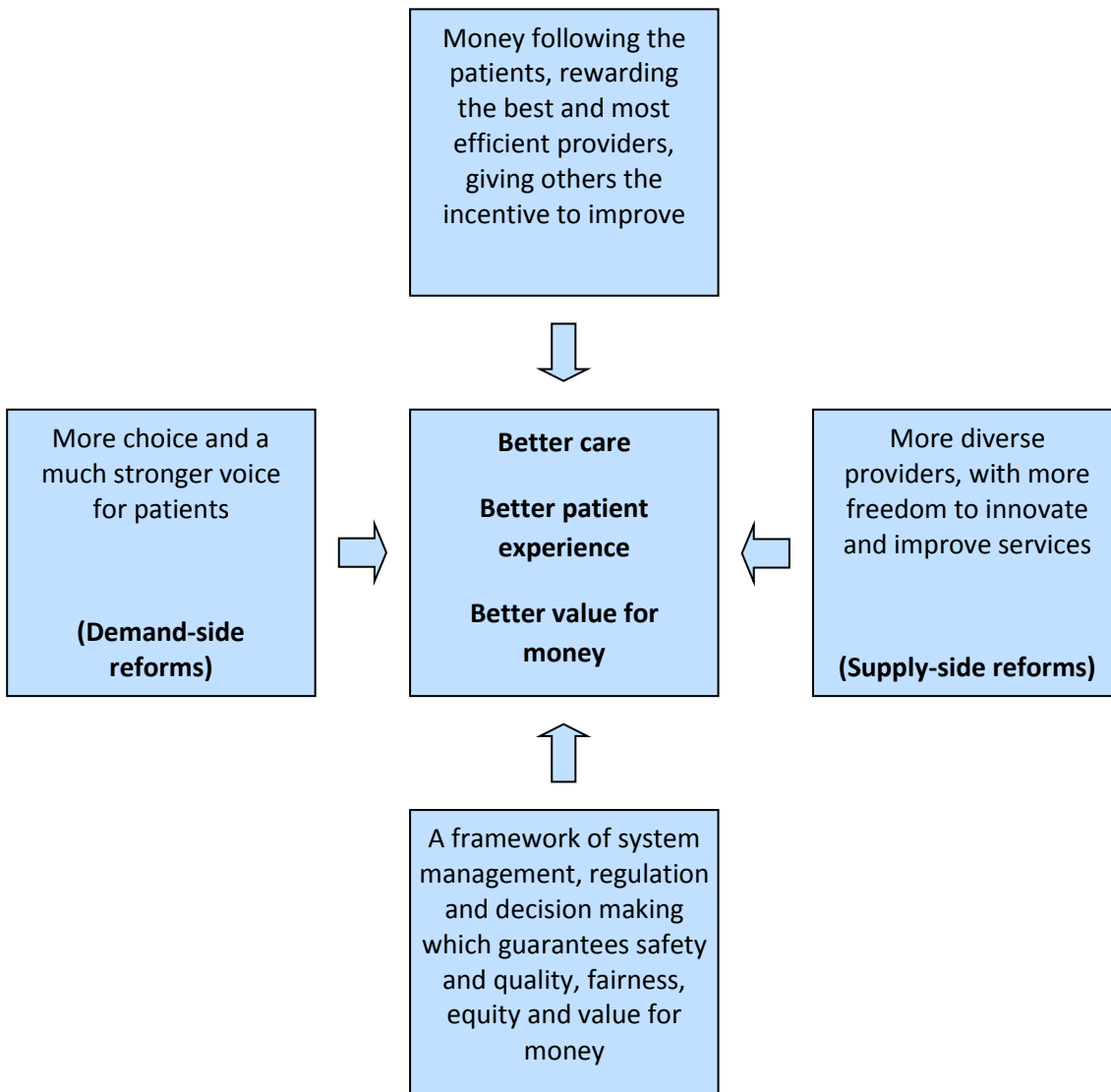
The broad aims of converting NHS trusts to foundation trusts are to enable local prioritisation of service improvements and to increase community

participation in the planning and running of services (therefore increasing trust responsiveness).”

(Brereton and Vasoodaven 2010)

The proposed system reform was clear in its intention to strengthen the voice of the patient and use their choices to shape health care provision. Previously attempts at introducing choice has been challenged as weak as the wider system reform to enable it be effective was deemed to be lacking (Klein 1995). This new model appeared to have addressed this with the associated interlocking reforms that had been introduced.

**Figure 2.1 Overview of system reform mechanisms**



(Department of Health 2005, p9)

Finally, the introduction of the NHS Constitution (Department of Health 2009) was designed to enshrine principles and values underlying NHS health care services. Seven founding principles outlined the underpinning values of health care. The constitution also set out a number of rights that would become legally binding. The

commitment to patient choice was formalised within the constitution and enshrined as a legal right.

### ***2.3.3 from 2010 onwards***

May 2010 saw the formation of a new political coalition government between the Conservative and Liberal Democrat parties. This change in government prompted the review of current health policy resulting in the publication of the White Paper, 'Equity and Excellence- Liberating the NHS' (2010). The White Paper explicitly re-stated its commitment to the core values of the NHS as a comprehensive service providing equitably to all patients free at the point of care. The service would be based on patients' needs not their ability to pay.

The White Paper stated a commitment to put the patient at the heart of everything that the NHS does and further renewed its commitment to providing greater choice for patients which would be facilitated through the provision of easily accessible information. Patient choice would be achieved through an 'information revolution and greater choice and control' resulting in;

“

- *Shared decision making becoming the norm; no decision about me without me*
- *Patients will have access to the information they want to make choices about their care. They will have increased control over their own care records*

- *Patients will have choice of any provider, choice of consultant led team, choice of GP practice and choice of treatment. We will extend choice in maternity through new maternity networks.”*

*(Department of Health 2010 p13)*

The change in government and a new decade in health policy had not altered the focus of PCP; rather the policy documents demonstrated renewed commitment and expansion of patient choice to include maternity care and choice of named consultant. In October 2010, to support the earlier White Paper (Liberating the NHS 2010), a further White Paper was issued (The Information Revolution, 2010). This outlined a vision of improved data collection, analysis and access, through which it proposed health and social care improvements can be achieved. This paper reiterated its commitment to the concept of ‘no decision about me without me’ and also emphasised the critical role of information in supporting the choice. To deliver the future vision of health care as described in these two White Papers the government constructed the Health and Social Care Bill (January 2011). The Bill promised to:

“protect and promote the right of patients to make choices with respect to treatment or other health care services provided for the purposes of the NHS”

*(Health and Social Care Act 2012)*

It also offered a definition of what ‘real choice’ means in the NHS:

*“Delivering real choice is:*

*- Choice of services to support healthy living*

- *Choice of provider and the way in which care is provided*
- *Choice of treatment including self-management support.”*

*(Health and Social Care Bill 2011)*

Described by Chris Ham as ‘one of the biggest shake ups of the health system since the NHS was established (Kings Fund 2010), the Health and Social Care Bill (Department of Health 2011) sets out a reform of health and social care delivery process through five key areas;

- Strengthening the commissioning of NHS Services
- Increasing democratic accountability and public voice
- Liberating provision of NHS services
- Strengthening public health services
- Reforming health and care arm’s length bodies”

*(Department of Health 2011 p3)*

The reforms continued the previous governments’ transformation of the English NHS into a market for publicly financed health care and creating greater plurality of provision (Mays 2011). The commitment to competition has been reinforced through the introduction of the ‘Any willing/ qualified provider’ commitment, offering further

opportunities for private and voluntary sector organisations to provide NHS funded services:

“The goal is to enable patients to choose from any qualified provider where this will result in better care. A phased approach will be implemented, introducing any qualified provider for services where there is a strong demand from patients for greater choice to improve services, starting with selected community and mental health services from April 2012.”

(Department of Health 2011)

As part of this new wave of changes, the Government set out a Mandate (Department of Health 2013) to NHS England outlining its expectations from the Commissioning Board. This mandate set out further commitments to choice as a right and its expansion to other services.

“To support the NHS to become more responsive and innovative, NHS England’s objective by 2015 is to have fully embedded all patients’ legal rights to make choices about their care, and extended choice in areas where no legal right yet exists. This includes offering the choice of any qualified provider in community and mental health services, in line with local circumstances. The Government has published a Choice Framework following consultation, to help patients understand the choices they can expect to have, and NHS



England is working further with Monitor on how choice can best be used to improve outcomes for patients.“

(Department of Health 2013 p23)

This section has outlined the development of health policy within the UK and explored how PCP has evolved. Over time, there has been an increasingly explicit focus on the role of individuals within the health system as ‘consumers’, and ongoing efforts to foster and support opportunities for consumerism to be exercised in practice. A succession of White Papers has continued to reference patient choice as a mechanism for putting patients first and at the heart of the NHS. The desire for patients to take a more active role in health care and help shape the delivery of services is clear in the policy ambitions. The introduction of legislation to underpin PCP can be viewed as a serious commitment to choice in health care. The reform programme has been underway for a number of years and the introduction of the Health and Social Care Act (2013) confirms its ongoing commitment to PCP. The table below highlights the key milestones outlining the introduction of PCP.

Table 2.2: Evolution of Patient Choice Policy

|              |  |
|--------------|--|
| January 1989 | White Paper - 'Working for Patients' – Introduction of the Purchaser/Provider split. Choices being offered to patients include place and time of treatment and also choice of meals. |
| June 1996    | White Paper – NHS: A service with ambitions – A recognition that information was required to support choice  |
| April 2002   | Introduction of Payment by Results (prospective case-based payment for NHS hospital services).   |
| July 2002    | Patients waiting more than six months for elective surgery offered the choice of moving to another hospital for faster   |

|   |   |
|---|---|
|   | treatment.  |
| October 2003                            | Introduction of NHS and Independent Sector Treatment Centres  |
| December 2005                           | Choice at the point of referral for all patients requiring surgery. An electronic booking system ('Choose and Book') introduced to enable all patients requiring elective care to be offered a choice of at least four providers. |
| June 2007                               | 'NHS choices' website launched to provide information to support patient choice.  |
| January 2008<br>(introduced April 2008) | For non-urgent treatment, patients given the right to choose any provider that meets NHS standards and can provide the service within the maximum price the NHS will pay ('Free Choice').   |
| January 2009                            | NHS Constitution enshrines choice as a patient right  |
| July 2010                               | White Paper – Equity and Excellence – Liberating the NHS outlines the plan to extend patient choice to offer named consultant and an extension of patient choice for maternity services through a new maternity network           |
| January 2011                            | Health and Social Care Bill outlines plans for 'choice mandate' to ensure that choice in commissioning is delivered through mandatory obligations   |
| March 2012                              | Health and Social Care Act is passed  |
| December 2012                           | Choice framework published outlining where choice can be exercised as a legal right   |
| November 2013                           | Mandate for 14/15 confirms patients right to have choice in health care   |

## **2.4 PCP Programme Theory and NHS response**

### ***2.4.1 PCP Programme Theory***

All policies contain a programme theory. Programme theory combines the assumptions underpinning a policy and how a policy will achieve the desired outcomes (Fotaki et al 2005). The function of programme theory is to set the theoretical sensibility of a programme (Rogers et al 2000). Programme theory offers a set of statements for a programme that explains how the programme will operate, why it will operate in that way and will also predict the outcomes and conditions required to deliver the outcome (Sidani and Sechrest 1999).

The stated objectives of PCP include shorter waiting times, choice of where patients would be treated, choice of when patients would be treated, improved quality and increased information for patients (Peckham et al 2013). From a review of the literature and a consideration of the wider health care reforms the following analysis sets out the programme theory underpinning PCP.

1. The Government asserts that the introduction of market elements into health care, in particular choice and competition will enhance efficiency and address non-responsiveness among provider organisations.
2. Competition among providers for contracts will incentivise providers to review (and if necessary improve) the quality and efficiency of the services to ensure that they are responsive to patient needs, making them the most attractive option to potential patients.
3. Payment by Results will generate standard tariffs for activity ensuring that price does not influence the market, and that providers compete principally on quality.

4. Money will follow the patient so those providers not attracting patients stand to lose out financially.
5. Increasing the number and diversity of eligible providers in “the marketplace” will allow patients to have a range of alternative providers to choose from.
6. Patients will have access to a range of information about the quality of services ranging from health care outcomes to cleanliness ratings to access indicators (e.g. car parking, waiting times).
7. Patients will use the information provided and act rationally to select the best performing hospitals.
8. Those hospitals that do not achieve quality and efficiency standards will fail and potentially may go out of business (i.e. exit the market) because they will not be selected by patients and therefore, lose income.

The intention of PCP is to stimulate change in the way health care is delivered so as to create a more efficient and responsive service to patients. The change would be led by patients choosing hospitals that respond to their needs. When considering the choice theories presented in the first section it appears that Rational Choice Theory is most prominent in the PCP model. PCP assumes that the patient behaves as a utility maximiser by evaluating the options available in order to seek out the choice that is most beneficial to them. It is assumed in health care that these choices will be based on dimensions of quality and effectiveness.

The policy assumes that the consequences for hospitals could be significant if they fail to respond to the change. Given the policy intentions and underpinning programme theory, the next section explores how PCP has been perceived by the NHS.

#### ***2.4.2. How choice has been perceived by the NHS***

PCP has been positioned as a lever to stimulate change and challenge providers to consider what patients want and how this can be delivered. It has introduced the patient experience as an important variable for consideration by providers who can use this as a lever to generate patient loyalty and potentially minimise the risk of losing patients (Dixon et al 2010). Another proposed benefit of patient choice is that it will empower patients by allowing them to be involved in decisions about their health care. Patients would be at the heart of the health care reform (Department of Health 2001). Patient choice has also been used to reduce waiting times for patients which was the aim of many of the earlier Patient Choice pilots targeting those patients that had waited a long time for their elective treatment.

A challenge from the NHS has been whether patients actually want to exercise choice. PCP assumes that patients want choice; however, the evidence is less conclusive. Evidence from the British Attitudes Survey 2004/5 showed that the majority of people wanted choice and this was particularly reflected in those groups that could not afford to pay for private health care (Jones and Mays 2009). On closer examination the question used in the survey was not directly about user choice but rather more general in asking 'How much say should NHS patients have?' The breadth of this question could be interpreted that individuals wanted a 'voice' in shaping services through consultation and survey rather than just an expression of individual choice (Taylor-Gooby 2008). More recent research indicates that although choice of provider may be important to patients they were happy to trade this for good quality care provided by local trusted health care professionals (Fotaki 2014).

Also, asking patients if they want choice in principle may yield a different answer to when they are actually faced with making choice, 'current choice' (Greener 2008).

A survey conducted by the Picker Institute (2006) rated aspects of health care that were important to patients and found that choice of hospital was one of lowest rated aspects. The nuance here is that when asked, patients are clear that they would like choice in principle. In practice it is rated of lower importance than a range of other factors such as quality of care and cleanliness.

In contrast to the arguments of people like Le Grand, some critics have argued that choice policy could actually increase inequities in health care provision (Appleby et al 2003, Fotaki 2014). The concern relating to equity is a significant one as it challenges the key founding principles of the NHS which was designed to be accessible to all. This concern is borne out of the fact that competition requires individuals to be able to access, assimilate and use information and potentially also to be able to travel to access higher quality care. These conditions are more favourable to higher socioeconomic groups (Besley and Ghatak 2003). Dixon and Le Grand (2006) tackled the equity question within their discussion of choice and concluded that if the system was designed and constructed to effectively support patients with differing needs and abilities to exercise choice then it would not cause inequity. To facilitate this, individuals from certain groups (e.g. lower socioeconomic groups, those with a lower level of education etc.) would need assistance from key workers such as patient care advisors to help them make choices and overcome the practical

elements such as help with transport. Despite the support mechanisms that are implemented, it is important to recognise those patient groups with low levels of literacy and communication difficulties that will continue to face barriers when exercising choice (Jones and Mays 2009).

The threat to equity of access is not just raised at an individual level it is also a concern at population level. As individuals exercise choice the impact could result in providers in particular geographical locations closing or shutting down certain services if the proportion of people selecting an alternative provider is sufficiently high. This would reduce service access across the population and potentially disproportionately affect those who are unable to travel to an alternative provider (Klein 2006). The threat is that those patients that can choose an alternative might leave behind services that are necessary to serve a particular geographical population but are no longer viable or able to improve (Thorlby 2006). At this point the evidence base in this area has not yet shown that patient choice causes inequity (Fotaki et al 2005, Robertson and Thorlby 2008), but the risks have been extensively described.

But the converse may also be a problem – namely, that the politicised nature of healthcare is such that no hospital provider will be allowed to fail (Dixon et al 2010). This serves to weaken the financial penalties and incentives on which choice operates, and therefore potentially weakens the impact of choice in health care overall.

Patient choice and equity remains an area of contention for the NHS. Choice is associated with individualism and autonomy whilst equity is traditionally associated with collectivism (Barr et al 2008). Taylor- Gooby (2008) suggests that this focus on individual choices rather than meeting social needs could actually weaken the NHS and the distribution of resources across it. This in turn may lead to a weakening of the social welfare system within which the reforms that have actually be designed to create efficiency have themselves caused greater inefficiency. The consequence that PCP can have between the boundaries of individual and collective realms requires significant consideration (Jones and Mays 2009).

The provision of information to support PCP can also create a challenge. Not all patients will have the level of knowledge and skill required to interpret and understand information. Also, the appropriate level of information on the quality of care may not always be easily available (Appleby et al 2003). For patients to exercise choice appropriately, consideration needs to be given to the type of information that is available and how patients can use this to help them to make choices (Rosen et al 2005). The task of providing meaningful information to patients about health care is complex. Some data – such as waiting times – is relatively straightforward, showing how long patients are waiting for treatment. However, high rates of medication error may illustrate a safety culture that has robust transparent reporting processes, on the other hand it could be an indicator of poor quality care (Jones and Mays 2009). It would be difficult for the patient to determine this from overall performance indicators, of the kind presented in standard information sources such as the NHS Choices website.



A final concern regarding the impact of PCP in the NHS relates to the fact that elective care constitutes only a small part of NHS services. PCP could inadvertently divert resources from other parts of the service in a bid to improve services and respond to patient choices (Fotaki et al 2005). Despite the extension of patient choice announced in Health and Social Care Bill (2011) the coverage of patient choice is still restricted to a relatively small segment of the NHS. The particular concern of critics in this area stems from the need to focus on management of long term conditions and improved outcomes for these patients, given that 70% of the NHS budget is spent on this group. It is suggested that for this patient group 'collaboration' rather than 'competition' is required (Ham 2007, Roland 2008) to support the needs of this patient group, care needs to be integrated across multidisciplinary care groups across primary and secondary care boundaries. The performance of the NHS for patients with multiple chronic conditions is poor in comparison to other countries and there is a potential for this to be worsened if care is not coordinated (Roland 2008). But integrated packages of care may in turn result in less choice for patients (Jones and Mays 2009).

PCP has raised a number of areas of concern for the NHS. The concern about the potential inequity of service provision is perhaps one of the most serious problems raised. The degree to which patient choice will become a reality remains challenged with the view from hospitals that choice is not a patient priority. Finally, the ability to provide meaningful information that supports choice is also a concern for the NHS. The ability to measure quality outcomes and demonstrate this to patients so that they can use it to make choice remains a concern for the NHS. The response to PCP

seems to be concern for the impact that this may have on patient populations, challenge in how it can operate in practice and scepticism that choice could ever become a reality.

## **2.5 Conclusion**

The chapter has explored choice theory in the NHS, health policy and charted the evolution of PCP. It is recognised that patient choice has evolved and that PCP has been introduced in the context of wider pro-market based reforms with the proposed aim to deliver improved efficiency and responsiveness of health care delivery. These wider reforms include the introduction of tariffs that standardise the cost of care to minimise the effect of price on choice, the introduction of alternative providers within the market to enable patients to choose alternatives and changes to the commissioning arrangements allowing local commissioning decisions to influence the provision of health care. Within this programme of reform the linguistic shift from 'patient' to 'consumer' is noted, although the extent to which the term consumer has permeated beyond health policy documents is unclear. This introduction of economic principles in the NHS reveals further governmental intentions to create the market based health care model. This reform is not just associated with one political affiliation but can be seen to be evidenced through Conservative, Labour and the current Coalition governments. A review of health policy has found that successive governments have been faced with the challenge of supporting an affordable NHS. As previously stated, the costs of the health care system have outstripped the expectations of many (Rivett 1986). The system reforms introduced in 2004, of which

PCP is expected to play a significant part, is designed to manage the financial flows across the health care system.

A range of choice theories have been explored with a focus in particular on the neo classical economic discourse which has been a key influence on the development of PCP. The notion that patients seek to maximise utility to seek out the best choice for them is the rationale that underpins PCP. This action will encourage competition between providers who are expected to become more responsive to patients needs and improve cost efficiency and quality in healthcare (Dixon et al 2010).

The programme theory underpinning PCP describes the change that the policy is intended to affect. It outlines that the patient as an informed consumer is designed to create a change in the way hospitals respond to patients. The notion that informed consumers will actively consider which hospital that they wish to be referred to is designed to stimulate providers to respond. The threat of competition from hospitals and the desire to attract patients is described as the lever for hospitals to review the services that they provide. This response should result in services being improved.

The NHS response to the introduction to PCP has been varied. A significant concern has been the threat to equity and how access to health care could be affected as a result of the introduction of patient choice. The fear is that those more articulate or educated are better positioned to exercise choice. The policy is seen to challenge the founding principles of the NHS which promised health care for all given that exercising choice may be easier for some groups rather than others. Whilst there have concerns highlighted that choice can create financial strain on hospitals and potentially threaten closure, there have also been concerns highlighted that hospitals

closure is political sensitive and it is very rare that hospitals are permitted to close. In this situation, it is perceived that the value of PCP is severely weakened as there is no real driver for hospitals to improve their services.

For patients to behave as consumers they need to access information which support the choices that they make. There remains a fundamental challenge to the concept of patient as consumer given that healthcare is not 'consumed' rather health care service is 'done to' patients. The challenge to provide meaningful information to support patient choice remains with many health care professionals disputing that this can be achieved.

Despite the concerns associated with PCP the government's reform programme continues and the latest Health and Social Care Bill strengthens the commitment to PCP. This commitment is reinforced through the extension of patient choice to choice of consultant led teams and choice of maternity services. This chapter has served as a context setting background for PCP and defined PCP as patient choice of secondary care provider. The next chapter details the empirical work exploring the impact of PCP in hospitals.

## **Chapter 3: The Impact of Patient Choice Policy (PCP) in NHS hospital trusts - A review of the evidence**

### **3.1 Introduction**

The previous chapter outlined the evolution of PCP in the NHS and noted how the commitment to PCP has continued despite changes in national government and structural reform. Explicit references to PCP can be found in the White Paper '*Equity and Excellence in the NHS*' (Department of Health 2010) and the subsequent Health and Social Care Bill (Department of Health 2011). It is clear that the policy continues to assume that patient choice is an effective lever for improving performance and that it is valued by patients. This chapter presents the findings of a review of the evidence on the impact of PCP in the secondary care setting sector. The first section outlines the aims and objectives of the review. The second section reviews the methodology and provides a detailed explanation of the search strategy, inclusion criteria, exclusion criteria and search terms used. The third section provides a themed narrative analysis of the empirical evidence through a review of the studies identified. The final section focuses on the gaps identified by the review and outlines the implications of this research.

### **3.2 Objectives of the review**

The specific aim of this literature review is to evaluate critically the empirical evidence in relation to the impact of PCP in hospitals. The review assesses the empirical evidence against the following key policy related questions;

- 1a. Do patients want to exercise choice of provider?
- 1b. What types of patient exercise choice?
- 1c. Is the patient exercising choice or has choice been delegated to another e.g. GP, health care professional, friends and relatives?
- 2a. Are patients able to exercise choice?
- 2b. Do patients have enough information to support the choice process and are they able to use this information in helping them to make choices?
- 2c. How do health care professionals help patients choose a provider?
3. What factors influence patient choice of provider?
4. What impact does choice have on providers?

### **3.3 Methods of Review**

#### ***3.3.1 Search strategy***

The research focus can be broken down into the following key concepts,

- Patient Choice
- Health policy
- Provision of Health care in a secondary/tertiary care setting.

These key concepts have been used to structure the search terms.

#### ***3.3.2 Publication Language and Publication dates***

Publications written in the English Language were considered as part of the literature review. Publication dates ranged from 1999 to June 2013.

### 3.3.3 Search Databases

The review used on the following key databases HMIC, Medline, PsycINFO, CINAHL, Econlit, Escbo, Web of Knowledge. A broad search was undertaken to ensure that a maximum number of published pieces of evidence were accessed. It was felt that this range of databases would capture the policy, service and organisational perspectives on patient choice of hospital.

Figure 3.1 – Description of Search Databases

| Name            | Description   |
|-----------------|---|
| <b>HMIC</b>     | <p><b>This database comprises of data from DH Data and the Kings Fund database. Both these databases cover UK NHS Health Services management, policy, standards and social care.</b></p> <p><b>The focus of the Kings Fund database is on improvements in health and health care.</b></p> |
| <b>MEDLINE</b>  | <p><b>The focus of Medline is medical information and also includes some advanced nursing practice.</b></p>   |
| <b>PsycINFO</b> | <p><b>PsycINFO covers subject areas within psychology including the clinical, social and biological elements.</b></p>   |
| <b>CINAHL</b>   | <p><b>A US database that covers all aspects of nursing and allied health professionals.</b></p>   |
|                 |   |

|                         |  |
|-------------------------|--|
| <b>Econlit</b>          | <b>A US database that covers economics</b>                         |
| <b>Escbo</b>            | <b>A database focused on business research</b>                     |
| <b>Web of Knowledge</b> | <b>A comprehensive database exploring social sciences research</b> |

### ***3.3.4 Inclusion criteria***

The search strategy's primary focus is on choice within a health care setting. This review of Choice literature has examined studies in the secondary care setting. The search aimed to cover 'Choice' in the broadest sense i.e. Choice of provider, Choice of appointment.

### ***3.3.5 Exclusion criteria***

Choice in other public services e.g. education, is outside of the scope of the literature review. The review has excluded the impact choice in a social care setting.

The review has excluded evidence from other countries and health systems and focused on the English NHS. The focus of the empirical review is to understand PCP in the context of the English health care system and examine in detail the interaction of PCP at hospital level.

### ***3.3.6 Research Evidence***

Literature from primary evidence sources has been used in the literature search. This includes studies that have applied sociological and scientific research methods.



### **3.3.7 Key terms**

The following key terms have been used with the search, choice, NHS, patient, Health care, impact and consumer. The ‘thesaurus mapping’ feature has been used for these terms allowing the search term to be indexed vocabulary in the databases. Some terms have been searched for as a subject term i.e. not thesaurus mapped. This has enabled a broad search in the first instance which can be narrowed at a later stage.

### **3.3.8 Data Extraction Sheet**

The following sheet was used to capture the essential details of each of the articles

|                   |  |
|-------------------|--|
| Reference: Number |  |
| Author            |  |
| Date              |  |
| Country           |  |
| Title             |  |
| Type of Choice    |  |
| Methodology       |  |
| Impact of Choice  |  |

This information has subsequently been summarised and collated into a literature review table.

### **3.3.9 Search Approach**

Each of the databases was searched separately. This maximised the search results as the thesaurus mapping feature is not consistent across databases and could have excluded valid results.

Each term was searched for separately and as the results were derived these were combined together to distil the results

Figure 3.2 – Search steps

|               |  |
|---------------|--|
| <b>Step 1</b> | <b>Search for ‘ Patient’</b>   |
| <b>Step 2</b> | <b>Search for ‘Choice’ (Choice behaviour returned in some databases)</b> |
| <b>Step 3</b> | <b>Search for ‘Healthcare’ and ‘Health and Care’</b>                     |
| <b>Step 4</b> | <b>Search for NHS</b>  |
| <b>Step 5</b> | <b>Search for Consumer</b>   |
| <b>Step 6</b> | <b>Use ‘or’ statement to combine ‘patient’ and ‘consumer’ results</b>    |
| <b>Step 7</b> | <b>Combine from Step 6 with Choice</b>                                   |
| <b>Step 8</b> | <b>Combine results 7 with Healthcare and Health and Care</b>             |
| <b>Step 9</b> | <b>Combine results from Step 8 with ‘ NHS’ results</b>                   |

### ***3.3.10 References Scanning***

The research reviewed additional publications found in the reference lists of selected articles.

### ***3.3.11 Quality Assessment***

The quality assessment of each article and study reviewed is based on a number of parameters. Firstly, the method of data collection used and how appropriate this is for the context of the study. This method should also be clearly documented in the article to ensure that it can be replicated. Secondly, an understanding of how the findings have been interpreted and whether these derive logically from the research question. It is important for a study to understand its own limitations and the implications that the study has for both theory and practice.

## **3.4 Search Results**

### ***3.4.1 Search Results by Database***

The table below summarises the results obtained from each of the databases that were searched.

Figure 3.3 – Results by Database Search

| Search Step   | Articles by Database |           |           |           |           |                  |              |
|---|----------------------|-----------|-----------|-----------|-----------|------------------|--------------|
|   | PsycINFO             | HMIC      | Medline   | Cinahl    | Escbo     | Web of Knowledge | Econlit      |
| 1. 'Patient'  | 58062                | 43354     | 43505     | 104235    | 65932     | <100000          | <b>1583</b>  |
| 2. 'Choice' (Choice behaviour)                                    | 10001                | 5821      | 23728     | 14439     | 124971    | 13263            | <b>64624</b> |
| 3. 'Healthcare' and 'Health and Care'                             | 58726                | 59275     | 25011     | 95023     | 2054      | 7617             | <b>23</b>    |
| 4. NHS  | 24737                |           | 11696     | 10585     | 7313      | 6053             | <b>255</b>   |
| 5. Consumer   | 15846                | 5229      | 56940     | 1060      | 552052    | 10753            | <b>37059</b> |
| 6. Use 'or' statement to combine 'patient' and 'consumer' results | 73844                | 46840     | 1063257   | 109295    | 614249    | <10000           | <b>11696</b> |
| 7. Combine from Step 6 with Choice                                | 993                  | 2499      | 2035      | 1269      | 1267      | 36366            | <b>137</b>   |
| 8. Combine results 7 with Healthcare and Health and Care          | 344                  | 221       | 1386      | 141       | 206       | 105              | <b>0</b>     |
| 9. Combine results from Step 8 with 'NHS' results                 | <b>88</b>            | <b>95</b> | <b>33</b> | <b>21</b> | <b>19</b> | <b>6</b>         | <b>0</b>     |

### ***3.4.2 Refining of Results***

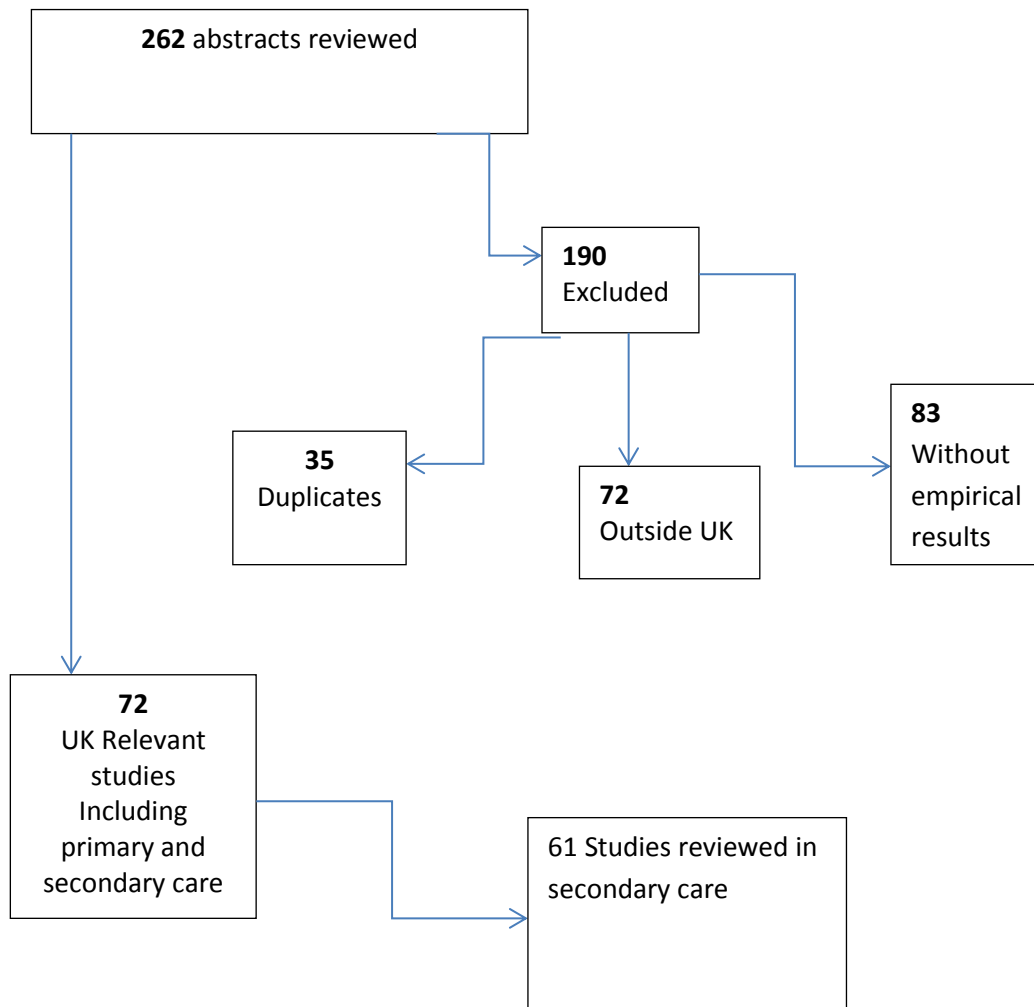
Using the results yielded from step 9 of the search approach 262 abstracts were reviewed in order to identify the relevant empirical studies that supported the investigation of the impact of patient choice within health care.

190 articles were removed for the following reasons;

- Duplicate abstract (35)
- Research outside of the UK (72)
- Studies not reporting empirical results (e.g. policy review) (83)

Upon reviewing the remaining 72 abstracts all were deemed to be relevant to the area of study but some included references to the impact of patient choice in primary care. Once these had been removed 61 studies remained that are included in the review.

Figure 3.4 Results of Abstracts



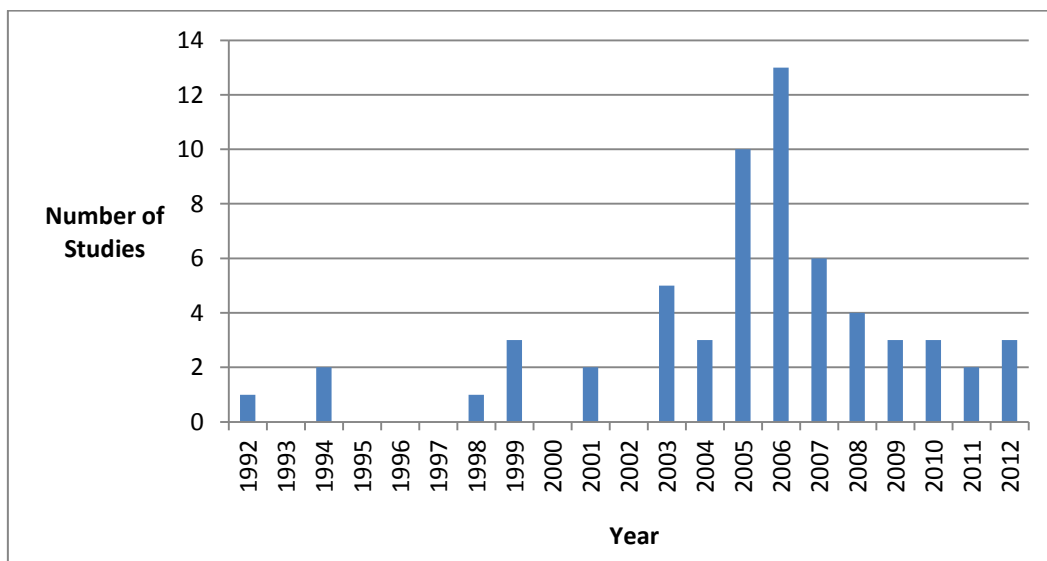
### 3.5 Review of Relevant Literature

#### 3.5.1 Overview of the included studies

The dates of publication of the studies ranged from 1992 to 2012. The table below identifies the studies reviewed by year of publication. The table illustrates a low number of studies (Wiles and Higgins 1992, Jones et al 1994, Mahon et al 1994) taking place before 1998. A large number of studies are clustered from 2003 to 2008. There are also a large number of studies published between 2005 and 2006. Again, this is not surprising given the dominance of the London Patient Choice Pilots between 2000 and 2004.

Whilst the earlier studies have focused upon the impact of PCP on patients and in primary care, the later studies have focused upon the impact of PCP in secondary care (Frosini et al 2012; Peckham 2011; Dixon et al 2010).

Figure 3.5 Studies by Year of Publication



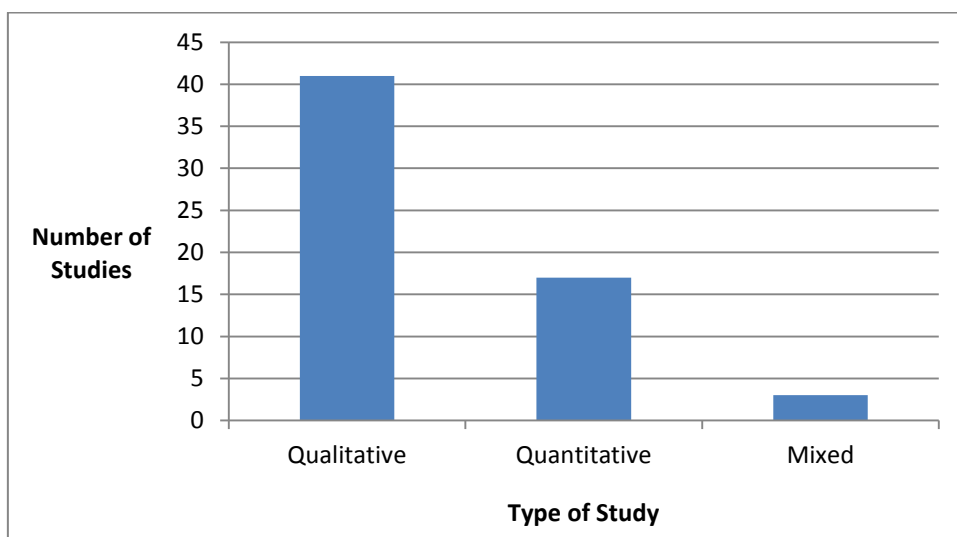
Three separate systematic literature reviews have addressed the impact of PCP in the NHS. The first review, undertaken by Goddard and Hobden (2003), sought to review and synthesise the experience of patient choice across a range of health care systems, namely Europe, New Zealand and Australia, in order to inform the development of policy in the NHS. The second major literature review was undertaken by Fotaki et al (2005). The report was produced for the National Co-ordinating Centre for the NHS Service Delivery and Organisation R&D (NCCSDO). The scoping review undertook an extensive analysis of the literature, set up expert panel workshops and used the knowledge of research team members. The review was synthesised around three key indicators, quality, efficiency and equity. The third and most recent systematic review was conducted by Jones and Mays (2009). This review focused on the impact of patient choice of provider policy in the English NHS and assessed the benefits as proposed by the government. The review also identified critics of the policy and highlighted their concerns.

### ***3.5.2 Research Methods***

The research methods adopted by the studies reviewed have varied. The figure below identifies the type of study by methodology. Many of the studies (67%) used qualitative methods to undertake their research. These methods included focus groups, interviews, observational studies and questionnaires.



Figure 3.6 Studies by method type



### ***3.5.3 Geographical Spread***

Over a third of the studies (36%) covered large geographical areas the English population. A smaller number (6%) covered the U.K. Over half (52%) of the studies reviewed were undertaken in London. The evidence reviewed illustrates a London bias and raises a number of challenges in terms of the ability to generalise findings across the NHS.

### ***3.5.4 Aims of studies***

The studies covered a range of aims. Patients' perception of choice has been addressed in a limited number of studies. A larger number of studies have explored the factors that are required to facilitate choice e.g., the type of information required and how this might be used.

A further sub set of studies have explored the impact that patient choice has had. These studies have investigated choice from a range of perspectives including the impact on patients, GPs and providers.

Figure 3.7 – Studies by Aim of Research

| <b>Aim</b>  | <b>Number of Studies</b> | <b>Study</b>  |
|---|--------------------------|---|
| <b>Patients perception of Choice</b>              | 7                        | Barnet et al (2008)<br>Mori (2004)<br>Health link (2006)<br>Ellins et al 2005)<br>Mori (2006)<br>Wallace and Taylor-Gooby (2009)<br>Dowding and John (2011)                               |
| <b>Identifying factors that influence choices</b> | 12                       | Lothian and Philip (2001)<br>Goddard and Hobden (2003)<br>Fotaki et al (2005)<br>Dawson et al (2006)<br>Spurgeon et al (2006)<br>Propper et al (2005)<br>Warwick (2007)<br>Propper (2002) |

|  |    |  |
|--|----|--|
|  |    | <p>Dealey (2005)</p> <p>Propper (2006)</p> <p>Miller and May (2006)</p> <p>Wallace and Taylor-Gooby (2009)</p> <p>Laverty et al (2012)</p> <p>Dowding and John (2011)</p> <p>Jones and Mays (2009)</p>   |
| <b>Information to support choice</b>                           | 14 | <p>Magee et al (2003)</p> <p>Ogden et al (2008)</p> <p>Coulter et al (1999)</p> <p>Henwood et al (2003)</p> <p>Thorlby (2006)</p> <p>Boyce et al (2010)</p> <p>Abbott et al (2006)</p> <p>Fotaki (1999)</p> <p>Health link (2004)</p> <p>Elmslie (1999)</p> <p>Feeney et al (2005)</p> <p>Finch et al (2008)</p> <p>Douglas et al (2005)</p> <p>Laverty et al (2012)</p> |
| <b>Impact of patient choice on doctor patient relationship</b> | 10 | <p>Doherty and Doherty (2005)</p> <p>Jones et al (1994)</p> <p>Earwicker and Whynes (1998)</p>   |

|  |    |  |
|--|----|--|
|  |    | <p>Longo et al (2006)</p> <p>Ford et al (2006)</p> <p>Edwards and Elwyn (2006)</p> <p>Rosen et al (2007)</p> <p>Mahon et al (1994)</p> <p>Weir et al (2007)</p> <p>Edwards et al (2005)</p>  |
| <b>Patient Satisfaction when exercising choice</b> | 15 | <p>Zaidi et al (2006)</p> <p>Knight (2007)</p> <p>Horrocks et al (2007)</p> <p>Ford et al (2003)</p> <p>Patiar et al 2006)</p> <p>Losina et al (2005)</p> <p>Beresford 2005)</p> <p>Wiles and Higgins (1992)</p> <p>Taylor et al (2004)</p> <p>Caress et al (2005)</p> <p>Lewin and Piper (2006)</p> <p>Jolley (2005)</p> <p>Fotaki et al (2008)</p> <p>Dowding and John (2011)</p> <p>Wallace and Taylor-Gooby (2009)</p> |
| <b>How choice affects providers</b>                | 7  | <p>Fotaki et al (2005)</p> <p>Roberston and Dixon (2009)</p>   |

|  |  |   |
|--|--|---|
|  |  | Dixon et al (2010)<br>Higgins et al (2010)<br>Siciliani and Martin (2006)<br>Greener and Mannion (2008)<br>May and Jones (2009)<br>Frosini et al (2012)<br>Peckham et al (2011) |
|--|--|---|

### 3.6 Thematic Analysis

The studies reviewed are concentrated across two decades. The focus of the research question was to understand the impact of patient choice policy upon secondary care. Whilst retaining a focus on the research question, the studies were reviewed and categorised into the following key themes;

- 1a. Do patients want to exercise choice of provider?
- 1b. What types of patient exercise choice?
- 1c. Is the patient exercising choice or has choice been delegated to another e.g. GP, health care professional, friends and relatives?
  
- 2a. Are patients able to exercise choice of provider?
- 2b. Do patients have enough information to support the choice process and are they able to use this information in helping them to make choices?
- 2c. How do health care professionals help patients choose providers?

3. What factors influence patient choice of provider?

4. What impact does choice have on providers?

Annex 1 outlines the studies categorized by theme.

### ***3.6.1 Do Patients Want Choice of Provider?***

The London Patient Choice Pilots (Dawson et al 2006) found that if offered choice, patients would exercise it. The study found that patients waiting for elective operations when offered a choice they would choose an alternative provider. The success of these pilots was used as the supporting evidence underpinning the rationale to gradually extend the opportunity from 4 or 5 providers to free choice (Department of Health 2005). Not all providers experienced the same level of uptake of choice as in the London Patient Choice Pilots. One provider found that only 5% of patients exercised their right to choose an alternative provider after waiting 6 months for elective surgery (Spurgeon et al 2006). It has been acknowledged that the model for choice underpinning Patient Choice Policy is different from the model piloted in the London Patient Choice Pilots (Dixon et al 2010). The key differences being the absence of advisers and the re-imburement of travel costs. This section explores the wider literature to determine the degree to which patients want choice in health care.

Whilst many of the studies reviewed have shown that patients want to be involved in health care this has not been found in all cases. Lewin and Piper (2006) conducted research within an acute Trust in Cambridgeshire to establish patients' perception of their care and interventions related to empowerment and strengthening patient

choice. A large proportion of respondents (73%) were male with a mean age of 63 years old. The female respondents (27%) had a mean age of 68 years old. 95% of respondents described themselves as of white origin with 94% being born in the U.K. A key finding from the study indicates that almost 90% of the respondents were content to entrust their care exclusively to health professionals based on their confidence in the clinical expertise of the medical and nursing staff. Only five respondents engaged with the notion of a partnership approach between patients and health care professionals, four of the respondents were female. The findings reported high levels of satisfaction from respondents and suggested that in the face of acute illness, patient empowerment became a peripheral concern and was readily abdicated.

A number of national surveys have been conducted to determine the level of choice available and its importance to patients (Mori 2004, Mori 2006). In the 2004 national survey choice in accessing GP services was ranked the highest with half or more feeling they had choice in who they could register with (54%) and their appointment date/time. This contrasts with around a quarter of people who said that they had a choice with their outpatient care/treatment – which hospital they visit (26%) and their appointment date/time (19%). When asked about the importance of choice, the choice of GP appointment date and time was rated the highest. The survey showed that the requirement for choice of GP, choice of provider and also date/time of treatment was important for patients. However, given the option to have choice of hospitals or pay more tax for increased quality in the local NHS provider, patients would opt to pay more taxes. This was the finding from the IPSOS Mori survey

undertaken on behalf of the Healthcare Commission (2006). 1,200 British adults were surveyed in July 2004 and 53% indicated that the option to pay for taxes for improved local services in comparison to 43% who preferred no increase in tax but a choice of hospital anywhere in the UK. Mahon et al (1994) also found that patients preferred their local provider but choose an alternative provider if waiting times were high or there was a need to access specialist health care. This expectation of good quality care from all providers was a consistent finding from a study conducted by Magee et al (2003).

Choice in the context of market reform and competition has created anxiety for some patients who feel that it challenges the traditional values of the NHS (Wallace and Taylor-Gooby 2009). A qualitative study undertaken by Wallace and Taylor-Gooby (2009) found that a quarter of their participants expressed outright hostility to patient choice. Their concerns were two fold, firstly the need to make a choice in the first place as they wanted consistent high quality service provision anyway. Secondly, the potential impact on equity and service provision.

Exercising choice in health care is clearly important to patients and patients have indicated the need to have some involvement in the decisions that are being made. When considering whether patients want choice of provider, it is clear that patients don't want to wait for treatment especially if their condition is worsening (Coulter et al 2006, Surgeon et al 2006). The research in these areas suggests that patients are not behaving as health care consumers and are consequently not seeking out the best hospital. The desire for good quality local service provision was reflected by



many studies (Mahon et al 1994, Magee et al, 2003, Wallace and Taylor-Gooby 2009).

### ***3.6.2 What Types of Patients Exercise Choice of Provider?***

It has been proposed that choice of provider was not priority for all patients and in particular for older people (Fotaki et al 2005). Goddard and Hobden (2003) found that the younger and better educated patients were more willing to exercise choice of provider when the alternatives were more distant. Weir et al (2007) explored whether older people would be receptive to choice and found that choice was very relevant to these participants who valued speed of access to services when specialist care was required. The need for GP advice in supporting the choice process was referenced by many of the groups. The scenario of GP advising on options and the patient then choosing was a model that many participants envisaged as being an effective choice model. The study concluded that the older population was certainly interested in patient choice. They valued the opportunity to choose using GP advice, personal experiences and knowledge from family and friends to help make their choices.

### ***3.6.3 Is the Patient Exercising Choice of Provider?***

The role of the GP is critical in facilitating patient choice of provider. The studies reviewed found that the healthcare professional is required to create an environment within which the patient can exercise choice but in many cases this did not happen.

A range of resources are available to support patients in making choices but a number studies demonstrate that the experience of family and friends and influence

of GPs are amongst the most significant factors that influence the choices that are made (Fotaki et al 2005, Dixon et al 2010. Magee et al 2003). Dixon et al demonstrated that only 4% of patients used the official NHS Choices website to support them in selecting a provider. The study found that patients relied more heavily upon their own experiences (41%) or the advice of the GP (36%) and family/friends (10%) to influence their choices.

Traditionally GPs have acted as gatekeepers to secondary care services (Earwicker and Whyne 1998). The choice of provider decision has rested with the GP. When exploring the factors that influenced GPs when making referrals to secondary care, the study found that GPs were primarily influenced by the special interest of the receiving clinician and length of wait for consultation.

The GP plays a significant role in offering choice of hospital. Many studies have found that very few GPs offer choice of hospital when referring patients for treatment (Mahon et al 1994, Healthcare Commission 2006, Wallace and Taylor-Gooby 2009). Mahon et al (1994) compared the rates of choice being offered over a two year period. They found that only 1 in 10 patients had been offered a choice of hospital by their GP (1991 9.9%: 1992 10.9%) and only 1 in 20 had asked their GP about other hospitals that they could go to (1991 4.7%: 1992 5.4%). It was noted that there was a considerable proportion of patients that did not know which hospital or consultant that they had been referred to (1991 67.6%: 1992 66.6%). This study highlights the influential role played by the GP in enabling patients to exercise choice.

This was confirmed by Ford et al (2006) who demonstrated that the effectiveness of the choice consultation was determined by the consultation skill level of the doctor.

Ford et al reviewed the opportunity for involvement during the consultation and assessed how many times this was exercised by patient and doctor. The results reveal that there were numerous opportunities for patients to be involved in the consultation and the degree to which this was achieved was related to the interpersonal skills of the GP. The study found a number of factors used by patients that would influence whether they had felt involved in the consultation. These included if they had felt respected by the doctor, the level of information shared and the length of the consultation.

#### ***3.6.4 Are patients able to exercise choice of provider?***

The NHS has been described as being 'paternalistic' towards its users (Coulter 1999, Macdonald 2003). The ability of patients to exercise any type of choice in the NHS has been fairly limited with the culture of paternalism perceived to be endemic throughout the NHS. The need to move away from paternalism is acknowledged with the need to engage patients in health care.

“The NHS needs to be less paternalistic and should inform patients to help them make joint decisions,” according to Mr Harry Cayton, the Department of Health's director for patient experience and public involvement”

(Macdonald 2003)

Rosen et al (2007) conducted a study exploring GPs' views on patient choice, the information required to support choice and how GPs would become involved in supporting choice given the pivotal role that they have in this aspect of the health

care process. The study found a variation of views from GPs in the role of advising about choice. 'Choice enthusiasts' definitely saw the role within their remit working in partnership with patients to review options available. At the extreme there were those GPs that felt it was their role to digest the information and make the decision on behalf of the patient. Others felt that patients would not be able to make sense of the information. All participants recognised that the provision of information was significant in the referral process but there was little consensus on what this information should look like recognising the difficulty in measuring clinical outcomes. There was widespread distrust of data produced by NHS organisations about their services and facilities and instead GPs used a wide range of factors such as personal relationships and waiting times to determine where referrals would be sent. The GPs interviewed all acknowledged that in future patients would want to be involved in the process. Some envisaged involving patients by handing over the necessary information and leaving them to work it out, while others suggested that they would actively advise patients.

For choice to be meaningful to patients information is required to enable the differentiation between alternatives (Lunt et al 1996). Studies have found that patients have remained sceptical about choice as they have described the 'appearance of choice' rather than the 'substance of choice' (Barnett et al 2008). The study found that patients felt that they were being asked to make choices but claimed that they were not provided with any information that would allow them to do so. Patients stated that without information how would they know which hospital or doctor was better than another. The study also found that patients were often unable to exercise choice because of the type or volume information that was being

provided. The study found that information provided by GPs was inadequate, not because it was unavailable, rather that there was too much so making it difficult to understand and process. The source of information was also considered to be important by patients. The study found that patients felt that information provided by hospitals would be partial and self-serving. This caused patients to distrust the information and as a result was not considered to be helpful to patients when exercising choice. Magee et al (2003) also found that patients tended to distrust official information and felt that providers would try and show themselves in a positive light. The study found that patients felt that the information may be biased towards hospitals showing the positive aspects only.

The quality of information and the ability of patients to understand were also found to be a problem. A study in South East London (Health link 2006) found that users trying to access maternity services stated that lots of different types of information regarding service provision were available but often not accessible in the correct language. The study found that patients felt unsupported by health care professionals who did not support them in making sense of the information. Although information was available it did not always help patients in making choices as they were unclear about what the information was representing.

The way in which information is presented also affects patients' ability to exercise choice. Boyce et al (2010) acknowledged in their research that decision making within health care was a complex process. In these circumstances the logic of rational decision theory in which individuals make choices that maximises their own interests may be abandoned in favour of intuition to guide their decisions. A key

finding of the study was that the way information was presented influenced the choices made. Participants found it difficult to trade off quality, patient safety and patient experience. Simply putting the information currently held about quality of care into the public domain would not result in making informed choices.

Abbott et al (2006) examined the role of the Patient Advice and Liaison Services (PALS). The results of the study illustrated that the PALS service was effective in providing service users with information. Given its 'insider' status i.e. working from within services, it was able to act as a communication agent between service user and organisation. This role was key to ensuring patient satisfaction with services. The PALS team were described by the study as the equivalent of a customer services department providing a critical link between a service and its users.

PCP requires the patient to change from being passive to becoming an 'informed agent' (Dixon et al 2010). Henwood et al (2003) investigated the role of the 'informed patient' and whether the patient in this role felt supported by the GP in making choices. The study assessed whether patients felt the need to research their condition before they visited the GP. It also found that in most cases participants did not feel they needed to inform themselves before visiting their GP. All respondents used the GP as the first port of call for health advice and information, furthermore the study found that patients expressed trust in their GP and felt that they were able to leave the decision making to them. The study noted that the skills they defined as 'information literacy' were not natural or easily learned by patients. In particular, they referred to such skills as knowing where to find information, information retrieval, understanding the information being provided and subsequently how they would use this to support the health care decision making process. Almost 50% of the

participants had used the internet to access health information. They were not able to reference the source of their information or comment on the credibility of the information provided. The study also found that the experience of those patients that had taken time to research their condition before their consultation with their GP found that their contributions were dismissed or rejected without much discussion. It was noted that patient choice could change the doctor patient relationship where the patient becomes informed and the consultation becomes a partnership. The study found that the provision of information itself would not create this environment and further work was required with both patients and health care practitioners to facilitate the 'informed patient'. For patients to be able to exercise choice they would need to be more actively involved in their health care. This is a change to the existing role that the patient currently has in health care.

When evaluating whether patients are able to exercise choice it is important to consider the provision of services to determine whether realistic choices are available, that is choice is only effective if there is something to choose between. Propper et al (2005) designed a cross sectional study that used routinely collected data to map choice in the NHS. Data such as NHS and Private facilities, patients waiting greater than 6 months for treatment and available beds was used to construct maps to show the location of available services. Electoral ward information was added to determine the population sizes of each segment and calculations were undertaken to determine the travel required for potential patients to available facilities.

The study found that for most patients in England there was a large potential for choice for elective care. The geographical areas of low choice alternatives include most of the south east (outside London) stretching to the coast, East Anglia, an area of South Bristol and Cornwall. To successfully exercise choice of provider, patients need to have providers to choose from. Travel time could be viewed as a potential barrier for patients exercising choice given that they may not be able to fund the cost of the additional travel. The study found that although in theory the potential for patients to exercise choice may exist in practice this may be hindered simply by the patient's inability to afford additional travel costs.

When determining whether patients are able to exercise choice the factors to consider include information availability, the role of the GP and other health care providers and whether real alternatives are available. The studies demonstrate the current information provision to support choice is not used widely by patients. The reasons for this are many including the complexity of the information presented, distrust of patients who perceive that providers may present themselves in a positive light and accessibility of information in terms of different languages. There is still heavy reliance on GPs to support the choices that are being made. In some cases this is reflected in the way the GP behaves and whether they value the concept of choice for patients. In other instances it is a reflection of the behaviour of patients who trust their GPs and rely on them to make the decision. The role of friends and family remains a key influence of patients when exercising choice.



### ***3.6.5 What factors influence patient choice of provider?***

Long waiting times for treatment have been a key influence on patients when exercising choice. Where waiting times for treatment are long patients seek to exercise choice and select alternative providers. The London Patient Choice Project (Dawson et al 2006) is one of the significant studies within this area. The study demonstrated that patients were prepared to travel away from their local provider for treatment if the treatment could be delivered sooner. This was particularly the case for Orthopaedic and cataract procedures. Patients were provided support through a patient care adviser and costs of travel to an alternative provider were also funded for patients that had waited greater than 6 months for their operation. The willingness of patients to choose an alternative provider was significant with many patients accepting the alternatives presented. This was noted again by Patiar (2006) who also demonstrated that patients were willing to use alternative providers if there was a shorter wait.

Consistent with the above findings, Zaidi et al (2006) found that patients treated at a dedicated treatment centre expressed high levels of satisfaction at the speed of access for their treatment. The study found that speedy access to the facility resulted in high levels of satisfaction for patients.

Whilst patients have not been seen to use performance information and clinical outcome information to influence their choices they have been concerned about standards of care. Miller and May (2005) asked participants to rate factors that influenced their choices when choosing a hospital. The results found that high standards of cleanliness were seen as the most important factor.

A number of studies found that patients were concerned about the quality of care, cleanliness of hospital and the standard of facilities. These factors influenced the choices that were made (Healthcare Commission 2006, Robertson and Dixon 2009, Dixon et al 2010).

The ability of services to offer out of hours appointments and weekend appointments was considered another factor that would affect patient choice. Feeney et al (2005) found that patients were keen to see out of hours provision and indicated that this would influence the hospitals that they would choose.

Ease of access to service in terms of location and the ability to use public transport is another factor that appears to have influenced the choice of patients (Horrocks and Coast 2007). A number of studies found that patients wanted to choose high quality local service provision (Taylor et al 2004; Magee et al 2003; Douglas et al 2004; Wallace and Taylor-Gooby 2009).

A study focused specifically on maternity care service provision also found the distance from home was the highest rated factor in their choices when selecting services (Elmslie et al 1999). The results indicated that 59% of women rated distance from home as the key factor influencing their choice with convenience for the family rated second highest by 51%.

Taylor et al 2004 found that patients tended to choose their local hospital. The study found that when patients were asked what had influenced their choices they found that 47% considered waiting times, 68% considered ease of access, 59% considered the reputation of the hospital and 54% considered the information on quality of care. Although waiting times for treatment were considered to be important, this was less

important than ease of access and quality of care. The importance of locality of service provision and ease of access was also found by similar studies (Goddard and Hobden 2003, Dealey 2005).

A number of studies have found that performance and poor quality did not necessarily influence patient choice (Coulter et al 1999, Greener and Mannion 2009; Dixon et al 2010; Lavery et al 2012). Greener and Mannion (2009) found that even with access to performance information which demonstrated poor performance by the local hospital provider, patients continued to choose local service provision rather than exercise choice. Lavery et al (2012) also found that even where hospitals had been involved in investigations related to issues with clinical quality this did not result in patients wanting to switch to alternative providers.

When assessing the factors that affect patient choice the following key factors are considered to be the major influences of patient choice; ease of access, waiting times, clinical quality, standards of care, and the reputation of the hospital and the consultants. In practice many studies have found that even when offered choice patients have preferred to choose their local hospital.

### ***3.6.6 Impact of choice on providers***

Measuring and quantifying the impact of patient choice on providers is a difficult task because PCP is part of a wider reform programme of health care within the NHS. To isolate those attributes that have occurred directly as a consequence of PCP is a challenge. Measuring quality in health care poses a separate challenge and whilst mortality rates and hygiene rates may be indicators, morbidity outcomes are still

widely debated. This section reviews the studies that have researched the impact of PCP to establish its affects if any.

A significant change at an administrative level has been the way hospitals receive referrals and the way in which appointments are booked (Peckham et al 2011). As a result of the introduction of a national electronic system to facilitate the sending of the referral and the way in which appointments were booked for patients, this changed the method of referral to hospitals from GPs. The impact on providers in this context was that providers were required to establish new processes that would support the new ways of working and reconfigure its administrative services to respond to the processes introduced by the system.

A potential consequence of PCP could have been an increase in demand for services which was previously been unmet. As providers deliver improved efficiency and reduce waiting times, GPs would start to refer patients that had previously been held back because of limited access. Dawson et al (2006) undertook a study using the information acquired from the London Patient Choice Project study from 2002 to establish whether demand had increased as a result of the choice initiative. The study found that Orthopaedics was the only service to have demonstrated an increase in demand for service and this additional demand was responded to by an internal increase in capacity rather than shifting to an alternative provider or an increase in waiting time. The study found no evidence to support the notion that there was a high degree of hidden demand within the health care system and that the introduction of patient choice would expose this.

A potential impact of patient choice on providers is that it helps to reduce waiting times. As patients are able to choose between hospitals it is suggested that they will choose providers whose waiting times are lower. As hospitals worked hard to attract patients they would seek out opportunities to improve efficiency and reduced waiting times. This notion was supported by Fotaki et al (2008) who found that a number of providers had used PCP as a lever to improve efficiency of services and reduce waiting times. Siciliani and Martin (2007) undertook an empirical analysis of the impact of choice on waiting times and found that too much choice (greater than 11 hospitals) would have a negative impact upon waiting times. Where the choice was limited to four or five hospitals, choice could lead to a reduction in waiting times. However, there is also evidence to suggest that PCP could increase waiting times (Nagpaul 2012). A review of referrals found that 6.4% of referrals were outside the normal catchment of area hospitals.

There is evidence to suggest that there is tension between PCP and waiting times (Peckham 2011). Hospitals were concerned at delivering the waiting times target and felt that choice could potentially interfere with the patients being treated speedily particularly if they chose to wait for treatment.

Thorlby (2006) investigated the impact that patient choice had on HIV units in London. The right for patients to choose which unit they can be treated in has been routine for some time and existed prior to the recent patient choice policy reforms. In addition to this a payment regime to incentivise providers was also put in place. The study found that staff were aware of the patient's right to move to other units. The

staff also recognised the need for the service to be responsive to the needs to patients. Staff rejected the notion that they were competing for patients and that they were influenced by the fact that patients could choose between units. Staff maintained that their motivation for good quality service was the minimum standard that they aspired to achieve. The senior members of the units were, however, concerned with the potential threat of losing patients and took steps to attract and retain them. This behaviour stemmed from the financial incentives that saw the funding coming directly back into the units. Patients were seen to switch from one provider to another predominantly on account of convenience rather than better quality. However, interviews with senior staff perceived the potential of patients being able to do this as a strong enough incentive for them to consider the level and quality of service that was being provided. The ability for patients to refer themselves directly to the provider seems to be another key element in influencing provider behaviour. The study provides an invaluable insight into a set of conditions within which choice was seen to affect providers and forced them to consider service provision and quality of care.

Other studies have found that the threat of losing patients has generated a limited reaction from providers (Dixon et al 2010; Peckham et al 2011; Frosini et al 2012). The studies in this area have not found significant improvements in service efficiency, significant reduction in waiting times or a huge shift on referral patterns. A study conducted by Dixon et al (2010) found that whilst many hospitals had acknowledged the potential threat of losing patients and were indirectly assessing opportunities to

improve quality there was little evidence that demonstrated an improvement in quality.

Whilst improvements in service efficiency have not been observed, many studies reported that providers have been concerned about their reputations and have made efforts to improve the patient experience (Dixon et al 2010, Jones and Mays 2009).

When trying to assess the lack of response to the threat of losing patients this could be attributed to the fact that many organisations are currently operating near to or at full capacity (Frosini et al 2012). Frosini et al found that the need to deliver waiting times targets has meant that providers are keen to explore ways in which demand can be contained rather than market expansion.

Another reason for the lack of response to PCP may be the provider's reliance on the loyalty of the patient (Dixon et al 2010; Peckham et al 2011; Frosini et al 2012). Each of these studies found that providers have relied on the notion that patients want local service provision and do not want to travel very far for treatment. Whilst new systems and processes have been introduced to support patient choice from a strategic perspective, there has been very little response from providers to threats or opportunities presented by PCP (Peckham 2011).

### **3.7 Discussion**

The evidence presented above generates a range of conclusions when exploring the impact of PCP. When patients are asked whether they would like choice of provider, there are a range studies that demonstrate that they do want to exercise choice.

Having a choice is deemed more important to patients than actually making the decision. The empirical evidence also indicates that there is a difference in what patients want and what they actually do. Although patients express the desire for choice they rarely exercise it when provided with choice. There is a sense that patients want to be a part of the health care process. They want to feel involved but whether this is the same as becoming empowered and making decisions, the evidence has yet to demonstrate.

The reliance on the GP to support choice of provider is identified across a range of studies which recognise the critical role that the GP has in this situation. GPs tend to make choices on behalf of the patient and a number of studies identify that the GP's judgement is often pivotal when making choices.

When determining whether patient choice would be more appealing particular population groups, the studies suggest that choice appeals in some shape or form across the population. The suggestion that older people are less likely to exercise choice is not substantiated by the literature with different findings across different studies.

There remains a theme throughout the literature that although patients want choice, in reality, they would prefer good quality services from their local health care provider. Patients don't really want to travel for health care and only tend to do so if the waiting times are much lower elsewhere, they need specialist care and transport costs are met. This tension in the literature almost suggests that if local health care provision was at an acceptable standard, PCP would have very little impact at all.



The need for information to support patient choice of provider is widely acknowledged. A number of studies have found that patients need information to support choice but when they are presented with it, they mistrust information that is provided by hospitals and government bodies. In practice, patients are relying on the experience of friends and family to determine choice of provider rather than information relating to quality, performance or outcome measures.

When assessing the impact of PCP in providers studies have found that hospitals have yet to respond to the threat of competition for patients. A number of studies show that hospitals appear to be relying on the loyalty of the patient and the ease of access factors that will retain the flow of patients to them. Recent studies indicate that providers are conscious about their reputations and are conscious of the factors that affect patient choices. However, this does not appear to have translated into action being taken to improve quality of services or change the way in which services are delivered.

The studies have found that whilst patients do want choice, exercising choice in practice is difficult for a number of reasons including the provision of information, the availability of alternative easily accessible services and the role of the GP. Similarly, providers have acknowledged patient choice but have not yet responded in way that was anticipated. The consequence of this is that it appears that PCP whilst recognised as a component of modern health policy is it having limited impact on both patients and providers.

### **3.8 Limitations of this review**

This review has focused upon studies within the UK. Models of PCP exist in other health care systems but this review has chosen to focus within the UK. The primary reason is that the focus of the research is to understand the impact of PCP in an NHS hospital trust and as such limited to the scope of the review to comparative environments.

The review has also narrowed the scope of study to patient choice of provider specifically; there are associated concepts such as empowerment, consumerism and consumer behaviour that could provide an insight into understanding choice behaviour that have not been fully explored. This review has not looked at the 'expert patient' literature in any detail. There may be research within this area that links to patients and how their role can be developed to support PCP.

### **3.9 Limitations of included studies**

The studies cited have been careful in documenting the limitations of their work. Only a few of the studies reviewed have made explicit attempts to engage with hard to reach groups e.g. those whose first language is not English and those who had low levels of literacy. Those studies that used a questionnaire approach or in interview technique will have excluded these types of groups by design as the method itself excluded them for participating.

Due to the scale of a number of the studies, it is difficult to determine whether the findings would be characteristic of the standard population and whether there are

other factors that have influenced the results. As previously stated, the studies undertaken show a southern bias, particularly in and around London. This geographical bias may pose difficulty when extrapolating the findings across the wider population.

### **3.10 Gaps in the literature**

The relationship between health care professional and patient has been explored at some detail within the literature. The area that requires further scrutiny is whether clinician to clinician relationships have been affected. GPs have tended in the past to refer to named clinician based on personal relationships, special interests and past referrals. It would be interesting to explore whether the choice process had affected relationships between primary and secondary clinicians e.g. more generalised referral patterns, patient influence or system barriers.

As previously discussed there is little empirical research that has focused on the impact of choice within a secondary/ tertiary care setting. The studies conducted by Dixon et al (2010) and Peckham et al (2011) are perhaps the most comprehensive which have explored the health economy impact of PCP. However, their exploration of the provider perspective has been limited to perceptions of staff within these organisations and has not been set against the theoretical framework of hospitals as organisations.

A number of studies found the impact of choice on providers have been limited. The studies have not provided sound evidence to suggest that PCP does improve service provision or increases responsiveness to patients' needs. It is yet to be evidenced

that PCP will stimulate hospitals in the manner that it was designed to by creating competition between providers, allowing patients to make rational choices which will lead to the selection of high performing providers. This would lead to poor performing hospitals being faced with losing patients and either having to improve care standards or where they cannot they will no longer be viable.

### **3.11 Implications of the evidence on the proposed study**

The empirical evidence reviewed has found that PCP is understood at policy level by patients, primary care and secondary care. The evidence highlights that whilst PCP is important to patients this is balanced against the desire to receive high quality local service provision. The literature demonstrates that the information required to help patients make choices is limited and that often patients will mistrust the published information and rely on the advice of the GP, friends and family. This study will build on the findings from the study conducted by Thorlby (2006), Dixon et al (2010) and Peckham et al (2011). Thorlby (2006) provided an insight into PCP and hospital behaviour when faced with patients with HIV being the opportunity to be treated at a centre of their choice. The study demonstrated that a few of the centres were aware of the 'patient choice' factor and explicitly considered how they would attract and retain patients. This study was conducted in a very specific context, in which patients directly accessed services and where the centre was able to see income directed back into local budgets. The study found evidence of provider response to patient choice and a concern by centres that they might lose patients. Even within this context, the evidence to support improved quality of service was hard to determine.

Dixon et al (2010) provided a comprehensive view of the impact of PCP across four health economies with perspectives of patient choice being obtained from the patient, GP and provider. The study found that within hospitals at a managerial and strategist level there was an acknowledgement of the potential impact that PCP may have. However, the study indicated little evidence of hospitals taking action as a consequence of this.

Peckham et al (2011) evaluated the construction and implementation of PCP across the UK and found evidence of impact in hospitals at an operational level but limited impact at a cultural and strategic level.

This study will build on the findings from the previous studies and will undertake a detailed case study within a hospital setting with a particular focus on the hospital as an organisation. The study will explore whether the impact of PCP in the hospital is consistent with the evidence presented. The study will use organisation behaviour theory to understand how the hospital has responded and how organisational culture and culture change theory can help to deconstruct the hospitals response to PCP. The literature review has found that the implementation of PCP in the NHS has been difficult and that its impact has been limited for both patients and hospitals. Given that PCP remains a critical component of current health policy it is important to determine what has influenced its impact.

### Annex 3.1 – Studies categorised by theme

| Ref No: | Author(s)   | Date | Title   | Location | Method/<br>Approach   | Type of Choice               | Theme  |
|---------|-------------|------|---|----------|---|------------------------------|--|
| 001     | Zaidi et al | 2006 | Raising the benchmark for the 21st Century- the 1000 cataract operations audit and survey: outcomes, consultant supervised training and sourcing NHS choice | London   | Questionnaire assessing patient satisfaction in addition to reviewing clinical outcomes | Choice of treatment provider | 4. Impact of choice on providers                     |
| 002     | Knight      | 2007 | Change management in cancer care: a one stop gynaecology clinic   | Somerset | Redesign of a cancer pathway to speed up decisions points and reduce anxiety levels     | Choice of appointment        | 3. Factors influencing patient choice of provider    |
| 003     | Magee et al | 2003 | Public views on health care performance indicators and patient choice   | England  | Focus group discussions across a variety of locations across the NHS                    | Choice of treatment provider | 2. Are patients able to exercise choice of provider? |

|     |                      |      |  |                 |  |                              |   |
|-----|----------------------|------|--|-----------------|--|------------------------------|---|
| 004 | Horrocks et al       | 2007 | Patient Choice: an exploration of primary care dermatology patients' values and expectations of care                                   | England         | Qualitative study supported by randomised controlled trial information | Choice of treatment provider | 3 Factors influencing patient choice of provider  |
| 005 | Ford S               | 2003 | What are the ingredients for a successful evidence based patient choice consultation?  | Oxford          | A qualitative study based on interviews                                | Choice of treatment          | 2. Are patients able to exercise choice of provider?  |
| 006 | Doherty and Doherty  | 2005 | Patient preferences for involvement in clinical decision making within secondary care and the factors that influence their preferences | Cheltenham      | Qualitative interviews   | Choice of treatment          | 2. Are patients able to exercise choice of provider?<br><br>3. Factors influencing patient choice of provider |
| 007 | Earwicker and Whynes | 1998 | General Practitioners referral thresholds and choices of referral destination: an  | Nottinghamshire | Qualitative study  | Choice of treatment          | 2. Are patients able to exercise choice of provider?  |

|     |             |      |   |                      |                                 |                     |  |
|-----|-------------|------|---|----------------------|---------------------------------|---------------------|--|
|     |             |      | experimental study  |                      |                                 |                     |  |
| 008 | Longo et al | 2006 | Involving patients in primary care consultations: assessing preferences using discrete choice experiments | South Wales          | Qualitative study               | Choice of treatment | 2. Are patients able to exercise choice of provider?   |
| 009 | Ford et al  | 2006 | Observing decision making in the general practice consultation: who makes the decisions                   | Oxfordshire          | Qualitative Observation studies | Choice of treatment | 2. Are patients able to exercise choice of provider?   |
| 010 | Health link | 2006 | Taking soundings on maternity choice – A consultation with women in South East London                     | London               | Qualitative interviews          | Choice of provider  | 2. Are patients able to exercise choice of provider?   |
| 011 | Fotaki      | 1999 | The impact of market orientated reforms on choice and information   | London and Stockholm | Qualitative interviews          | Choice of provider  | 2. Are patients able to exercise choice of provider?<br><br>4. Impact of patient choice on providers |



|     |                   |      |  |             |                                      |                              |   |
|-----|-------------------|------|--|-------------|--------------------------------------|------------------------------|---|
| 012 | Edwards and Elwyn | 2006 | Inside the box of shared decision making: distinguishing between the process of involvement and who makes the decision | England     | Telephone semi structured interviews | Choice of treatment          | 1. Do patients want choice of provider?   |
| 013 | Thorlby           | 2006 | Where the patient was king<br><br>A study of patient choice and it effect on five specialist HIV units in London       | England     | Face to face interviews              | Choice of treatment provider | 1. Do patients want choice of provider?<br><br>4. Impact of choice on provider on providers |
| 014 | Rosen et al       | 2007 | An anatomy of GP referral decisions  | England     | Qualitative study                    | Choice of treatment          | 2. Are patients able to exercise choice of provider?  |
| 015 | Ellins et a       | 2005 | How engaged are people in their health care?   | England     | Quantitative Telephone survey        | Choice of treatment          | 1. Do patients want choice of provider?   |
| 016 | Patiar et al      | 2006 | Patient satisfaction with NHS elective   | Basingstoke | Quantitative                         | Choice of treatment          | 1. Do Patients want choice of   |

|     |              |      |  |            |                           |                               |   |
|-----|--------------|------|--|------------|---------------------------|-------------------------------|---|
|     |              |      | tonsillectomy outsourced to the private sector under the patient choice programme  |            | Questionnaire             | provider                      | provider?<br>4. Impact of patient choice on providers   |
| 017 | Losina et al | 2005 | Offering Patients the Opportunity to Choose their hospital for total knee replacement: Impact upon satisfaction with the surgery | England    | Qualitative Questionnaire | Choice of treatment provider  | 1. Do patients want choice of provider?   |
| 018 | Ogden et al  | 2008 | The value of choice: a qualitative study.  | Surrey     | Qualitative study         | Choice of treatment /provider | 1. Do patients want choice of provider?<br><br>3 Factors influencing patient choice of provider |
| 019 | Barnett et   | 2008 | The value of choice: a   | South East | Semi structured           | Patients' perception          | 1. Do patients want choice of   |

|     |                   |      |   |                   |  |  |   |
|-----|-------------------|------|---|-------------------|--|--|---|
|     | al                |      | qualitative study   | England           | interviews   | of the definition of choice  | provider?<br>2. Are patients able to exercise choice of provider?   |
| 020 | Coulter et al     | 1999 | Informing patients: An assessment of the quality of patient information materials           | England           | Focus groups   | Choice of information to support treatment decisions   | 2. Are patients able to exercise choice of provider?<br>3. Factors influencing patient choice of provider |
| 021 | Health link       | 2004 | Taking the soundings. A patient and public involvement in the London Patient Choice Project | London            | Face to face interviews<br>Semi structured interviews<br>Surveys | A view from organisations supporting hard to reach groups on what elements of choice their patients would want | 1. Do patients want choice of provider?   |
| 022 | Wiles and Higgins | 1992 | Study of patients who choose private healthcare for treatment                               | Wessex<br>England | Questionnaire Survey   | Choice of private health care  | 3. Factors influencing patient choice   |

|     |              |      |  |                    |  |   |  |
|-----|--------------|------|--|--------------------|--|---|--|
|     |              |      |  |                    |  |   | of provider  |
| 023 | Jones et al  | 1994 | Monitoring changes in health services for older people                         | South Wales        | Postal questionnaire<br>Interviews                               | Choices in participating in the decision making process | 2. Are patients able to exercise choice of provider?   |
| 024 | Mahon et al  | 1994 | Choice of hospital for elective surgery referral: GP's and patients' views     | North West England | Surveys with patients<br>Survey with GPs'<br>Interviews with GPs | Choice of hospital                                      | 2 Are patients able to exercise choice of provider?  |
| 025 | MORI         | 2003 | Patient Choice in Birmingham, Solihull and The Black Country                   | England            | Qualitative and quantitative                                     | Choice of provider, demand for choice                   | 1. Do patients want choice of provider?  |
| 026 | Taylor et al | 2004 | Implications of offering 'Patient Choice' for routine adult surgical referrals | England            | Randomised control trail   | Choice or treatment provider                            | 1. Do patients want choice of provider?<br><br>3. Factors influencing patient choice of provider |

|     |                    |      |   |            |   |  |  |
|-----|--------------------|------|---|------------|---|--|--|
| 027 | Higgins et al      | 2010 | Exploring the development of the relationship marketing in the National Health Service: An empirical analysis of supplier – purchaser relationships in a quasi-market environment | England    | Quantitative Survey   | Customer focused relationship marketing                      | 4. Impact of patient choice on providers             |
| 028 | Emslie et al       | 1999 | Developing consumer led maternity services: a survey of women's views in a local health care setting  | Scotland   | Postal questionnaire/<br>Interviews<br><br>Qualitative and quantitative | Choice of location, choice of clinician, choice of treatment | 3. Factors influencing patient choice of provider    |
| 029 | Lothian and Philip | 2001 | Maintaining the dignity and autonomy of older people in the health care setting   | England    | Qualitative review of literature  | Choice of treatment  | 2. Are patients able to exercise choice of provider? |
| 030 | Henwood et al      | 2003 | Ignorance is bliss sometimes: Constraints on the emergence of the informed patient in changing landscapes of health information   | Brighton   | Qualitative interviews  | Choice of treatment  | 2. Are patients able to exercise choice of provider? |
| 031 | Feeney et al       | 2005 | Do medical outpatients want out of hours  | Nottingham | Quantitative Questionnaire survey                                       | Choice of appointment  | 3. factors that influence patient choice             |

|     |              |      |  |                    |  |   |   |
|-----|--------------|------|--|--------------------|--|---|---|
|     |              |      | clinics?   |                    |  |   | of provider   |
| 032 | Weir et al   | 2007 | Expanding choice options for older patients in relation to practice based commissioning: a qualitative study of older patients in a small GP surgery | London             | Qualitative Focus Groups                             | Choice of access/ treatment/ provider                       | 1. Do patients want choice of provider?   |
| 033 | Finch et al  | 2008 | Future patients? Telehealthcare, roles and responsibilities  | U.K.               | Qualitative In depth semi structured interviews      | Choice of consultation /treatment method                    | 2. Are patients able to exercise choice of provider?                                    |
| 034 | Caress et al | 2004 | Involvement in treatment decisions: what do adults with asthma want and what do they get? Results of a cross sectional survey                        | North West England | Quantitative Survey                                  | Choice of treatment   | 1. Do patients want choice of provider?   |
| 035 | Dawson et al | 2006 | The impact of patient choice and waiting time on the demand for health care: results from the London Patient Choice Project                          | London             | Quantitative review of demand data and waiting times | Evaluation of the choice project and its impact upon demand | 1. Do patients want choice of provider?<br><br>4. Impact of patient choice on providers |

|     |                 |      |  |              |                                     |  |  |
|-----|-----------------|------|--|--------------|-------------------------------------|--|--|
| 036 | Propper et al   | 2005 | Mapping choice in the NHS: a cross sectional study of routinely collected data                           | England      | Quantitative cross sectional survey | To identify where in England there were likely to be constraints on choice of hospital for patients waiting longer than six months for elective care | 2. Are patients able to exercise choice of provider? |
| 037 | Douglas et al   | 2005 | Rheumatology patient preferences for timing and location of outpatient clinics                           | Birmingham   | Qualitative Questionnaire           | The study wanted to identify patient preferences for times and locations of their outpatient appointments  | 3 factors that influence patient choice of provider  |
| 038 | Lewin and Piper | 2006 | Patient Empowerment within a coronary care unit: Insights from health professionals drawn from a patient | Peterborough | Qualitative Questionnaire           | To evaluate patient empowerment and the strengthening  | 1. Do patients want choice of provider?              |

|     |                      |      |  |               |   |   |   |
|-----|----------------------|------|--|---------------|---|---|---|
|     |                      |      | satisfaction survey  |               |   | g of patient choice in the coronary care unit patients  |   |
| 039 | Siciliani and Martin | 2006 | An empirical analysis of the impact of choice on waiting times | England       | Quantitative analysis on a number of attributes | To determine the impact that choice would have on hospital waiting times  | 3 factors that influence patient choice of provider<br><br>4. Impact of choice on providers |
| 040 | Warwick P            | 2007 | Back to the future in NHS reform                               | County Durham | Qualitative case study                          | To identify how the current reforms differ from the mid 1990's when competition was previously discussed in the NHS | 4. Impact of choice on providers  |



|     |                     |      |  |                        |  |  |  |
|-----|---------------------|------|--|------------------------|--|--|--|
| 041 | Greener and Mannion | 2009 | Patient Choice in the NHS: What is the effect of choice policies on patients and relationships in healthy economies    | West Yorkshire         | Qualitative case study                       | To determine how a provider organisation interpreted patient choice policy and how it then responded | 4. Impact of choice on providers                     |
| 042 | Propper et al       | 2001 | Waiting times for hospital admissions: the impact of GP fundholding  | North West Anglia      | Quantitative review of hospital episode data | To determine the impact GP fundholding had on hospital waiting times                                 | 4. Impact of patient choice on providers             |
| 043 | Abbott et al        | 2006 | Patient Advice and Liaison Services: strengthening the voices of individual service users in health care organisations | London                 | Longitudinal qualitative study               | To understand how PALs interact with service users   | 2. Are patients able to exercise choice of provider? |
| 044 | Edwards et al       | 2005 | Shared decision making and risk communication in practice: a qualitative study of GPs                                  | Gwent Health Authority | Qualitative interviews                       | The study looked how risk communicat   | 2. Are patients able to exercise choice of           |

|     |               |      |   |             |                                     |   |  |
|-----|---------------|------|---|-------------|-------------------------------------|---|--|
|     |               |      | experiences   |             |                                     | ion training could help in the shared decision making process   | provider?  |
| 045 | Jolley S      | 2005 | Single rooms and patient choice   | Nottingham  | Qualitative interviews              | To identify how single rooms were allocated to patients and determine how much of this was influenced by patient choice | 4. Impact of patient choice on provider              |
| 046 | Propper et al | 2007 | Impact of patients socioeconomic status on the distance travelled for hospital admission in the English National Health Service | England     | Quantitative evaluation of HES data | To establish the degree to which patients would travel for treatment  | 3. factors that influence patient choice of provider |
| 047 | Fotaki et al  | 2008 | What benefits will choice bring to patients? Literature review and an assessment of the   | UK, EU, USA | Qualitative literature review       | To assess the demand for patient choice   | 1. Do patients want choice of provider?              |

|     |                |      |  |         |                               |  |  |
|-----|----------------|------|--|---------|-------------------------------|--|--|
|     |                |      | implications   |         |                               |  | 3. factors that influence patient choice of provider |
| 048 | Dealey C       | 2005 | The factors that influence patients choice of hospital and treatment                   | UK      | Qualitative literature review | To determine the factors that are affecting patient choice   | 3. factors that influence patient choice of provider |
| 049 | Miller and May | 2006 | Patient Choice in the NHS. How critical are facilities in influencing patient choice   | England | Qualitative focus groups      | To determine the factors that affected patient choice  | 3. Factors that influence patient choice             |
| 050 | Boyce et al    | 2010 | Choosing a high quality hospital. The role of nudges, scorecard design and information | London  | Qualitative focus group       | What information do patients want when choosing a hospital?<br><br>What is important to patients when choosing a hospital? | 2. Are patients able to exercise choice of provider? |

|     |                     |      |  |         |                               |   |  |
|-----|---------------------|------|--|---------|-------------------------------|---|--|
|     |                     |      |  |         |                               | Do people learn how to make better decisions?   |  |
| 051 | Roberston and Dixon | 2009 | Choice at the point of referral: Early results of a patient survey | England | Questionnaire                 | The study analysed the experience of patients when a referral was made and how they chose their hospital                  | 2. Are patients able to exercise choice of provider?<br><br>3. Factors that influence choice of provider |
| 052 | Dixon et al         | 2010 | Patient Choice:<br>How patients choose and how providers respond   | England | Questionnaires and interviews | How do patients experience choice<br><br>What factors influence<br><br>The role of the GP<br><br>How providers respond to | 3. Factors that influence choice of provider<br><br>4. Impact of patient choice on provider              |

|     |                          |      |  |                    |  |  |  |
|-----|--------------------------|------|--|--------------------|--|--|--|
|     |                          |      |  |                    |  | choice   |  |
| 053 | Frosini et al            | 2012 | Competition in the NHS: a provider perspective   | England            | Semi structured interviews   | To analyse how the NHS has experienced competition in the NHS  | 4. Impact of patient choice on provider      |
| 054 | Wallace and Taylor Gooby | 2009 | New Labour and reform of the English NHS:  | South East England | Qualitative interviews   | To explore how users perceive and respond to the market reforms within the NHS                       | 1. Do patients want choice of provider?      |
| 055 | Laverty et al            | 2012 | High profile investigations into hospital safety problems in England did not prompt patients to switch providers | England            | Quantitative data analysis of Hospital Episode Statistics (HES) data | To determine if hospitals that had been investigated for safety problems would affect patient choice | 3. Factors that influence choice of provider |
| 056 | Dowding and John         | 2011 | Voice and Choice in Health Care in England   | England            | Quantitative survey data (from a five year                           | To understand  | 3. Factors that influence choice             |

|     |                |      |   |         |  |  |   |
|-----|----------------|------|---|---------|--|--|---|
|     |                |      | : Understanding Citizen Responses to Dissatisfaction  |         | on line survey)                        | how voice and choice mechanisms interact in the context of recent public policy  | of provider<br><br>4. Impact of patient choice on provider  |
| 057 | Peckham et al  | 2012 | A comparative study of the construction and implementation of patient choice policies in the UK | UK      | Qualitative multiple case study design | To examine the content and practice of the patient choice policies in the four countries and assess their impact on health system performance and responsiveness to patients | 2. Are patients able to exercise choice of provider?<br><br>3. Factors that influence choice of provider<br><br>4. Impact of patient choice on provider |
| 058 | Spurgeon et al | 2006 | Piloting the uptake of patient choice in a single Trust   | England | Quantitative                           | To compare the differences between those patients that   | 3. Factors that influence choice of provider  |

|     |                    |      |   |                                    |             |   |   |
|-----|--------------------|------|---|------------------------------------|-------------|---|---|
|     |                    |      |   |                                    |             | exercised choice with those that declined   |   |
| 059 | Goddard and Hobden | 2003 | Patient Choice – A review   | Europe, New Zealand, and Australia | Qualitative | To review and synthesise the experience of patient choice across a range of health care systems   | 3. Factors that influence choice of provider  |
| 060 | Fotaki et al       | 2005 | Access to Healthcare Patient Choice and the Organisation and Delivery of Health Services: Scoping Review. | England                            | Qualitative | To review three key indicators of quality, efficiency and equity in the context of patient choice | 2. Are patients able to exercise choice of provider?<br><br>4. Impact of patient choice on provider |
| 061 | Jones and Mays     | 2009 | Systematic Review of the impact of patient choice on provider in the English NHS                          | England                            | Qualitative | The impact of patient choice of provider in the English   | 4. Impact of patient choice on provider   |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
|  |  |  |  |  |  | NHS and<br>assess the<br>benefits as<br>proposed by<br>the<br>Government |  |
|--|--|--|--|--|--|--|--|



## **Chapter 4: Understanding the culture of hospitals and cultural change**

### **4.1 Introduction**

Hospitals are long standing and enduring social institutions that can present particular challenges for health care reform (Mickan and Boyce 2007). The structure and configuration of hospitals have been viewed as literally immovable and a reflection of the enduring institutional and cultural practices of previous generations of health care professionals (McKee and Healy 2000). The previous chapters have focussed on the evolution of Patient Choice Policy (PCP) and a review of the impact that it has had upon providers. The programme theory underpinning PCP proposes that the fear of competitors within the market will be one of the levers that will drive a change in behaviour from hospitals. In practice, the empirical research has shown that hospitals have changed very little in response to PCP. The context of PCP focusses on external factors to incentivise providers and it does little to consider the culture of the hospital and how it behaves and a consequence how this might affect the success of PCP.

The purpose of this chapter is to use the lens of organisational culture theory to explore how hospitals behave as complex and dynamic organisations and in doing so consider how this may be important to how PCP has been received by the hospital. To set the scene, the first section explores the evolution of theories with regard to organisation culture, outlines the rival definitions of organisation culture that have been developed in the literature and introduces some of the conceptual underpinnings of this contested concept. The second section addresses the theories

of culture change in the hope to offer insight on how organisational cultures can be changed. The final section explores the cultures of hospitals and how these might be purposefully managed and changed. This is of particular interest as PCP requires hospital culture to change and in particular to become more responsive to the needs of its patients.

## **4.2 Evolution of Organisation Culture theory**

### ***4.2.1 Origins and Development of Organisational Culture***

The concept of organisational culture has attracted much attention in the management, business and sociology literature over recent decades (Peter and Waterman 1982, Kotter and Heskett 1992, Davies et al 2007). It has increasingly been viewed as a lever for stimulating improvement in quality and performance in health care systems (Department of Health 2000).

The term 'culture' is derived from the Latin (*cultura*, to cultivate or till), meaning to attend to animals or tend to crops (Williams, 1983). In the 19<sup>th</sup> century, the term evolved to refer first to the betterment or refinement of the individual, especially through education, and then to the fulfilment of national aspirations or ideals. In the mid-19<sup>th</sup> century, the term "culture" was used by some social scientists to refer to a universal human capacity (Boundless, 2014). This defined culture in terms of the human capacity to classify and represent experiences in terms of symbols. In the 20<sup>th</sup> century culture became a central concept within the discipline of social anthropology. Culture was described the range of human phenomena that cannot be attributed to genetic inheritance (Boundless 2014).

The term organisational culture first appeared in the academic literature in 1979 in an article by Pettigrew (Scott et al 2003). However, the cultural aspects of organisation have been the subject of much earlier study. The Hawthorne studies conducted between 1927 and 1932 examined the effect of different levels of lighting on the productivity of employees within the workplace and concluded that people at work were motivated by more than pay and conditions. They also suggested that individuals sought recognition and a sense of belonging within the workplace (Huczynski and Buchanan 1991). The contribution of this approach has been described by some as a watershed in management thinking which has laid the foundation for a people centred view of management and organisations (Huczynski 1992).

It was, however, in the 1980's that culture entered into mainstream management thinking through the works of a number of US authors (Peters and Waterman 1982; Deal and Kennedy, 1982). These books claimed that culture was a key determinant of organisational performance and proposed that organisations that had strong cultures were high performing. Whilst these claims created controversy and contestation (especially as some of the successful companies began to experience performance problems) the notion that culture is an important aspect of organisation success gained hold. The interest in the concept of culture is linked to the view that the management of change requires attention to cultural phenomena in organisations; in particular where radical change is required this would suggest the need for a cultural revolution rather than evolution (Demers, 2007).

#### ***4.2.2 Defining Organisational Culture***

Despite the vast amount of literature on organisational culture consensus of opinion has yet to be reached on the definition of organisation culture (Davies et al 2000). The complexity in understanding organisational culture relates to the variation of perspectives from researchers in terms of how they each define 'organisation' and 'culture'. As Hatch (1997) notes organisational culture is perhaps the most difficult of all organisational concepts to define. The complexity of the concept can be illustrated through the fact that in 1952, Kroeber et al identified 164 alternative definitions of culture (Kroeber et al 1952).

A colloquial definition describes culture as the way we do things around here (Schein 1985). Although approaches differ in their foci and emphasis organisational culture can be characterised broadly as the shared values, beliefs, attitudes and behaviours of individuals and collectives (Morgan 2000, Brown 1995).

“Culture ... is a pattern of beliefs and expectations shared by the organisation’s members. These beliefs and expectations produce norms that powerfully shape the behaviours of individuals and groups in the organisation.”

(Schwartz & Davis 1981:33)

The concept of 'organisational climate' adds a further layer of complexity when attempting to define culture and a long standing academic debate remains as to the differences between the two (Bellot 2011). As with organisational culture, organisational climate is equally difficult to define. A definition of organisational

climate is to consider it as the way individuals perceive, see and feel about organisational culture (Armstrong, 2009). Whilst both climate and culture have much in common, they are different concepts with their roots from two different domains; Culture has its roots in anthropology whereas climate is grounded in psychological process and theories (Bellot 2011).

Exploring an organisation's culture is important as it provides insights into understanding of how an organisation behaves. It not only provides insight into what people are doing but helps to understand how and why they might be doing it. An exploration of organisational culture can shed light on the values and beliefs of individuals and the degree to which these align with the values and goals of the organisation.

#### ***4.2.3 Organisational Culture – Ontological and Epistemological considerations***

Selznick (1957) created the distinction between two types of enterprise; one of a rational instrumental organisation, the other as a value infused organisation. Selznick proposed that as people were brought together in the workplace that this would create the opportunity for the creation of a dynamic social institution. This perspective supported the notion that organisations have cultures. Culture has been conceived as having a number of component parts including, artefacts, language in the form of jokes, metaphors, stories, myths and legends, behaviour patterns in the form of rites, rituals, ceremonies and celebrations, norms of behaviour, heroes, symbols and symbolic action, beliefs, values and attitudes, ethical codes, basic assumptions and history (Brown 1995). An alternative perspective is proposed by Critical theory in which culture is presented as a root metaphor and culture is something that the

organisation 'is' rather than 'has' (Smircich 1983). From an interpretive perspective, organisations are cultures. In this approach the organisation is considered as a manifestation of human consciousness. Culture is the process of sense-making created and sustained through communication and interactions. The rituals and stories are 'generative processes' that yield and shape meanings. An understanding of organisational culture as a root metaphor has its own challenges, this approach focuses entirely on symbols and meanings when in reality organisations are normally economic entities in which material conditions, external environment, competition and performance exert a strong influence on underlying organisational values and working procedures (Alvesson 2002). The root metaphor approach does not consider these dimensions.

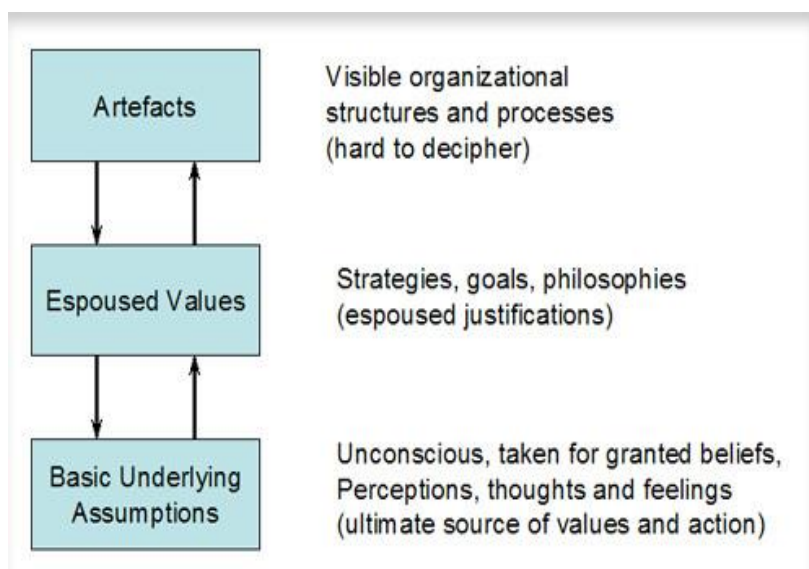
The different approaches to define culture have both similarities and differences. The similarities demonstrate that understanding culture is complex as it is associated with the subconscious and emotional mechanisms within the organisation. The differences are primarily based on how one would understand culture; this can be achieved through visible observation of the organisation or through the application of a metaphor. Culture as a root metaphor allows the organisation culture to be presented in a way that people perceive it (Smircich 1983).

#### ***4.2.4 A functionalist framework***

Schein's widely cited model of organisational culture proposes that three levels of culture exist within any organisation (See Figure 4.4). The deepest level is represented by a set of basic assumptions which are embedded unconsciously in human relationships. The next level is signified by the conscious beliefs, values and

attitudes of the organisation - this level is termed as espoused values. The third level is considered to be the most superficial expression of culture and is described as artefacts. These artefacts consist of the visible elements of culture such as easily observable patterns of behaviour, rites, rituals and ceremonies. Schein's model seeks to elucidate the relationship between the three levels and explore how each level shapes the overall culture of the organisation.

Figure 4.1- The three levels of the Schein Model



(Schein 1990)

This model recognises the relationship between seen and invisible aspects of culture, but challenges the notion that unseen assumptions can be directly derived from observable artefacts. Schein (1990) acknowledges the relationship between actions, situations and individuals and proposes that this contributes to shaping the organisation's culture. His theory proposes that an organisation may have espoused

values that can be in conflict with every day (artefact level) actions. This, in turn, can conflict with underlying assumptions. Schein's model suggests that an organisation can aspire to achieve a set of corporate or managerial values and beliefs which may differ from those that employees within the organisation actually experience on a day to day basis. This distinction in culture is described as the 'espoused culture' versus 'culture in practice' (Argyris and Schon 1983). The espoused culture of an organisation is usually represented through corporate information used by the organisation to represent and market itself e.g. through annual reports, values and mission statements. This aspect of the culture reflects how the organisation chooses to represent itself. In contrast the 'culture in practice' can be determined through the perceptions and actual experience of employees. This representation of culture reveals how the organisation behaves in practice. Indeed it is possible for there to be conflict between the espoused culture and the culture in practice creating confusion and contestation in the organisation (Brown 1995).

Schein's model of culture is based on the definition of culture being hierarchical in nature. Many other authors share the view that culture comprises of multiple levels from the most visible to the most intangible (Gagliardi 1986; Lundberg 1985).

Schein's model has not been without its critics, a key criticism of Schein's theory concerns the linear presentation of the model and how little attention is given to how movement between the levels is achieved. It has been suggested that the relationship between the three levels of culture is far more integrated and overlapping than the model implies (Hatch 1993, Parker 2000). Another key criticism of Schein's model is that it represents culture in a short sighted way. Critics propose that culture is a complex, communicative phenomenon rooted in the history of the organizations



past events (Smircich 1983). The strength of the model is that it draws together a number of key elements that contribute to culture specifically recognising the learned nature of organisations and also the partly unconscious dimensions. The model provides a holistic view of understanding organisational culture and acknowledges the levels of culture that exist within an organisation recognising that this can affect how effective the organisation is. Organisations not only consume culture but are also responsible for producing culture (Deal and Kennedy 1982, Schein 1985). This approach defines culture as the social glue that holds the organisation together (Martin and Siehl 1983). Many theorists have proposed that 'strong' cultures are more successful than weaker ones (Deal and Kennedy 1982; Peters and Waterman 1982). However, the evidence to support this assertion is weak (Scott et al 2003).

#### ***4.2.5 Organisational Sub Culture***

Organisational culture can create an impression of a single homogenous entity, but in practice this is rarely the case (Brown 1995). Organisations of different shapes and sizes can exhibit a range of sub cultures. These sub cultures emerge through the multiple groups that exist within the organisation (Gregory 1983). The classifications of the sub cultures are determined by a range of variables. These variables can include age, gender, education and occupation (Parker 2000). Parker distinguishes three typical principles of group formation:

- distinction between functions and units on the basis of the location of units and job description

- distinction between genders and distinction according to years spent in the organisation
- professional distinction e.g. on the basis of educational background

In addition to the principles that govern the establishment of sub cultures Martin and Siehl (1983) identify three different types of sub culture, enhancing, orthogonal and counterculture. Enhancing subcultures are illustrated by the way in which they reflect the principle values and beliefs of the organisations. These subcultures are characteristic by similarity to the dominant organisational culture and are usually found in situations where employees are committed to the organisation. Orthogonal subcultures can be characterised by groups within the organisation who are broadly committed to the organisational values and beliefs but also have a separate set of beliefs that do not conflict with the dominant values. Countercultures are represented within an organisation by groups/individuals who seek to challenge and resist the dominant values and beliefs.

#### ***4.2.6 Organisational Culture – Stability***

Meyerson and Martin (1987) propose three perspectives that can be used to understand organisational culture: integration, differentiation and the fragmented perspective. Integration is deemed to have occurred when there is wide agreement on the basic beliefs and standards of behaviour within an organisation. Within this perspective, culture can be used to establish managerial control, secure the commitment of employees and consequently achieve organisational effectiveness (Peters and Waterman 1982). Differentiation can occur when the behaviours of

groups within the organisation is varied. The culture of the organisation can be influenced by internal and external influences. This situation can create conflict within sub cultures and the emergence of a diversity of culture (Martin and Siehl 1983). Differentiation, whilst continuing to recognise the organisations overall culture acknowledges that there are variations within (Rollinson 2008). The fragmented perspective occurs in situations where consensus cannot be achieved. The organisation responds in an ad hoc way to changing conditions. Sub cultures may find commonality within each culture but opposition can occur between sub cultures (Martin and Siehl 1993). The fragmented perspective suggests that the organisation does not have a single culture and is full of inconsistency and ambiguity.

The study of organisational culture is important as it is considered to be one of the most significant factors in bringing about or impeding organisational change and also in modernising public services (Jung et al 2009). The theories examined in this section illustrate the organisation cultures are complex and can exist at many levels within the organisation. In addition to this culture should not be considered as a homogenous entity and that due consideration should be given to sub culture and counter cultures that can also affect how the organisation behaves.

#### ***4.2.7 Measuring Organisational Culture***

Given the challenges associated with defining organisational culture, it is perhaps not a surprise that measuring culture is likely to be a complex process (Doherty et al 2013).

Taras et al (2009) propose that scholars tend to focus on different elements of culture influenced by their particular field of study. Following a comprehensive review of the

literature on advances in measuring culture they found 121 instruments available to quantify culture. These findings concur with earlier reviews; Mannion et al (2008) identified 70 instruments and available approaches for exploring and assessing organisational culture. A variety of methodological approaches and research designs can be identified among the instruments including the most popular approach which tends to a self-report questionnaire (Mannion et al 2008). The advantage with this type of approach is that it is often less time and resource consuming in terms of administration and analysis. A broad aspect of the organisation can be covered. The consequence, however, is a less deep approach with perhaps a missed opportunity to capture unanticipated findings (Jung et al 2007).

In the context of health care, instruments such as the Competing Values Framework, Critical incident technique, Organisational Culture Survey, Practice Culture Questionnaire, General Practice Learning Organisation Diagnostic tool, the ward Organisational feature Scales, and Perceived Organisational Culture are the limited number of instruments that have been applied (Mannion et al 2008).

There is wide spread agreement that whilst a range of instruments exist no single tool will provide a reliable and trustworthy assessment of an organisation's culture (Taras et al 2009; Mannion et al 2008; Scott et al 2003). Given this a mixed method approach to exploring culture is proposed (Doherty et al 2013).

#### ***4.2.8 Summary***

To summarise the section has outlined the origins of the concept of organisational culture and has described the difficulties associated in defining it. The section also sets out the different perspectives of organisational culture that exist and how they

have been linked to understanding how organisations behave and perform. The next section looks more closely at organisational culture change theory and how this relates to organisations.

## **4.3 Organisational Culture Change**

### ***4.3.1 Defining Cultural Change***

Understanding organisation cultural change is deemed as important as many writers in organisation development propose that the only viable way to change an organisation is to change its culture (Bennis 1969).

The complexity of conceptualising organisational culture, understanding the variation and sub cultures that exist and the associated difficulties in measuring culture leads one to consider that cultural change is not something that will happen at the 'flick of a switch' (Doherty 2013). Davies et al (2007) suggest that the task of cultural change within the NHS is substantial and affected by both internal and external influences. The external influences can include public opinion, media reporting and regulatory frameworks (Doherty 2013). Internal influences such as specific groups and sub cultures pose a challenge when attempting cultural transformation (Scott et al 2003).

Whilst there are a wide number of models that exist for understanding organisational culture change, none have received widespread acceptance as the definitive means of modelling culture change processes (Mannion et al 2005). This position is reflective of the lack of theoretical consensus surrounding the definitions of organisation culture and change processes (Scott et al 2003). This section sets out

some of the models that exist that provide insight into how organisation cultures change.

Cultural models assume that change occurs naturally as a response to changes in the environment; cultures are always changing (Morgan 1986). Change within an organisation entails changing values, beliefs, myths and rituals (Schein 1985). An example of a cultural change model is proposed by Schein (1985). Schein's model views culture as a collective and shared phenomenon that is reflected at different levels through the organisation. His view is that leaders interpret events and history for people that can alter culture and therefore create change (Cameron and Freeman 1991).

#### ***4.3.2 Models of Cultural Change***

A number of models have emerged that have proposed how organisation culture can be changed. These include Lundbergs model (Lundberg 1985), Schein's model (Schein 1985), Dyers model (Dyer 1985) and Gagliardi's model (Gagliardi 1986).

Lundberg's model acknowledges the complexities associated with organisational culture change (Lundberg 1985). His model accepts the layers of culture that exist within an organisation and also the different sub cultures that exist within an organisation. All these conditions create an environment within which planned culture change is difficult (Scott et al 2003). His model focusses upon the internal and external factors in changing organizational culture (Brown 1995). Lundberg proposes that external and internal factors must exist for organisational change to be

successful. The external factors that need to be fulfilled are domain forgiveness and organisational congruence (Scott et al 2003). The more forgiving the domain the more likely it will be for the change to succeed and moderate organisation congruence is also likely to help the change to succeed. Lundberg specifies four internal conditions that are required to support the change. These include sufficient change resource, system readiness, co-ordinated mechanisms for communication and stable leadership (Lundberg 1985). Lundberg's model has been criticised for the over simplification of organisational dynamics and also failure to acknowledge the power conflicts that can occur when change is introduced (Brown 1995).

Schein's model of culture change assumes that an organisation has three stages of development which each has its own culture (Schein 2004). The three stages are described as birth and early growth, organisational midlife and organisational maturity (Schein 2004). In the first stage of birth and early growth, the cultural emphasis is on cohesion and socialisation. In this stage, change occurs naturally as the change experts are brought in to help guide and steer the organisation (Brown 1995). In the second stage of 'organisational midlife' the culture is deemed to be fully formed and ready for planned changes and organisational developmental techniques to support the instigation of cultural change (Schein 2004). The final stage of organisational maturity, cultural change is achieved through re-organisation, coercive persuasion and turnaround approaches (Scott et al 2003). In the final stage, change is forced rather than planned creating changes in culture as new values are introduced. The challenge to Schein's model is that some organisations have characteristics that exhibit both the midlife and maturity stages at the same time. In

practice, it can be difficult to distinguish between the different stages (Scott et al 2003).

Dyer's model of change focusses upon the role of leader in cultural change (Dyer 1985). Dyer's framework is derived from case histories from five large US organisations (Scott et al 2003). Dyer's definition of culture is based on four levels, consisting of artefacts, rules, names, norms, values and finally, assumption. The first step of the change process is a crisis creating a challenge to the leadership in its ability to deliver for the organisation. The model requires the leadership function to manipulate the culture. This is done by setting new standards, symbols and practices and also weakening the previous leadership that existed. It is this activity that supports the changing of culture through the introduction of new rules, symbols and values (Robbins and Judge, 2007). The model relies on crisis that requires change and also the emergence of new leadership that then engenders a new culture to embrace the change (Schein 2004). The model is recognised for its focus on the role of leader but is also criticised for the over emphasis on this (Scott et al 2003).

Finally, Gagliardi's conception of culture is very similar to that of Schein, Lundberg and Dyer in that he perceives culture as the unconscious assumptions that are perceived as material artefacts (Scott et al 2003). His model of cultural change, however, is different as he proposes that cultural change is incremental rather than radical (Brown 1995). The model proposes that leaders have the power to create cultural change and create the type of culture that they want. As the leader displays the type of behaviours that they expect the followers within the organisation take on these values. Over time these values are embedded throughout the organisation (Scott et al 2003). At the end the culture become unconsciously embedded and the



organisation becomes emotionally transfigured, a process that Gagliardi terms as idealization (Brown 1995). A criticism of this model is that it does not describe how obstacles to change are dealt with; in fact, it assumes that over time the leader can create the required culture (Scott et al 2003).

Whilst each of the cultural change models described are different they share a number of common elements. First crisis as a start point for change; and second the need for leadership to discover the need for change. Success in reinforcing new order values and rejecting the previous values is seen as a third key element. The fourth element is described as the re-learning and re-education that occurs in the organisation that supports the assimilation of the new culture (Mannion et al 2005).

#### ***4.3.3 Problems in Implementing Change***

The previous section outlined a range of models designed to understand or facilitate organisational and culture change. The models have highlighted a range of factors that first, provide the catalyst for change and secondly, the process required to enact the change. Whilst recognising the models that exist to support organisational change, the literature suggests that the process of creating change is difficult (Nadler in Mabey and Mayon-White 1983). Three major problems tend to emerge when implementing change.

Resistance to change is the first major problem that impacts the organisation to effect and enact change (Watson 1969). The resistance can occur for a variety of reasons including the individuals believing that current ways are better than the proposed

future state. In this case resisting the change could be considered as an appropriate response. Individuals may find the unknown state unsettling which causes them anxiety and as such they are reluctant to engage with change. Finally, if change is imposed then the individual may perceive a loss of autonomy and self-control (Nadler in Mabey and Mayon-White 1983). To minimise the resistance to change it is necessary to motivate changes in behaviour or to address or respond to legitimate concerns. It is important to recognise that the opposition to change may be valid as the change proposed may not be what is required.

The second major problem affecting change is organisational control (Nadler 1983). During change there is a danger that as goals, structures and people shift, it becomes difficult to monitor performance and make corrections. This may cause a general de-stabilisation of the organisation. The consequence of this is that the organisation loses focus on what is important and this affects its ability to function correctly.

The third obstacle to implementing organisational change is power (Tushman 1977). The uncertainty created by change creates ambiguity, which in turn tends to increase the probability of political activity (Thompson and Tuden 1959). Individuals and groups within the organisation may take action based on how the change will affect their relative power position within the organisation.

#### ***4.3.4 Summary***

This section has defined cultural change and described a number of different cultural change models. It has drawn out the similarities and differences in the models and presented and explored how cultural change can occur in organisations. In addition,

factors that affect change being implemented have also been discussed. The section illustrates the complexity in changing the cultures of organisations and the factors that are instrumental in making change happen. The final section of this chapter explores how hospitals behave as organisations. It will review the characteristics of hospitals and consider how they relate to the theories discussed.

#### **4.4 How Hospitals behave**

##### ***4.4.1 Culture and Hospitals***

The NHS has been characterised to have its own unique culture (Greengross et al 1999). The characteristics of which include co-existing and overlapping sub cultures that may share common values but may also diverge or clash (Konteh et al 2010). Whilst recognising the difficulties that exist in defining culture, the assumption here is that organisation's culture is a property that emerges from its constituent parts (Davies et al 2000). There are a range of different cultures found within hospitals (Martin 1992). A number of professional groups from manager, doctors, nurses therapists, porters, cleaners and any other professional groups whilst brought together to support health care delivery each have their own sense of professional identity, values, beliefs and working practices (Scott et al 2003). Professional sub cultures are not the only type of sub culture to be found in a hospital, often services are sub divided into specialisms and services. A sub culture can emerge from these specialisms that is often based on the disease patterns, complications, therapies and treatments that they deal with (Scott 2003). The consequence of the many cultures that can be found in hospitals is a tendency of these cultures to be rival and compete

with each other. Professional sub cultures can be found in hospitals and emerge from professional groups having long established autonomy and working practices that can conflict with bureaucratic controls and standards (Raelin 1985). The two dominant cultural groups within hospitals are doctors and managers whose relationship has been described as a power struggle (Harrison et al 1992). In some cases it has been found that loyalty to the professional sub culture is greater than to the organisation and that this could impede managers' authority to influence work practices (Degeling et al 2003).

Bate et al (2000) researched organisational change in a hospital that was going to be rebuilt through a Private Funding Initiative scheme (PFI) with the new hospital being relocated on a new site. The key findings of the research found that the culture within the organisation consisted of several sub cultures with each professional group seeking to retain its own elite position within the organisation. Meyerson and Martin would describe this as differentiated where each group is aligned to their professional perspective. Bate describes this 'Tribalism' is an innate feature of professional organisations. He suggested that tribalism itself is not a sign of a failing organisation but that it impacts the organisation when it is not managed properly.

“What distinguishes the effective professional organisation from the ineffective one – is the result of such tribalism being allowed to get out of control and drift into anarchy.”

(Bate 2000 p491)

The study provides further evidence of sub cultures within hospitals and that this was only considered to be problematic where the sub cultures conflicted with the overall organisational culture. This study also found that the planned change was resisted by the hospital and the sub cultures all held on to their professional values. Tribalism is a common feature of the sub cultures present within organisations that rival amongst each other when responding to organisational change (Harrison et al 1992). Mannion et al (2005) propose the following critical points when considering hospitals and organisational cultures. Cultural change is difficult, sometimes undesirable and can be unrealistic for some parts of the organisation to change its values at short notice and cultural change cannot be forced.

Stock et al (2007) conducted a study assessing whether the culture of an organisation could support the reduction of hospital errors. The study found that the culture of the organisation had an impact on the rate of hospitals errors. Where culture included participation and collaboration with groups there was greater opportunity to reduce hospital errors. This cultural perspective could be described as integration where teams within departments were clear about roles and undertook joint decision making activities. This process helped to create a safer environment with everyone focussed upon a common goal of delivering safe patient care. The study used a number of critical success factors to help teams establish their current levels of performance against hospital errors. Although the study attributed the success of the reducing errors to a participative and collaborative culture, it could equally be attributed to improve methods of communication. The study highlights the

important of looking beyond behaviours and exploring interactions between cultural sub groups.

Lok et al (2005) reviewed the relationship between organisational culture and leadership in relation to the commitment of individuals to change and support for organisational goals. The study explored culture at both organisational and department level. There was a clear relationship between a department's culture and the commitment of individuals within the team. If the culture was innovative and supportive this created greater commitment than if the culture was bureaucratic. Similarly, the study found a relationship between leadership style and commitment. If the leadership style demonstrated engagement and consideration then there was greater commitment from individuals. In contrast if the leadership style was structuring and directive then lower levels of commitment were achieved from the individuals.

Organisational culture has been linked directly to patient experience, safety and quality of care (Dixon-Woods et al 2013). This study found that positive cultures where staff felt valued respected and supported and where relationships are good between managers, staff, teams and departments resulted in high levels of engagement. This in turn contributed to organisations delivering high quality patient care, safety and positive outcomes. This study used a multi-method approach to evaluate the causes of recent failures in health care including the case of the Mid Staffordshire NHS Foundation Trust which reported catastrophic failings in the quality and safety of care (Francis 2013). It found that the desire to deliver high quality safe care was a goal that all organisations aspired to achieve. Amongst a number of other institutional variables culture was seen as instrumental in supporting the achievement

of this goal. It is important to acknowledge that shared goals alone will not deliver success. If individuals do not accept the vehicle that is designed to deliver the goal then they may not be seen to engage and the change may not be delivered.

The studies presented above reveal that organisational culture exists at many levels within the hospital. The added level of complexity within a hospital is that cultural levels co-exist with professional sub cultures. The sub cultures often have competing values which create tension with corporate culture. The challenge for the hospital is how it balances its sub cultures to support the organisational goals.

#### ***4.4.2 Changing Hospital Culture***

Attempts at organisational change in the NHS have remained a common feature since its inception with regular changes of health policy resulting in structural change and regulation (Davies et al 2000). In addition to changes in technology, government policy changes and increased regulation have also contributed to the changing environment in health. Factors such as increased consumerism, a greater disposition for patients and carers to complain and better informed patients due to improved access to information are also drivers for change within hospitals (Boak and Jones 2002). Despite this hospitals have traditionally been recognised as being resistant to change (Scott et al 2003). Empirical studies have found change to be successfully implemented where common goals could be established (Bate et al 2000).

Gagliardi's theory of cultural change proposes that strong leadership can lead cultural change. The model suggests that leaders set standards of behaviour and would be seen to behave in a particular way. Staff would observe these behaviours and then adjust their own until eventually the new set of behaviours became embedded across the organisation. Kan and Parry (2004) focused specifically on nurse leadership to understand how change could be affected in hospitals. The study explored the concept of multiple realities. Each professional group within the organisation had its particular view of goals and direction, for the organisation to progress there was a need for these goals to be subsumed together. If these 'multiple realities' diverged rather than converged then the ability to affect change was difficult. In the context of nurse leadership, if nurses are not enabled with greater power their leadership will be repressed and their ability to effect will be limited. The study showed the need for each professional group to be empowered to enable change to be delivered.

Implementing change in hospitals has traditionally been difficult because of the different functions performed by key stakeholders (McAlearney et al 2006), in particular the contrasting roles of doctors and managers.

“Leaders in administration are accountable for maximising results across multiple divergent stakeholders..... in sharp contrast to physicians' focus on helping individual patients, one at a time.”

(McAlearney et al 2006 p12)



This study also highlighted the traditional autonomous decision making role of the physician in contrast to the traditional consensus based decision making in general management highlighting that to effect change through clinical groups there was a need to support them through training and coaching. This study proposed that leadership can be taught and that medical teams need to learn new cultural values through this process.

The challenges between medical teams and management are referenced through a number of studies exploring change in hospitals. Yiedler (2005) explored the impact on a hospital when changes were proposed to the medical imaging service. The study provided useful descriptions of the differences between management and clinical roles. The study also highlighted the tensions that exist between the groups with particular reference to the power of the medical profession. This power stems from the fact that they have control over diagnosis in health care and this puts them a position of power in the situation. The study examines the differences between leadership and management and acknowledges the inherent dominance that the medical profession has held within health care and particularly in hospitals. The study found that the physicians strive to create an identity for themselves; often greater credence is given to group identities which helps them to gain position and power within organisations.

Organisation cultural change theories have proposed a number of different models to support managed change in organisations (Van den Ven and Poole 1995). These

models describe the different conditions within which change can be initiated. Change within hospitals has been recognised as challenging given competing professional groups with their own cultural identities competing values, resources and power structures. Change that is imposed is often resisted particularly if there is a belief that the current state is better (Gilmore et al 1997).

#### **4.5 Conclusion**

There is much debate regarding the nature of organisational culture and how it should be defined. Some organisational culture theories describe it as how organisations and the individuals within it behave. Organisational culture is often known as ‘the way things get done around here’ (Schein 1985). This reflects the functionalist perspective where culture is deemed to be a tool that can be a powerful lever to re-orientate organisational action (Demers 2007). In contrast the interpretive perspective proposes that the organisation is the culture and the organisation is a socially constructed system of meaning which is continually being accomplished and reproduced (Smircich 1983).

The chapter has outlined the origins of culture and described the prominent definitions that exist. Whilst there is much debate on how culture is defined and also how it can be measured, there are over 121 instruments identified in the literature to quantify it, the importance of organisational culture is widely recognised across a range of disciplines (Doherty et al 2013).

The chapter also describes Schein's model of culture proposes three levels of culture that exist across organisations with level 1 described as artefacts which tend to be the most visible manifestations of culture, level 2 as values and beliefs and level 3 as assumptions which tend to be unspoken unconscious beliefs.

A number of models of culture change have also been presented. Many of the models describe the importance of the role of the leader in instigating cultural change and although the models differ they have a number of similarities (Mannion et al 2005).

The hospital environment presents a cultural mosaic of subcultures that exhibit a range of different characteristics (Davies and Mannion 2013). The ability to enable change in this complex environment is challenging. A number of studies cited have described the factors that have affected the success of change. The need for individuals to have shared values and vision helps in supporting and delivering cultural change.

Clearly, the introduction of PCP has changed the environment for hospital providers as it proposing change in the way patients will access hospital services. The theories of culture and cultural change are relevant when understanding the impact of PCP in hospitals as they can provide insight into how hospitals behave and the levers required for change. The following chapter will draw on the theoretical insights discussed here to construct the theoretical framework for the empirical part of the study. The theoretical framework will then be used to explore the link between hospitals as organisations and the impact of PCP on the culture of a large teaching hospital.

## **Chapter 5: Conceptual Framework - Patient Choice Policy and its Interaction with the Hospital Culture**

### **5.1 Introduction**

The earlier chapters present an overview of developments in Patient Choice Policy (PCP) and related empirical research to explore the impact of PCP in the NHS. Chapter 4 provides a review of theory and concepts associated with organisational culture and culture change.

The purpose of this chapter is to integrate and synthesise these bodies of literature and in doing so, develop and refine the conceptual framework for the study. It is organised into three sections. Based on the programme theory underpinning PCP, section one summarises the assumptions of PCP. The second section explores these assumptions in the context of the literature and identifies the areas for further development. The final section uses the lens of organisational culture and cultural change in order to provide a conceptual framework for investigating and analysing PCP. The framework is then used to guide the empirical analysis to ensure that insights from the theoretical literature have been reviewed.

### **5.2 Patient Choice Policy Programme Theory and Assumptions**

#### ***5.2.1 PCP Programme theory***

In reviewing English health policy it is noted that patient choice has steadily emerged through a range of governmental reforms of the NHS. PCP specifically has remained a key feature of health policy for over a decade. The aim of the policy in the NHS is

to provide patients with the choice of hospital for elective treatment. This choice is offered at the point that a decision to refer a patient is made by the GP. The policy has recently been expanded to include choice of consultant in addition to choice of hospital. The choice pilots in London in 2002 are recognised for their contribution in influencing and shaping PCP (Dawson et al 2006). It is important to note that the patient choice pilots operated under a different set of conditions than the emergent PCP that was subsequently launched. This facility also concluded at the end of pilots and was no longer available as part of patient choice. It is important to note the differences between PCP and the pilots as the success of the policy should not be assumed given that the policy offers a materially different model for patient choice. Programmes work where they introduce the appropriate ideas and opportunities to groups in the appropriate social and cultural conditions i.e. contexts (Pawson and Tilley 1997).

PCP has continued to be an important part of health reform (NHS Mandate 2013). Recent reforms have renewed the commitment to it and the essence of the policy has not significantly changed from its original aims. The aims of the policy can be observed through the programme theory as set out below;

- The Government asserts that the introduction of market elements into health care, in particular choice and competition will enhance efficiency and address non-responsiveness among provider organisations.
- Competition among providers for contracts will incentivise providers to review (and if necessary improve) the quality and efficiency of the services to ensure that

they are responsive to patient needs, making them the most attractive option to potential patients.

- Payment by Results will generate standard tariffs for activity ensuring that price does not influence the market, and that providers compete principally on quality.
- Money will follow the patient so those providers not attracting patients stand to lose out financially.
- Increasing the number and diversity of eligible providers in “the marketplace” will allow patients to have a range of alternative providers to choose from.
- Patients will have access to a range of information about the quality of services ranging from health care outcomes to cleanliness ratings to access indicators (e.g. car parking, waiting times).
- Patients will use the information provided and act rationally to select the best performing hospitals.
- Those hospitals that do not achieve quality and efficiency standards will fail and potentially may go out of business (i.e. exit the market) because they will not be selected by patients and therefore, lose income.

The mechanism introduced by PCP is the action to allow patients to choose where they can be referred for hospital treatment. The context provided by PCP is a range of alternative providers to choose from and information about providers. The intended outcome of PCP is that the services provided by hospitals will become more responsive to the needs of patients as they will want to ensure that they continue to attract as many patients as possible. This in turn will delivered cost effective services to patients.

This represents the ideal model for PCP and proposes how PCP should work in practice. The model is based on a number of assumptions which are explored in detail in the next section.

### ***5.2.2. The assumptions underpinning PCP***

Despite its prominence in health care reform, PCP exists at a descriptive level. Whilst the policy describes what is to be achieved, it does not make specific statements about how this will happen. Nor does it describe how it should be implemented and how it will be made to work in practice. Rather it contains assumptions on how it has been designed to function. Each of these assumptions will be considered in turn.

#### *Patients will behave as consumers;*

PCP assumes that patients are able to act as autonomous consumers. The underpinning theory that supports the policy position is Rational Choice Theory, which proposes that individuals are 'utility maximisers' (Dixon et al 2010). Rational choice theory assumes that individuals act rationally and that people calculate the likely costs and benefits of any action before deciding which course to take (Green 2002). Conceiving the patient as a consumer suggests that a quasi-market can operate in health care. Inherent in this assumption is the notion that patients will want to act as consumers. The policy does not necessarily describe what will bring about this change in patient behaviour but rather assumes that it will just occur because choice is made available. The role of the patient within health care has traditionally been that of service user, this shift to treating patients as consumers assumes that patients will become fully knowledgeable about choice of hospital in health care and make meaningful choices. This assumption may be based on a general trend of

increasing consumer behaviour where the population exercises choice in many different aspects of their lives. The view here is that people are information literate and want to take on this role in health care. It may be that advocates of the policy view PCP as aligning the NHS with other public services and challenging the previous paternalistic model in which the role of the patient has been far more passive service user.

*GP role changes from decision maker to facilitator;*

PCP is based on the assumption that GPs will change their behaviour when speaking with patients. Rather than referring the patients to where they think they should go for treatment which has traditionally been the role of the GP, PCP assumes that they will help patients to make these choices instead. This poses a significant change to the role of GP from decision maker to facilitator. It also assumes that GPs are aware of the information available to support patient choice and the patient's choice will become a key consideration when they are referring them to hospital. It assumes that the GP accepts the role of PCP in improving health care delivery and will therefore change their behaviours to help support it. PCP does not outline any incentive for the GP to change the referral consultation. For some GPs the disincentive could be lengthier consultations.

*Hospitals will recognise the patient in the role of consumer;*

PCP assumes that hospitals will accept the patient in the role of consumer and will seek to understand what patients want and will respond by improving their services



to be more responsive to patient-defined priorities. It also assumes that hospitals will want to share information with patients to market how good they are so that patients will choose them. It assumes that hospitals understand the factors that influence patient choice and will focus their attention on these factors.

*Hospitals are incentivised to change;*

PCP is embedded into a wider programme of system reforms, a key element of which is enabling 'money to follow the patient'. Consequently, patient choice carries direct financial incentives and penalties, in as much as patient decisions to 'go elsewhere' will lead to a loss of income. The assumption here is that the hospital sector will operate as a quasi-market, with financial flows and payment systems directly reflecting patient choices. It assumes that hospitals will realise that they can no longer take for granted the traditional flow of patients and referral patterns that have existed previously. The policy assumes that hospitals that do not attract patients will start to lose income and subsequently will face the threat of closure. It also assumes that the threat of patients choosing other hospitals will stimulate service improvement with hospitals wanting to continue to attract patients (Greener et al 2006).

The introduction of alternative providers in the 'market place' is designed to incentivise hospitals to change. The programme theory of PCP uses competition as means of stimulating improvement in public service. Choice and competition was deemed by Le Grand (2007) as essential to delivering an effective and responsive service and a way of improving the quality of public service provision.

*Information is available and can be used by patients to make choices;*

PCP assumes that information will be readily available to patients. This information will guide patients on the difference between hospitals and can be used to support patients in making choices. The need for information to support patient choice is widely acknowledged. In fact, without adequate information provision it is proposed that the opportunity to exercise choice does not exist at all.

“High quality information empowers people. With poor information they cannot make effective choices; and without information they have no real choices at all.”

(Health Information Strategy, 2004)

To support patients in making the right choices on behalf of themselves and their families, policy makers commit to ensuring that information describing the quality of services will be made available.

“We want patients to make the right choices for themselves and their families. So we will empower... with clear information on the quality of each service offered by every NHS organisation – across all settings of care.”

(NHS Next Stage Review, 2008)

The policy intention is clear in wanting to empower patients to make choices for themselves and the commitment by policy makers is that the information will be available and usable for patients.

Finally, PCP assumes that patients will use this information when making choices about treatment. The intention here is for the public to be swayed by performance information and choose on the basis of quality of service. The programme theory relies on this behaviour influencing hospitals to improve the quality of their services.

The provision of information about hospitals and its subsequent application by patients is a critical component of PCP.

The section has identified a number of assumptions underpinning PCP. To summarise, for PCP to work as envisaged by the policy makers first, patients need to behave as consumers. In this role they would need to have access to information about hospitals to help them to distinguish the differences between the services offered and make their choices based on this information. This consequently changes the role of the GP from decision makers to facilitators and supports the patient as a consumer in choosing a hospital for treatment. Second, hospitals need to review and assess the quality of their services and be able to demonstrate that they can provide what patients are looking for. Hospitals may need to consider the competition that exists as they will now be competing for patients rather than the traditional flow of referrals from GPs. Finally, the policy assumes that information about hospitals will be available and be used by patients in determining the choices that they will make. The following section uses the empirical and theoretical literature to explore the assumptions of PCP.

## 5.3 Exploring the assumptions

### *5.3.1 Do patients behave as consumers?*

Patients have not traditionally behaved as consumers and rely on key decisions about health care being made on their behalf by health care professionals (Coulter at 2006: Spurgeon et al 2006). For some patients taking on the role of consumer may be a daunting proposition as they have traditionally relied upon the GP and other health care professionals in supporting them and have not necessarily expected choice in health care. Previous studies have shown that choice in health care is more complex than choice in other services and whilst patients have wanted to be involved in health care decision making they have not always wanted to make choices (Taylor et al 2004, Lewin and Piper 2006, Dixon et al 2010).

The traditional role of the patient in health care has been weak, with them acting as service user rather than consumer. PCP requires that the patient is able to take a stronger role in health care. PCP depends on the patient choosing performing hospitals and rejecting others who appear to be failing on quality standards. In practice, a number of studies found that performance and poor quality were not necessarily affecting the choices made by patients (Coulter et al 1999, Greener and Mannion 2009; Dixon et al 2010; Lavery et al 2012). Lavery et al (2012) also found that even where hospitals had been involved in investigations related to issues with clinical quality this does not result in patients wanting to switch to alternative providers. There may be a number of reasons that affect the decision of patients to remain with their local service provider; a possibility is that PCP does not consider the relationships that may exist already between hospitals and its patients. It does

not consider the loyalty that patients may have towards their local services and the trust that they have established between themselves and health care professionals. Using a market analogy, PCP has not considered the 'brand loyalty' that may exist between hospital and patient. The loyalty demonstrated by patients and their wanting to accept local provision even if the quality is poor (Lavery et al 2012) tends to suggest that the relationship between the hospital and patient is deeper than that of consumer and provider. PCP assumes that health care provision can be perceived as a 'market good' when many perceive it as a 'service good' (Morris et al 2007).

### ***5.3.2 Are GPs behaving as facilitators rather than decision makers?***

GPs have tended to determine where patients go when they are referred for hospital treatment (Rosen et al 2007). The introduction of PCP requires that this role changes from GP to patient. The programme theory does not take account of the role of the GP in the context of PCP but rather proposes that this transition will take place due to the consumer tendencies of patients. In reality, patients rely on the advice and steer from GPs in making these types of decisions (Dixon et al 2010). There are some studies that indicate that GPs have not been very forthcoming in offering patients the choice (Mahon et al 1994; Ford et al 2006; Wallace and Taylor-Gooby 2006). These studies indicate that GPs are not acting as facilitators and have continued in their role as decision maker. There are a few barriers that prevent GPs in exercising the role of facilitator. The first barrier exists at a practical level, the time allowed for consultation may not be sufficient to permit a choice discussion. The second barrier relates to the GP perspective that the patients' interests are best served when choices are made for them by well-meaning and knowledgeable clinicians. This is problematic for PCP

as patients will not be able to act as required and this will directly affect the outcome of PCP.

### ***5.3.3 Do hospitals perceive patients as consumers?***

Hospitals have traditionally held a paternalistic view towards patients (Coulter 1999; Macdonald 2003). For PCP to deliver the intended outcome it is important for hospitals to recognise a change in the role of the patient. The programme theory is based on the notion that it is this recognition that will stimulate a change in hospitals to become consumer focused. Arguably, PCP has been naïve in expecting that hospitals can and will change. The instinctive paternalistic values centred on protecting patients have been a long standing feature of hospitals. The dominance of the medical profession 'knowing what is best for patients' has been recognised as a strong cultural value within hospitals (Klein 1995; Kennedy 2004).

It is widely accepted that organisational culture should not be considered as a homogenous entity, but rather that organisations comprise several cultures (Pettigrew et al 1992, Martin and Siehl 1983). Accepting that there are many organisational sub cultures in the hospital the challenge this presents is that PCP may have different meanings and values across the organisation. The consequence is that this may affect the way different groups within the organisation perceive and interact with the patient. These groups may or may not be accepting of the patient as a consumer. If the patient is not perceived as a consumer then a fundamental part of the policy is undermined.

### ***5.3.4 Are hospitals incentivised to change?***

Historically, hospitals have traditionally been recognised as difficult to change (Scott et al 2003). The difficulty arises from the scale and complexity of these organisations and the wider environments within which they operate. Change can often be resisted and this has been a major problem that affects the ability of organisations to effect and enact change (Watson 1969). Resistance can occur for a variety of reasons including the belief that current ways are better than the proposed future state; they may find the unknown state unsettling which causes anxiety and finally, if it is imposed change then the individual may perceive a loss of autonomy and self-control (Nadler in Mabey and Mayon-White 1983). To minimise the resistance to change it is necessary to motivate changes in behaviour or to address or respond to legitimate concerns.

The empirical evidence reveals that hospitals perceive PCP of limited significance. Studies have found that whilst they were aware that a small percentage of patients were switching with the offer of choice and hospitals were more concerned about the consequence of this on their reputation rather than concerns about service quality or the broader concerns of financial viability (Dixon et al 2010; Peckham et al 2011). The intrinsic factors of change, that is, hospitals responding to PCP because they feel it is the right thing to do, appear not to have been met.

The policy relies heavily on external factors to leverage change such as creating an environment within which there is competition and proposing penalties such as loss of revenues and ultimately closure. The reality for hospitals to 'go out of business' is unlikely since the need to provide health care remains. The closing of

hospitals is not a simple business transaction and invokes much public and political involvement. In reality, hospital closure is not a routine occurrence and in fact generates an emotive reaction from members of the public when local service provision is targeted. Hospital closure is also prevented for reasons of equity and access. A service closure that forces patients to travel for treatment may become a barrier to access for those that are less able or unable to afford travel costs. From a health economy point of view, hospital closure can have an adverse impact on the health community that it serves. The incentive to change based on a threat of closure can be considered to be fairly weak from a hospital point of view.

The NHS has experienced constant change over the last few decades. In addition to this, services are experiencing financial pressures and hospitals are being forced to consider alternative models of care that do not involve hospital treatment. The question to pose here is whether the NHS has the capacity and capability to adopt PCP. The Health Foundation (2015) suggest that for health policy to be credible it requires transformation funds to support the policy implementation, strong and consistent political leadership and an assessment of providers of NHS care on their ability to make change. None of these actions have been undertaken as part of the introduction of PCP. This may explain why the policy is not having the intended impact.

To summarise, PCP programme theory identifies incentives and opportunities for hospitals to change. In practice, the levers of change have been weak and the policy has not been implemented with the rigour required to secure its success.



### ***5.3.5 Does meaningful information exist to support patients making their choices?***

The programme theory underpinning PCP outlines the need for meaningful information to be made available to enable patients to exercise choice without which the policy cannot function as intended (DH 2004). As part of PCP development one of the primary sources of information made available to patients has been the 'NHS Choices' website. The website was launched in June 2007 by the Health Secretary Patricia Hewitt who states that;

“NHS Choices puts patients in the driving seat – giving them access to information not previously available to them so they can make informed decisions from advice about healthy eating to identifying the right hospital for their treatment.”

(Hewitt 2007 in EHI)

Whilst the provision of information to support PCP has, on the face of it, been met it is important to note that the majority of information that is available is web based. This can be problematic for PCP as it limits accessibility to those that are computer literate and have access to a computer and potentially excludes large population groups. This has the potential to attenuate the impact of PCP as not all patients will have access to information to aid them make choices.

In terms of the content of information available, much of it tends to be quantitative performance information that many patients find difficult to understand or they distrust (Barnet et al 2008). The format of the information is also limited and therefore not readily accessible to those with literacy, numeracy or language barriers. Once again, this is problematic for PCP as patients will be excluded from making choices because they cannot access the information designed to help them.

Greener and Mannion (2009) found that despite access to information which highlights poor performance by the local hospital provider, patients continue to choose this provider rather than choose to go elsewhere. It is difficult to determine why patients have chosen to ignore the information and continue to choose poor performing hospitals. What this does demonstrate is that the information alone is not influencing the patient's choice. This evidence challenges the assumption that information can be used to influence the choices made by patients.

## 5.4 Analytical framework

### *5.4.1 Organisational Culture and Cultural Change theory and PCP*

To date the empirical literature has reported that PCP has had only a limited impact on hospital behaviour despite it being designed to stimulate positive organisational change. (Fotaki et al 2005, Jones and Mays 2009, Dixon et al 2010, Peckham et al 2011, Frosini et al 2012). Whilst these studies have shown that PCP is not delivering on its aim as a lever for service improvement they have not explored empirically the reason for the lack of response by hospitals.

The important and original contribution of this research is that it explores the impact of PCP through the lens of theories of organisational culture and uses concepts associated with culture change as a means of understanding the organisations response to PCP.

This section synthesises the empirical and theoretical literature and based on this assembles the conceptual framework for the study. This is detailed in the figure 1 below (Figure 5.1. – Conceptual Framework – Exploring the Impact of Patient Choice Policy in an NHS Hospital). The programme theory underpinning PCP has been set out in chapter 2. This sits at the heart of the conceptual framework describing at a simple level how the policy is intended to operate. The figure also sets out the enablers and barriers of PCP at a micro, meso and macro level.

### ***Micro Level***

The empirical literature confirms that choice of hospital is important to patients (Dixon et al 2010) and that some patients want to be involved in making decisions about their health care (Lewin and Piper 2006). However, patients do not often use the information available to exercise choice but rather rely on the informal experience of friends and relatives to influence their decisions (Dixon et al 2010). This may weaken the extent to which patient choice serves as a driver for service and quality improvement.

PCP is premised on the notion that patients will use performance information to influence the choices that they make. In practice, it has been found that some patients mistrust the information that is presented and are therefore reluctant to use this to inform their decisions (Magee et al 2003). For some patients loyalty to their local provider is strong and even in cases where there are issues of poor quality that are under investigation this does not necessarily result in patients electing to choose other hospitals (Lavery et al 2012).

Finally, a key barrier is that GPs may not always have time to discuss choice options with patients (Rosen et al 2007), resulting in a situation where choice is more rhetorical than real. The choice of hospital should take place at the point when a GP makes the decision to refer a patient for secondary care treatment.

Therefore at the micro level, individuals (e.g. patients, GPs) are not necessarily thinking and acting in ways that PCP has assumed (they will). Consequently the behavioural drivers for PCP are limited.

### ***Meso Level***

The financial consequences of losing patients – especially in an era where (to an extent) ‘money follows the patient’ – could be significant for hospital providers. PCP assumes that the risk of losing ‘business’ will underpin and stimulate hospitals to better understanding patient needs and experiences, and use this as a basis for improving services, to ensure patients see them as the provider of choice. One might therefore assume that the senior leadership team in the hospital recognise the opportunity associated with PCP and try to stimulate change in the hospital.

But, a hospital does not reflect a single monolithic ‘culture’ but comprises different levels of culture and many competing and cooperating professional sub cultures (Davies and Mannion 2013). This may result in different professional groups of the hospital perceiving patient choice differently, and potentially interpreting and responding to PCP in different (potentially competing) ways. There is evidence of enduring paternalism within some clinical cultures (Scott et al 2003); where this is the case, patient choice may again be perceived more as rhetoric than a reality.

There are several other organisational barriers to patient choice acting as an effective lever for quality and service improvement. For example hospitals may be resistant to organisational change or suffer from ‘change fatigue’ given the level of constant change in the broader policy environment. Also, the incentives for hospitals to compete for patients may be poor in an environment of many competing priorities, including the need to meet externally imposed performance targets and severe financial pressures.

Therefore at the meso level, there are a number of barriers that can attenuate PCP from operating in the way that it was intended. Consequently, the organisational drivers for PCP may also be limited.

### ***Macro Level***

The system wide reforms associated with PCP create an environment within which competition is possible as more providers are introduced into the market, tariffs are fixed so that choice is not based on cost and the system is designed for the money to follow the patient (Department of Health 2005). In addition to this, a national system has been implemented in the English NHS to allow patients to choose alternative providers and book their own appointments.

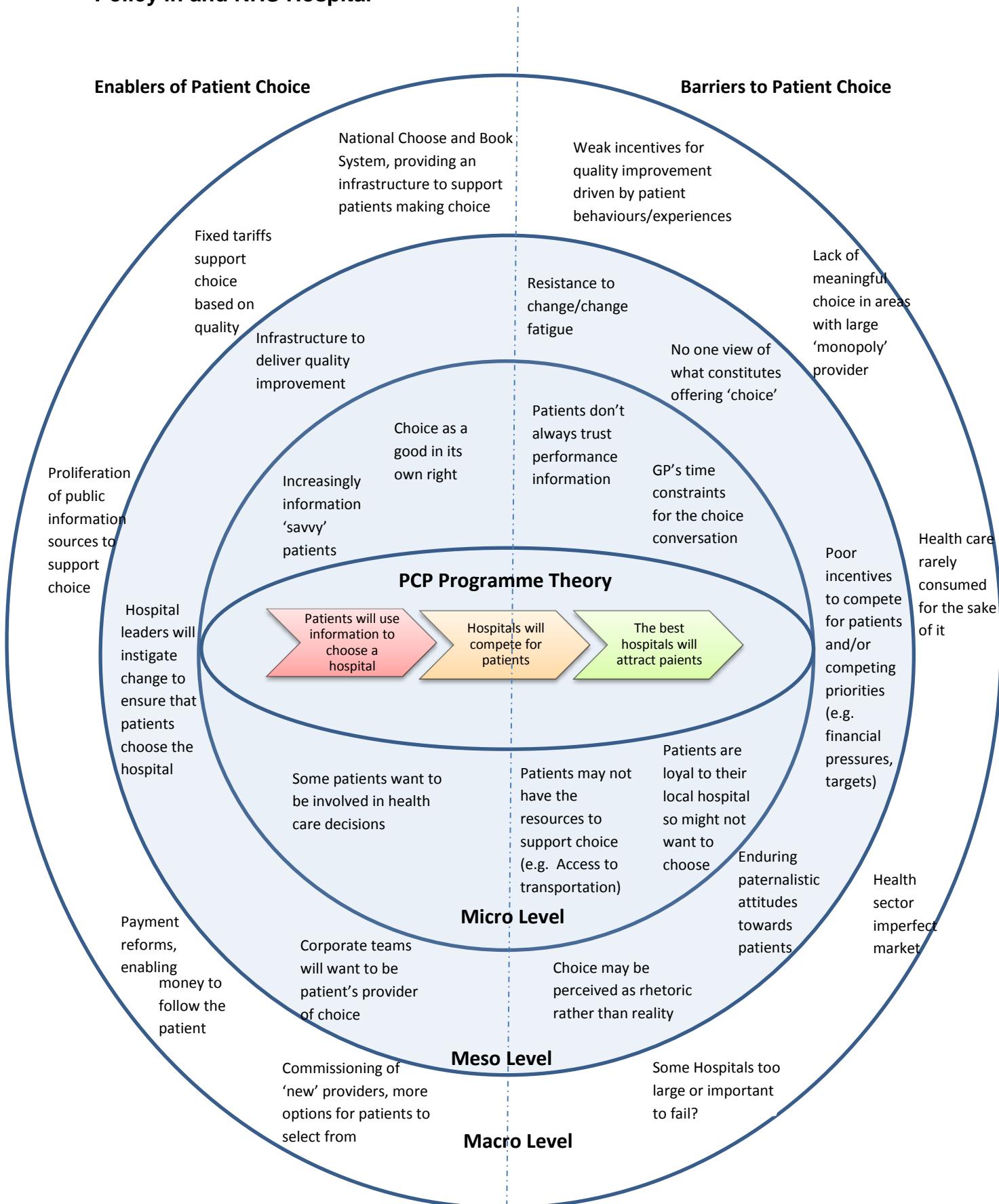
Certainly the direction of travel throughout the 2000s and early 2010s has been on the development of pro-market-based health system, with the expansion of opportunities and development of an infrastructure for patient choice and provider competition. But PCP and the underlying infrastructure to support it has emerged in an environment with numerous, sometimes unaligned and competing priorities, and questions therefore remain about whether the incentives for hospitals to improve quality (especially when the driver for this is patient-defined needs and the patient experience) are powerful enough. Moreover, the principle that sufficient switching from poorly to highly performing providers might trigger a provider to closure is very unlikely to happen in practice, despite much concern about this possible eventuality when PCP was originally introduced. Some hospitals are just too big and/or strategically important to fail, and the issue over hospital closures is deeply political

and arouses much public attention and emotion. This reality challenges the impact of PCP as the consequence of hospitals not engaging may be insignificant.

PCP is based on rational choice theory and assumes that patients will act as self-interested and fully informed consumers. In reality the healthcare system does not operate as a perfect market and consumers do not act as fully rational agents. This fundamentally challenges the way in which PCP is designed to operate. At the macro level, there are therefore further barriers identified that could prevent PCP functioning as intended.

In summary, the framework draws together the components of PCP and organisational culture theory to describe how the policy patient of choice and the hospital as a complex, dynamic organisation interact with each other. The framework identifies a range of enablers and barriers at the micro, meso and macro level relating to PCP and can be used to explore how these influence organisational behaviour with the hospital. The conceptual framework suggest that to explore the impact of PCP fully it is necessary to consider both organisational culture and the ways in which professional sub-groups in the organisation perceive and respond to the policy.

**Figure 5.1 – Conceptual Framework – Exploring the Impact of Patient Choice Policy in and NHS Hospital**





#### ***5.4.2 Measuring the Culture of the Hospital***

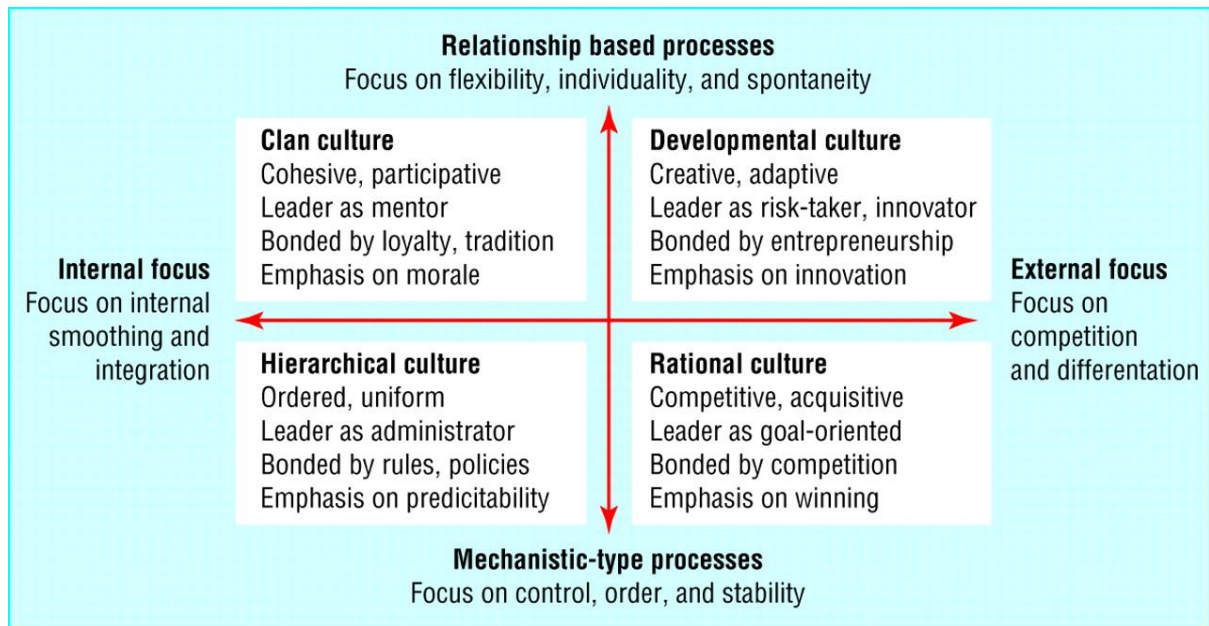
In exploring the culture of the hospital it is necessary to identify an appropriate method to use. A range of instruments have been developed to aid the exploration of organisational culture. A review of the literature conducted by Jung et al (2009) identified seventy instruments for exploring or assessing organisational culture. In this review, Jung et al (2009) categorised the instruments and provided guidelines on how different instruments could be used for different purposes. The use of a qualitative approach using a typology to explore culture allows for a detailed and meaningful analysis of underlying values beliefs and assumptions within an organisation (Yauch and Steudel 2003).

The Competing Values Framework (CVF) model was developed by Cameron and Freeman (1991). They recognised the difficulty in objectively assessing the culture of an organisation as individuals express culture across the range of elements which include stories, language, artefacts etc. Researchers began to characterise individual experiences into a limited number of categories as they argued that information gathered could be collated axes of bias and psychological archetypes (Jung 1973). Cameron and Freeman used the Jung's model of psychological archetypes (Jung 1923) as the basis of the CVF model. The model (figure 5.2) is based on two intersecting axes. The first axis represents what is happening in the organisation and ranges from organic factors to mechanistic factors. Organic processes describe the level of flexibility and spontaneity in the organisation. Mechanistic processes describe the level of stability, order and control that is felt in the organisation. The second axis outlines the positioning of the organisation in relation to the external world with

internal maintenance at one end of the axis and external positioning at the other. Internal maintenance is characterised as the smoothing and level of integration that exists. External positioning characterises the level of competition or differentiation that can be described (Mannion et al 2005). Each quadrant of the model presents a culture type for organisations. The clan culture is described as internally focussed and has mechanistic processes. The hierarchical culture is also internally focused but has mechanistic processes resulting in order, control and stability. The developmental culture is outward facing and has organic processes that indicate individuality and spontaneity. Whilst the rational culture is also outward facing, its processes remain mechanistic. The model can be used to assess how individuals perceive the culture of their organisation and Cameron and Freeman (1991) suggest that it would be possible for all categories of culture to occur simultaneously within an organisation.

The competing values framework will be used in the study as a means of measuring the culture of the organisation. Given the complexities associated in defining culture the tool will provide a common definition and will provide strong face validity in terms of assuring consistency in understanding the results. The study will use the CVF tool to measure culture within the hospital and to aid the understanding of PCP within this context.

Figure 5.2: Competing Values Framework Model



(Mannion et al 2005 p162 -3)

## 5.5 Conclusion

This chapter has provided an overview of the aim of PCP, its underpinning programme theory and the assumptions that PCP makes. PCP introduces the concept of choice of hospitals for patients. The choice model is based on rational choice theory which proposes that individuals make rational choices which are in their best interests. Through the introduction of the policy the role of the patient is changed from service user to consumer.

The chapter outlines a number of assumptions made by the policy including the notion that patients are able to exercise choice and that these choices will be based on quality and cost effectiveness. A further assumption is that quality information will

be available to support patients to make choices and that hospitals will have acknowledged the role of the patient as consumer and become responsive to their needs.

The intention of the policy has been to introduce competition as an incentive to hospitals to become more focussed upon quality and efficiency. The ambition of PCP has been to improve services through the responsiveness of hospitals. A review of the empirical literature has found that PCP has had relatively limited impact on hospitals and the evidence to suggest that it has improved the quality of services is not evident.

The programme theory describes the mechanism of patient choice as the mechanism that is designed to create action. Payment flows have been changed to follow the patient and alternative providers have been introduced as a means of creating an environment within which PCP can operate. Upon exploring the assumptions in detail it is proposed that PCP has not considered the hospital as an organisation and how change is achieved in practice in this complex environment. This lack of attention to the context within which the policy is being implemented is a challenge for the success of the policy.

A review of organisational change theory proposes that change in organisations is delivered through culture change (Doherty et al 2013). Organisation culture theory conceives the hospital as a complex organisation with multi professionals and managers delivering health care services across a range of population groups. Services are delivered in the context of constant political challenge, technological advancement and public scrutiny. Cultural transformation of organisations has been

recognised as necessary alongside structural and procedural change if organisations are to deliver improvements in quality and performance (DH 2000).

The chapter sets out the conceptual framework for the study and outlines the importance of organisational culture and cultural change theories in understanding how and whether PCP is implemented in the hospital. The chapter proposes that the policy has been naïve and not adequately considered the environment within which PCP is being introduced. The chapter sets out the justification for using the CVF as a tool to measure the culture of the organisation and to explore PCP in the context of an NHS hospital. The next chapter will describe in detail the methodology that will be used to conduct the research.

## **Chapter 6: Methodology**

### **6.1 Introduction**

The overall aim of this research was to explore the impact of patient choice policy (PCP) on organisational behaviour in an NHS Teaching hospital. As stated in chapter 2, PCP was introduced as part of a wider set of system reforms designed to improve the way in which health care is delivered. As a result it may be difficult to isolate or disentangle the impact of PCP. The research takes cognisance of this and ensures that the wider systems reforms are recognised and appropriately acknowledged when undertaking the research.

The purpose of this chapter is to define the research methodology used in the study. The research methods selected for the study are described and justification is given for the choice of research design and methods.

The primary aim of the research is to understand;

**The influence of patient choice on organisational behaviour in an NHS Teaching hospital with a particular focus upon how this has influenced and shaped changes in organisational culture.**

The study explores this through the following key questions;

1. How is PCP viewed by different staff groups within the organisation?
2. How has the organisation's culture changed in response to PCP?
3. What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?

## **6.2 Methodology**

### ***6.2.1 Philosophical Concepts Influencing the Choice of Research Design***

When undertaking research, it is critical to be clear of the research aim and the expected outputs. This understanding influences the design of the study and ensures that the most appropriate forms of data gathering and analysis are used. Easterby-Smith et al (2008) argue that there is a need to understand the philosophical issues and their relationship with data. This allows the researcher to determine the type of data that the study will collect and how it will be collected, analysed and interpreted. Knowledge of the underpinning philosophy also determines the most effective approach for the study as it aids understanding of the limitations and strengths of particular approaches. Finally, the researcher may also be creative in adapting research designs on the basis of their strengths and limitations.

In the research literature, two broad contrasting philosophical approaches to research can be discerned: positivism and social constructionism (Easterby-Smith et al 2008). The positivist approach is based on the notion of objectivity and assumes

that the external world exists externally to, and therefore can be measured independently of, our perception of it (Burrell and Morgan 1979). An early representation of the positivist view was made by French philosopher, Auguste Comte in 1853 who stated that;

“All good intellects have repeated, since Bacon’s time, that there can be no real knowledge but that which can be based on observed facts.”

(Comte in Easterby- Smith et al 2008, p57)

Critics of the positivist approach argue that the social world does not operate according to the fundamental ‘natural laws’ and propose that there is a need to undertake research in areas where the answer may not be known, but a framework is constructed that allows observation and interpretation to take place (Crombie and Davies 1996). The challenge to positivism is that reality is not objective and exterior to the individual, but rather it is constructed by individuals and given meaning by individuals (Burrell and Morgan 1979). This approach is known as interpretivism.

The aim of the study is to explore the influence of PCP within a hospital through addressing a range of specific questions.

Given this context Pawson and Tilley (1997) propose that social policies are embedded social systems that can be understood only through examination of the social rules and institutions within which they are embedded. A given policy is embedded in different contexts with different people, different institutions, different providers; different settings will offer different outcomes and potentially different effects. Taking a critical realist perspective they propose that a policy is affected by its personnel, its place, its past, and its prospects. Pawson and Tilley (1997)



postulate a formula that they propose that enables programmes to be understood. The formula consists of the following four elements, mechanism, context, outcome pattern and context-mechanism-outcome-pattern-configuration. Mechanisms are described as the interventions of the programme initiative. Context is defined as the environment within the programme is designed to deliver change i.e. the set of conditions within the change has been designed to occur. The outcome pattern is described as the intended and unintended consequences of the change. The final concept of context-mechanism–outcome pattern configuration enables mechanisms and contexts to be harmonised to predict outcomes (Pawson and Tilley 2004). Pawson and Tilley (1997) propose that the implementation and impact of policies is crucially shaped by how those policies are understood and interpreted by people. For PCP to be understood it is important to consider how the hospital has perceived PCP. This suggests a value in an interpretivist exploration of policy implementation.

A further consideration for the study has been to surface the epistemological stance of the researcher (Bryman 2004). Burrell and Morgan (1979) identify two key approaches, objective or subjective. The objective approach to methodology is termed Nomothetic, whilst the subjective approach is termed Ideographic. A nomothetic methodology applies itself to methods traditionally used in the natural sciences with a focus on quantitative methods. In contrast the ideographic methodology relies on the researcher being close to the area of study to ensure that the context is understood. The ideographic methodology focuses upon the use of qualitative methods facilitating rich data gathering (Silverman, 2005). Holloway (2005) outlines the following as key characteristics of qualitative enquiry;

- An emphasis on obtaining and analysing textual data;
- A focus on extensive interaction with the people being studied, which provides an opportunity for the research to be open and unstructured;
- Based on field work (e.g. unstructured and semi-structured interviews);
- An emphasis on a flexible plan of inquiry.

The approach undertaken for this study was the ideographic methodology within which a large amount of rich qualitative data was captured through in depth interviews which were subjective in nature. It was felt that a qualitative research design would be the best approach as it would allow a rich description of organisational culture to be revealed in the context of PCP. The following sections detail the research design, the selection of the study case and the methods of data gathering and analysis.

### ***6.2.2 Research Design***

The research strategy used by the study should support the logic of the research question and provide the most suitable procedures for researching it. Blaikie (2007) describes four key research strategies inductive, deductive, retroductive and abductive. The abductive research strategy sets out to describe and understand social life in terms of individuals and understand how they have assigned meaning to it. Abductive research strategies are effective in settings exploring 'what' and 'why' questions allowing researchers to understand how individuals conceptualise, interpret and give meaning to reality (Blaikie 2007). The empirical review of PCP studies found that the research on the influence of PCP within hospitals was sparse and provided little insight into the effects of patient choice on hospital cultures,

structures and strategies both at an organisational and individual level. With this in mind the study employed an abductive research strategy that provides insight into the meaning of patient choice in the hospital setting and constructs the impact that this had upon the organisation.

A range of research techniques can be used when undertaking research e.g. surveys, historical analysis, action research, ethnography, case studies etc. (Easterby-Smith et al 1997). The choice of approach should be determined by the type of research questions that the research wished to inquire upon and the level of control that the researcher has within the study (Yin 2009: Eisenhardt 1989).

In the table below Yin (2009) outlines the criteria that guide researchers in selecting the most appropriate method for the study.

Table 6.1 – Situations and Relevant Research Methods

| <b>Methods</b>    | <b>Form of Research Question</b>     | <b>Requires Control of Behavioural Events</b> | <b>Focuses on contemporary events</b> |
|-------------------|--------------------------------------|---|---------------------------------------|
| Experiment        | How, Why                             | Yes   | Yes                                   |
| Survey            | Who, what, where, how many, how much | No  | Yes                                   |
| Archival analysis | Who, what, where, how many, how much | No  | Yes/No                                |
| History           | How, Why                             | No  | No                                    |
| Case Study        | How, Why                             | No  | Yes                                   |

(Yin 2009)

The case study approach is defined as;

“An empirical inquiry that investigates a contemporary phenomenon within its real-life context”.

(Yin 2003)

Eisenhardt (1989) concurs with this definition by adding that the case study research strategy concentrates on perceiving the dynamics present within single settings.

### ***6.2.3. Case Study Design***

The case study approach is effective for examining the ‘how’, ‘why’ and ‘what’ questions which support researchers to enquire about areas that they have little or no control (Saunders et al 2007). Saunders et al (2007) note that the case study approach is frequently employed in exploratory and explanatory research and is suitable for the study of complex social phenomena.

Case study design has been categorised by authors in different ways, George and Bennett (2005) suggested the following types of case studies and attempted to identify the case study approach with theory development;

**Theoretical/configurative ideographic case study** – Not used to generate theory but used to build on existing theory

**Discipline configurative case study** – Uses existing well established theory to rationalise case findings

**Heuristic case study** – Used as a method of identifying new variables, hypotheses or causal paths

**Theory-testing case study** – Used to test the condition of a theory. It can be used to explore theories that are most or least likely to be implemented

**Building block case study** – Used as an exploration of different phenomena to establish common patterns

Yin (1994) and Eisenhardt (1989) identified the following sub categories that can further refine the design of the study.

**Procedural characteristics** – Many variables of interest, multiple sources of evidence, theoretical propositions to guide the collection and analysis of data

**Types of case studies** – explanatory, exploratory, descriptive

**Designs** – single case (holistic), single case (embedded) or multiple case studies (holistic), multiple case studies (embedded) designs

**Used methods** – qualitative, quantitative or both

The research design approach selected for this study is the single case holistic study method. The level of case study has been at organisational level. The approach uses an abductive research strategy combining primarily qualitative data capture with some quantitative data relating to the case of study. Qualitative research using case study methods provides an opportunity for researchers to observe complex phenomena and understand the interaction and behaviours in the organisation (Lee, 1999). PCP in the hospital environment is a complex contemporary phenomenon to study. To gain an understanding of PCP within the context of a hospital it proposed

that a qualitative case study design is the best approach as it this allows a rich description of the behaviours and interactions within the organisation to be explored providing some insight into how PCP has been perceived. Table 6.2 below outlines the specific research questions that have been explored.

**Table 6.2 - Research Questions**

1. How is PCP viewed by different staff groups within the organisation?
2. How has the organisation's culture changed in response to PCP?
3. What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?

The research questions are typically 'how' and 'what' questions reinforcing their suitability to the case study approach. The research questions distil the wide base literature of PCP and organisational culture and cultural change theory to understand the impact of these two phenomena as they combine within the hospital setting.

“Qualitative research conducted within the interpretive paradigm is informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience. This research seeks explanation within the realm of individual consciousness and subjectivity from the standpoint of the participants rather than the observer of action.”

(O'Connor and Netting 2002 p780)

#### ***6.2.4 Strengths and Limitations of the Case Study Approach***

This section describes the strengths and weaknesses of this design and considers how this has been handled by the study. The case study approach has been used frequently within the context of social sciences and management research (Garson, 2009). One of its key strengths is characterised as;

“An empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident,”

(Yin 2009 p18)

Two other strengths of the case study approach are identified as the opportunity to be close to real life situations and the vast amount of detail obtained from the case. These elements are described as particularly important as they provide a method of understanding human behaviour that is not easily found in rules based theories (Flyvbjerg 2004). The case study method also allows the researcher to refine their own skills and become experienced in high level, concrete, context dependent experience (Flyvbjerg 2004). This proximity to the case of study allows researchers to expand their knowledge and understanding of reality using feedback from the area of study.

Eysenck (1976) discussed the merits of the case study approach and concluded that;

“We simply have to keep our eyes open and look carefully at individual cases – not in the hope of proving anything, but rather in the hope of learning something!”

(Eysenck 1976 in Flyvbjerg 2004)

Other strengths of the case study approach lie in its applicability to real life and human situations and the process of accessing this through written documentation (Soy 1997). The vast amount of rich data produced allows the researcher to explore complex situation and phenomena an opportunity not presented with many other research methods.

The strengths of the case study approach are realised when it is applied in a setting where descriptive or explanatory questions are being researched and the researcher aims to do this by obtaining a first-hand understanding of the events through direct observation (Yin 2004).

Whilst recognising the strengths of the case study approach the research methods literature (Yin 2009, Eisenhardt 1989, Easterby-Smith et al 2008) describes the limitations that are commonly associated with this approach.

Flyvbjerg (2004) outlines five weaknesses of the case study approach. These five areas are identified and discussed below.



1. The case study approach generates practical (context-dependent) knowledge and this less valuable than general theoretical (context-independent) knowledge
2. Case study cannot contribute to scientific development because one cannot generalise on the basis of an individual case
3. Case study is less useful for hypothesis testing and theory building and is more suited to hypothesis generation i.e. the first stage of the total research process
4. Case study contains a bias towards verification and therefore there is a tendency to confirm the researcher's preconceived notion
5. Case study information is often difficult to summarize and develop general propositions

(Flyvbjerg 2004)

The first challenge to the case study approach is its inability to demonstrate the rigour of a scientific approach and prove theory. This challenge is based upon the premise that the approach is content specific and practical in terms of its outcomes (Flyvbjerg 2004). The case study approach is not designed to prove theory, its strength is derived from its ability to enable close contact and observation and provide depth, understanding and learning. The nature of the research question will determine whether the case study method is appropriate (Yin 2004).

The second limitation of the case study approach is the opportunity to generalise based on an individual case (Easterby-Smith et al 2008). Greenhalgh et al (2005) describe the dilemma as one of trading external validity i.e. direct transfer from one context to another with internal coherence and richness. The ability to generalise the findings from case study methods have been tackled in different ways by researchers. Yin's approach is to describe the case as a member of a family of cases

which provide the analytical framework to understand (Greenhalgh et al 2005). Stake (1995) presents a contrasting view in which the case is meaningful in its own right. Simons in Greenhalgh (2005) states that;

“The hallmark of a good case study is metaphorical (rather than scientific) generalisability.”

(Simons in Greenhalgh 2005)

In this situation, it is proposed that the case has value in representing information at a metaphoric level and that it can be used as a lens to view common features of similar cases rather than directly translating its findings to other cases.

The third limitation posed by Flyvbjerg is that the case study approach is the notion that it is limited to hypothesis generation rather than theory generation and thus is limited to the first stage of the research process. But this notion is not fully supported by case study research itself. For example, Eisenhardt (1989) describes a range of examples where the case study approach has been used successfully to generate theory.

Table 6.3 – Examples of Inductive Case Study Research

| Study                                  | Description of Cases  | Research Problem  | Data Sources   | Investigator                       | Output   |
|--|---|---|--|------------------------------------|--|
| <b>Burgelman (1983)</b>                | 6 internal corporate ventures in 1 major corporation                | Management of new ventures                              | Archives<br>Interviews<br>Some observation                   | Single investigator                | Process model linking multiple organisational levels                                 |
| <b>Mintzberg and McHugh (1985)</b>     | 1 national Film Board of Canada, 1939 – 1975 with 6 periods         | Formulation of strategy in an adhocracy                 | Archives<br>Some interviews                                  | Research Team                      | Strategy- making themes “grass roots” model of strategy formation                    |
| <b>Harris and Sutton (1986)</b>        | 8 Diverse organisations   | Parting ceremonies during organisational death          | Interviews<br>Archives                                       | Research team                      | Conceptual framework about the functions of parting ceremonies for displaced members |
| <b>Eisenhardt and Bourgeois (1988)</b> | 8 microcomputer firms   | Strategic decision making in high velocity environments | Interviews<br>Questionnaires<br>Archives<br>Some observation | Research team<br>Tandem interviews | Mid-range theory linking power politics and firm performance                         |
| <b>Gersick (1988)</b>                  | 8 project groups with deadlines                                     | Group development in project teams                      | Observation<br>Some interviews                               | Single investigator                | Punctual equilibrium model of group development                                      |
| <b>Leonard-Barton (1988)</b>           | 10 technical innovations  | Internal technology transfer                            | Interviews<br>Experiment<br>Observation                      | Single investigator                | Process model  |
| <b>Pettigrew (1988)</b>                | 1 high performing and 1 low performing firm in each of 4 industries | Strategic change and competitiveness                    | Interviews<br>Questionnaires<br>Archives<br>Some observation | Research teams                     | In progress  |

(Eisenhardt 1989)

Eisenhardt demonstrates the ability for case study methods to support theory generation but advises two notes of caution. First, the case study may generate intensive empirical evidence; it can lead to theory that is overly complex. Secondly, theory from the case study is built using a bottom approach. There can be a danger in some situations that the theory generated describes idiosyncratic phenomena which cannot raise the level of generality to theory.

The fourth limitation of the case study approach, as described by Flyvbjerg (2004) suggests that the subjective nature of the study will lead the researcher towards their own personal bias and seek to fulfil their own preconceived notions. Flyvbjerg contests this view and argues that this inherent subjective bias is a feature of most qualitative methods. This does not mean that the approach is any less rigorous than quantitative hypo-deductive methods. Campbell (1975) suggests that the case study seeks to falsify rather than verify ideas. Through the case study approach the researcher is able to get close to the subjects under study and shape his thoughts through the study process as feedback is obtained from the case.

The final limitation of the case study approach to be discussed is the fact that the case study approach can produce a vast amount of rich, intensive data. This can then cause the researcher difficulty in analysing the data and synthesising ideas and theories (Eisenhardt 1989, Easterby-Smith et al 2008). Peattie (2001) argues that the temptation to summarise dense case studies should be avoided. This act can devalue the case and lose the learning that has been gained. The strength of the case study should be exercised appropriately and be used to generate social theory

rather than factual findings of high level generalisations of theory. Yin (2009) reinforces this view and claims that the value added from the case study approach is its ability to enrich the understanding of individuals and their reality.

This section has outlined the strengths and limitations of the case study approach. The opportunity to research an area in detail within a real life context needs to be balanced against the level to which the information can be generalised and the outputs distilled and summarised. The construction of a case study requires the researcher to exercise both skill and judgement. The components of a robust case depend upon the following key elements;

“Iteratively defined through a sequence of sampling (to identify somewhere to start), progressive focusing (to refine and systematically explore what has been sampled), theorising (about interactions within the arbitrarily defined case and across the boundary with the world beyond it), analysing (testing how well the data fit the theory) and interpreting (deriving meaning from the data).”

(Greenhalgh 2005, Yin 1994, Stake 1995)

### ***6.2.5 Justification of case study design for this study***

A case study design was selected for this study the justification for this is set out below:

Case study design is appropriate when an empirical study proposes to investigate a contemporary phenomenon within a real-life context (Yin 2003). Yin (2003) proposes that a case study differs from history as the focus of the case study is on contemporary events. There has been challenge that the focus on contemporary events is a necessary characteristic of a case study and a proposition that methods such as a review of archival data can be used by historical researchers.

The present study focusses on the understanding how participants have perceived PCP and the impact that this has had within their organisation. PCP is current health policy which remains a central plan of the systems wide reform of the NHS. The case study method seems to be an appropriate design for this study.

The situations and methods set out in table 6.1 indicate that when a research question takes the form of a 'how', 'what' or 'why' question, the case study is an appropriate method. The aim of the study is to understand how PCP has impacted the culture of a hospital; how it has changed as a result of PCP and perhaps shed some light on the factors affecting PCP and how this relates to the intended outcomes of PCP. Given these questions it is proposed that the case study method is appropriate.

When a researcher is unable to manipulate behaviours and has no control over the events, case study becomes an appropriate method of study. In the current study,

the researcher has no control over the events and the case study approach allows for a deep exploration of the factors impacting PCP within the hospital environment.

Yin (2003) suggests that a case study design should be considered when the context of the study is important to the phenomenon under study. A case study approach was considered appropriate as it was the context of the hospital that was deemed to be critical to the study.

### **6.3 Selecting the Case**

#### ***6.3.1 Background***

The fieldwork for the study was conducted at Middlechester<sup>1</sup> NHS Trust. This is a large secondary and tertiary health care provider providing health care services for its local population and also a range of specialist services that can attract patients from the regional and in some cases the national population. Within the local Health Economy, the Trust receives a large proportion of its referrals from the local population - 75% of all elective referrals received and 90% of non-elective/GP referrals come from Local area (Market Assessment Overview, Board discussion day 2009). This case has been chosen for a number of reasons;

The case is surrounded by a number of hospitals within a 20 mile radius. Studies have shown that 47% of patients are willing to travel within a 30 mile radius to be treated quicker (Dusheiko 2014). PCP programme theory requires that alternative providers are available for patients to choose from for PCP to operate as intended.

---

<sup>1</sup> Middlechester NHS Trust – Pseudonym for large acute teaching hospital

The case satisfies one of the conditions of PCP, where the threat of losing patients can be considered a reality for the Trust.

The Trust has maintained its reputation for clinical excellence for a number of years due to its teaching status. The case allows the researcher to determine a teaching hospitals reaction to patient choice and whether this has had any influence on how it has responded PCP

The nature of teaching hospitals is such that they inevitably treat the sickest and complex cases referred from other provider. May this perspective have influenced the organisations response to PCP in that this flow is not affected by PCP so might this dilute the threat and reduce the incentives.

The researcher has been employed in the Trust for more than 20 years. At a practical level this has enabled the researcher to have access to data about the Trust and also access to interviewees.

Given the size of the organisation there is an opportunity within the case to compare clinical services with each other to see if there are any differences in perceptions towards PCP.

Many of the above features are common across the range of acute teaching hospitals across the NHS. The selection of this case can facilitate a degree of generalisability with regard to the wider teaching hospital population group.

Finally, access to the case has been negotiated through the Senior Management team of the Trust. The researcher has been employed in a senior position within the



Trust for more than 20 years. A paper outlining the research aims of the study was submitted for approval to the Senior Management Team to obtain permission to use the organisation as a case. This request was approved by the team. It is recognised that researching your own organisations creates a potential for bias and could affect the results obtained. This situation is discussed in more detail later in this chapter under the reflexivity section outlining the consideration that has been given to this issue.

### ***6.3.2 A description of the Case***

The Trust is one of the largest hospitals within England. The clinical services are delivered across a number of sites and over 1 million patients per year are treated. Whilst providing local services to the surrounding population, the hospital provides regional and national clinical services e.g. Neurosurgery, Cardiac Services, and Oncology Services.

The corporate vision of the Trust encompasses the following aspirations. That Middlechester Teaching Hospitals NHS Trust is a locally, nationally and internationally renowned centre of excellence for patient care, education and research. The vision is underpinned by three broad goals that focus on the achievement of clinical excellence, improving service delivery and becoming the hospital of choice.

## **Trust Location**

The Trust is the largest provider within a large city. It also has two private hospitals within the city and has 3 district general hospitals surrounding it, all within a 20 mile radius.

## **Current Performance of the Trust**

Over the last few years, the Trust has failed to achieve a number of national targets including the referral to treatment waiting times standard, infection control standards, the cancer waiting time standards and the 4 hour standard for emergency care. The current year, 2014, has shown significant performance in most areas but the 4 hour target and the Referral to Treatment target remains a challenge. The Trust has defended its poor performance by stating that the size of the organisation and the case mix (predominantly complex cases) has created additional challenges. Recent bench marking data has shown that organisations of a similar size and case mix have overcome these challenges and have significantly better performance than the Trust. Despite the performance challenges, the Trust's reputation for clinical excellence is based on its clinical outcomes, leading edge surgical techniques and low mortality rates.

A review undertaken by an external control showed that the Trust employed 24 full time members of staff per one million pounds compared with 28 per million for comparative Trusts. It is believed that the Trust has not explored fully the potential of redesigning staff roles and as such has an expensive staff base.

The Trust's estate covers 6 different sites and in comparison to similar sized Trusts (in terms of budget) they are able to deliver the same volume of activity in two thirds of the Trust's estate. A major review of the Trust's estate is being undertaken with a view to rationalisation to enable costs to be reduced.

The financial position of the Trust (financial year 2013/14) currently shows a significant gap projected for the end of the year. A cost improvement target of 5% has been allocated to both corporate and operational areas to contribute to the gap. The Trust is preparing an application for Foundation Trust status which it hopes to submit in 2015. This requires the Trust to present 5 year business and financial plans. This process is new for the Trust as its business plan has been an annual activity and the financial plan has only focussed on the current year and the forthcoming year. To facilitate financial growth and efficiency the Trust has commenced a significant change programme that has set out to deliver efficiency through service redesign using lean principles.

The case is interesting from a number of perspectives. The case is surrounded by potential competitors, it has not been performing well against national performance standards and it is as financial challenges. From a context point, PCP was designed stimulate organisations like the case to change and improve the way in which it delivered its services.

## 6.4 Sampling

Easterby-Smith et al (2008) describe sampling strategies as a method to determine the subjects that will participate in the study. The significance of the sample is that its selection determines the conclusions that can be drawn from the data that is collected e.g. market testing for a product range would be ineffective if it did not include sufficient numbers of people from the target population.

Sampling strategies vary from random sampling i.e. once the population has been appropriately identified a deliberate decision to try and obtain a random set of responses to quota sampling where a specific number of individuals within defined categories are recruited and finally purposive sampling where a targeted group of individuals are selected because of a specific set of attributes (Easterby-Smith 2008). Qualitative studies tend to use purposive sampling methods as a way of seeking out the groups and individuals that can provide an insight into specific research questions (Stake 1995, Eisenhardt 1989). The need to generate random sampling in qualitative research is deemed to be unnecessary. Saunders et al (2007) suggests that the researcher understanding their research questions and selecting candidates that fit within their research context is far more valuable.

The study uses purposive sampling as a method for identifying the areas of study and also the professional disciplines that will be interviewed. This approach allows

the flexibility to explore the study within the context of the research questions creating a relevant research framework and context (Schwandt 2007).

#### ***6.4.1 Selecting the Specialties for Study within the Case***

The Trust provides service across a range of 36 main specialties. The practicalities of trying to interview staff across all these specialties is challenging and is not necessary when trying to determine the impact of patient choice upon the organisation. Using the opportunities provided by theoretical sampling Bryman (1988) suggests that qualitative studies can ensure generalisability through theoretical knowledge rather than creating statistical significance. To provide meaning to the research context the study has focussed on two specific areas of the Trust.

The first specialty selected, was one that has experienced a large proportion of patients that have exercised choice of hospital when booking their first outpatient appointment. This was determined using statistical information on the number of bookings made through the National Choose and Book system (see table 6.5 below). This selection assumes that patients referred to this specialty have had an encounter with patient choice principles. It is also assumed that this specialty may have noticed that their patients have been referred through a different route into the organisation and they may have changed what they do in response to this new process.

The second specialty selected was one where only a small proportion of patients have exercised choice of hospital when booking their first outpatient appointment. It was assumed here that few patients had experienced choice and that the specialty

had experienced minimal changes as a result of the national Choose and Book system.

In terms of determining the specialties, national and local data sources were used to assess the usage of choose and book (Appendix 1&2). These data sources were used a proxy measure to determine patient choice.

The table below shows the national specialty trend with regard to percentage of referrals made via Choose and Book system.

Table 6.4 – National Choose and Book referral rates by Specialty

| <b>Low Volumes of Choose and Book Referrals</b> | <b>High Volumes of Choose and Book Referrals</b> |
|---|--|
| Dental Medicine                                 | Surgery – Vascular                               |
| Hepato-Gastroenterology (Surg and Med)          | Rheumatology                                     |
| Oncology (phasing out)                          | Neurology  |
| Genito-Urinary Medicine                         | Cardiology                                       |
| Learning Disabilities                           | Surgery - Not Otherwise Specified                |
| Occupational Therapy                            | 2WW  |
| Palliative Medicine                             | Urology  |
| Complementary Medicine                          | Children's & Adolescent Services                 |
| Health Promotion                                | Gynaecology                                      |
| Diagnostic Pathology                            | GI and Liver (Medicine and Surgery)              |
| Surgery – Cardiothoracic                        | Ear Nose and Throat                              |
| Orthotics and Prosthetics                       | Dermatology                                      |
| Genetics  | Ophthalmology                                    |
| Infectious Diseases                             | Orthopaedics                                     |
| Dietetics                                       | Surgery - Vascular                               |

|                                    |              |
|------------------------------------|--------------|
| Dentistry and Orthodontics         | Rheumatology |
| Mental Health - Child & Adolescent | Neurology    |
| Immunology                         |              |
| Rehabilitation                     |              |
| Allergy                            |              |
| Sleep Studies                      |              |
| Diabetic Medicine                  |              |

*Source: Department of Health - Bookings by Specialty by SHA August 2010*

Table 6.5 – Trust Local Choose and Book Referral Rates by Specialty

| <b>Low Volumes of Trust Choose and Book Referrals</b> | <b>High Volumes of Trust Choose and Book Referrals</b> |
|---|--|
| <b>140 - Oral Surgery</b>                             | <b>120 - ENT</b>                                       |
| <b>300 - Medicine</b>                                 | <b>317 - Allergy</b>                                   |
| <b>307 - Diabetic Medicine</b>                        | <b>100 - Surgery</b>                                   |
| <b>110 - Trauma &amp; Orthopaedics</b>                | <b>321 - Paediatric Cardiology</b>                     |
| <b>160 - Plastic Surgery</b>                          | <b>171 - Paediatric Surgery</b>                        |
| <b>214 - Paediatric Trauma &amp; Orthopaedics</b>     | <b>310 - Audiological Medicine</b>                     |
| <b>361 - Nephrology</b>                               | <b>410 - Rheumatology</b>                              |
| <b>430 - Elderly Medicine</b>                         | <b>104 – Colorectal Surgery</b>                        |

*Source: Department of Health – Bookings by Specialty by SHA August 2010*

The Trust Activity Enabling strategy 2010/11 to 2015/16 highlighted that the Trust has lost 5% of its outpatient referral market share to surrounding providers. The report also shared results from a GP survey undertaken in 2007 that showed that patients were choosing alternative providers (52% of respondents). The report

demonstrated that surrounding providers' services had attracted referrals from the following different specialties; ENT, Orthopaedics, General Surgery, Gynaecology, Maternity referrals. Based on the analysis of both the local and national data, the specialties selected for study were;

- ENT - High volume referral speciality with a significant proportion of Choose and Book referrals both nationally and locally. The local information within the Trust has shown that evidence of patient choice within this service has been observed.
- Diabetic Medicine - Low volume referrals with a low proportion of Choose and Book referrals both nationally and locally.

#### ***6.4.2 Selecting the Individuals to Participate in the Study***

Qualitative research does not prescribe the number of participants required to fulfil the research criteria (Patton 2002). The number of participants needs to be governed by the sample construction being underpinned by robust theoretical assumptions (Bryman 1984). The two specialties selected test contrasting scenarios; scenario one, where greater impact of patient choice is expected versus scenario two, where less impact of patient choice is expected. In addition to these two specialties, it was important for the study to capture the corporate perspective of the organisation. The executive team was used to represent the overarching governance of the organisation.



Table 6.6 – Sample Selection and Criteria for Selection

| Area                     | Participants   | Criteria for Selection   |
|--------------------------|--|--|
| <b>Executive Team</b>    | Executive and Non-Executive Directors (x10)  | <ul style="list-style-type: none"> <li>• Closer to Policy Makers</li> <li>• Greater understanding of desired impact of choice</li> <li>• Opportunity to direct and influence the organisation</li> </ul>   |
| <b>ENT</b>               | <ul style="list-style-type: none"> <li>• Consultants, Doctors</li> <li>• Nurses, matrons, ward sisters, staff nurses</li> <li>• Administrative clerical staff</li> <li>• Managerial staff</li> <li>• 10 interviews in total</li> </ul> | <ul style="list-style-type: none"> <li>• Staff closer to the patient will be more distant to patient choice policy therefore they will have experienced less impact of patient choice</li> <li>• There will be a difference in clinical and non-clinical perspectives</li> <li>• Staff within this specialty will show a greater understanding of patient choice policy given that this is a specialty within which the opportunity to exercise 'choice of provider' is more common</li> </ul> |
| <b>Diabetic Medicine</b> | <ul style="list-style-type: none"> <li>• Consultants, Doctors</li> <li>• Nurses, matrons, ward sisters, staff nurses</li> <li>• Administrative clerical staff</li> <li>• Managerial staff</li> <li>• 10 interviews in total</li> </ul> | <ul style="list-style-type: none"> <li>• Staff closer to the patient will be more distant to patient choice policy therefore they will have experienced less impact of patient choice</li> <li>• There will be a difference in clinical and non-clinical perspectives</li> <li>• Staff within this specialty will show a lesser understanding of patient choice policy given that this is a specialty within which the opportunity to exercise 'choice of provider' is less common</li> </ul>  |

Silverman (2005) describes the need for the sample to be meaningful within the research context and fulfil robust criteria. Table 6.7 summarises the sample was constructed. The executive team were identified as a critical part of the sample as this team have responsibility for the implementation of NHS policy. It was assumed

that this team will have responsibility for understanding the policy and setting its direction within the organisation.

Finally, combinations of both clinical and non-clinical staff were selected to participate in the study. The assumption here was that those closest to patient care were potentially furthest away from understanding policy. It was expected that there would be different perceptions from staff groups dependent upon how close they are to the patient versus how close they were to policy cascade.

30 interviews were conducted across the study. Eisenhardt (1989) suggests that there may be a need for cases to continue to be undertaken until theoretical saturation has taken place i.e. where no new themes are generated. Lincoln and Guba (1985) describe this as reaching 'the point of redundancy'. The study found that the 30 interviews yielded sufficient rich data and no new themes were emerging from the data. It was deemed at this point that saturation had been achieved.

Participants were invited to take part in the study via an invitation letter and an information sheet summarising the key aims of the study (Appendix 3 - Information to Participants). This activity was undertaken via email and respondents were asked to confirm participation via email. Table 6.8 shows the participants by role and by department.

Table 6.7 – Participants by role by department

| Role           | Corporate | ENT | Diabetic Medicine |
|----------------|-----------|-----|-------------------|
| Senior Manager | 3         | 1   | 1                 |
| Senior Nurse   | 2         | 3   | 3                 |
| Senior Doctor  | 1         | 2   | 2                 |
| Middle manager | 2         | 2   | 2                 |
| Junior staff   | 2         | 2   | 2                 |

### 6.5 Data Gathering

A wide range of methods can be used to capture data in qualitative studies, each with strengths and weaknesses and Table 6.9 sets out the different sources of evidence and their associated strengths and weaknesses (Yin 2009). Yin (2003) states that the accumulation of converging evidence and triangulation of data over a given issue is the aim of data collection.

**Table 6.8 Sources of evidence and their strengths and weaknesses**

| Sources of evidence | Strengths  | Weaknesses   |
|---------------------|--|--|
| Documentation       | <ul style="list-style-type: none"> <li>• Stable – repeated review</li> <li>• Unobtrusive – exist prior to case study</li> <li>• Exact – names etc.</li> <li>• Broad coverage – extended time span</li> </ul> | <ul style="list-style-type: none"> <li>• Retrievability – difficult</li> <li>• Biased selectivity</li> <li>• Reporting bias – reflects authors bias</li> <li>• Access many be blocked</li> </ul> |
| Archival records    | <ul style="list-style-type: none"> <li>• Same as above</li> <li>• Precise and quantitative</li> </ul>  | <ul style="list-style-type: none"> <li>• Same as above</li> <li>• Privacy may inhibit access</li> </ul>  |
| Interviews          | <ul style="list-style-type: none"> <li>• Targeted – focuses on case study topic</li> </ul>   | <ul style="list-style-type: none"> <li>• Bias due to poor questions</li> </ul>   |

|                         |   |   |
|-------------------------|---|---|
|                         | <ul style="list-style-type: none"> <li>• Insightful = provides perceived causal inferences</li> </ul>                                 | <ul style="list-style-type: none"> <li>• Response bias</li> <li>• Incomplete recollection</li> <li>• Reflexivity – interviewee expresses what interviewer want to hear</li> </ul>                                 |
| Direct observation      | <ul style="list-style-type: none"> <li>• Reality – covers events in real time</li> <li>• Contextual – covers event context</li> </ul> | <ul style="list-style-type: none"> <li>• Time consuming</li> <li>• Selectivity – might miss facts</li> <li>• Reflexivity – observers presence might cause change</li> <li>• Cost – observers need time</li> </ul> |
| Participant observation | <ul style="list-style-type: none"> <li>• Same as above</li> <li>• Insightful into interpersonal behaviour</li> </ul>                  | <ul style="list-style-type: none"> <li>• Same as above</li> <li>• Bias due to investigators action</li> </ul>   |
| Physical artefacts      | <ul style="list-style-type: none"> <li>• Insightful into cultural features</li> <li>• Insightful into technical operations</li> </ul> | <ul style="list-style-type: none"> <li>• Selectivity</li> <li>• Availability</li> </ul>   |

(Yin, 2003b, page 86)

The principle data collection used for the study was semi- structured interviews and a review of documents. This approach would support a target focus on the case study topic supported by access to stable information about the organisation. Archival records were not used as PCP is such a contemporary phenomenon; it was perceived that relevant information would be contained within current documents.

Direct observation and participant observation methods were discounted for a couple of reasons. The researcher had been given permission to undertake the study within the organisation on the understanding that when conducting the research participants would be clear on the role that the individual was in. The Trust Chief Executive was clear, that she would want to be clear when the individual was operating as a

researcher and when she was fulfilling her employed role. It was felt that observation could possibly create that confusion so it was decided that observation as a method would not be used. In addition, the study wanted to obtain insight into a particular topic and whilst observation could provide insightful interpersonal behaviour and context this may or not be related to PCP. It is for these reasons that the participant observation and direct observation were not used in the case study.

### ***6.5.1 Review of documents***

The role of reviewing documents is to corroborate the information gathered at the interview stage (Yin 2003). The study aimed to explore the culture of the organisation and how this impacts on PCP. A review of documents was designed to not only corroborate the information gathered within the interviews but to provide some insight into the different levels of culture that exist within the case. Corporate documents tend to reflect the espoused values and beliefs of an organisation (Schein 1980). The documents reviewed are listed in Appendix 3 – Documents Reviewed and consisted of documents that would provide some insight into the corporate goals of the organisation. Given that PCP was designed to stimulate change for the organisation, the documents reviewed were used to determine the importance of PCP and if it was featuring at all as a consideration for decision makers within the organisation. The models of cultural change set out in Chapter 4 outline the importance of leadership and the identification of a need to change as a requirement for cultural transformation (Mannion et al 2005)

The strategy documents were reviewed to examine the awareness of PCP at the corporate level and the degree to which this might be influencing the future direction of the organisation. The broader documents were reviewed to explore the corporate culture of the organisation. All information collected from different sources was cross checked to increase the validity of the study.

### ***6.5.2 Interviewing***

In this study semi structured interviews were used, with each of the interviews ensuring that the research questions act as a guide for issues to be explored. A Topic guide (Appendix 4) was constructed that facilitated the discussion in each interview. The duration of interviews ranged from 45 minutes to 1 hour and 15 minutes. Data gathered from the interviews was recorded and subsequently transcribed.

The methodology employed was one which started with general open questions, moving on to checking answers and probing for more information based on answers given, followed by checking meaning with the interviewee and finally, direct questions where issues had not been covered.

The challenges associated with measuring culture are widely recognised (Mannion et al 2003). The competing values framework (CVF) was used in the interviews to explore the organisation's culture and the degree to which it has changed. The detailed rationale for using the CVF is set out in Chapter 5 but to summarise, the CVF has a sound theoretical basis and is easy to use. The CVF uses a culture typology that permits its use in an explanatory framework to aid qualitative analysis (Mannion et al 2005).

## 6.6 Methods of Data Analysis

Data captured through qualitative studies can yield a large volume of deep rich unstructured information that requires analysis (Yin 2009). An analytical strategy is required to enable the researcher to organise and analyse the data into a meaningful structure.

Framework analysis was the approach that was used by the study to analyse the qualitative data that had been captured. Framework analysis is an approach developed by Ritchie and Spencer (1994). Described as an approach that;

“Is better adapted to research that has specific questions, a limited time frame, a pre-designed sample and a priori issues.”

(Srivastava and Thomson 2009)

The thematic framework analysis provides the opportunity to include both *a priori* theoretical (deductive approach) and empirical (inductive approach) issues into the analysis process (Pope and Mays 2000). The approach also allows the structuring of the data for analysis purposes rendering it more objective (Lacey and Luff 2001). The framework analysis approach was explicitly developed in the context of applied policy research and has been successfully used by health services researchers (Todd 2003; Griffiths et al 2001).

The Framework analysis approach uses five steps: familiarisation; identifying a thematic framework; indexing; charting and mapping and interpretation (See table 6.9 below). The primary purpose of the approach is to enable researchers to describe what is happening in a particular setting and mechanism for interpretation. Although used in a many settings it is often used in health care (Srivastava and Thomson 2009). Framework analysis was used in this study as it allows for an analytical process that starts from a priori themes, to which new themes and categories were added as the data is explored. So it provides a structure and is sensitive to emergence from the data itself. This made it well suited to policy-applied research.

Figure 6.9 Five stages of data analysis in the framework approach

- *Familiarisation*—immersion in the raw data (or typically a pragmatic selection from the data) by listening to tapes, reading transcripts, studying notes and so on, in order to list key ideas and recurrent themes
- *Identifying a thematic framework*—identifying all the key issues, concepts, and themes by which the data can be examined and referenced. This is carried out by drawing on a priori issues and questions derived from the aims and objectives of the study as well as issues raised by the respondents themselves and views or experiences that recur in the data. The end product of this stage is a detailed index of the data, which labels the data into manageable chunks for subsequent retrieval and exploration
- *Indexing*—applying the thematic framework or index systematically to all the data in textual form by annotating the transcripts with numerical codes from the index, usually supported by short text descriptors to elaborate the index heading. Single passages of text can often



encompass a large number of different themes, each of which has to be recorded, usually in the margin of the transcript

- *Charting*—rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts. For example, there is likely to be a chart for each key subject area or theme with entries for several respondents. Unlike simple cut and paste methods that group verbatim text, the charts contain distilled summaries of views and experiences. Thus the charting process involves a considerable amount of abstraction and synthesis
- *Mapping and interpretation*—using the charts to define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings. The process of mapping and interpretation is influenced by the original research objectives as well as by the themes that have emerged from the data themselves

(Ritchie and Spencer 1993)

There are a range of other techniques available for analysing case study, such as pattern matching, explanation building, time series analysis, logical models and cross case analysis (Yin 2009). Given the explanatory nature of the research question and associated objectives, the preferred method for analysis was framework analysis given the flexibility that it allowed the researcher in the analytical process.

“Data analysis often takes place alongside data collection to allow questions to be refined and new avenues of inquiry to develop. ...Textual data are typically explored inductively using content analysis to generate categories and explanations;”

(Pope et al 2006)

As previously stated, software can be used to aid the indexing step of framework analysis. For the purpose of this study, Nvivo was used as the software to support the indexing of the qualitative data. Interview data was transcribed verbatim and imported into the software. Data were broadly grouped into the organisational change, strategy, structure and culture themes. Further themes emerged from the data that were coded separately such as the different meanings of patient choice and emotions associated with the policy principles. Once the data had been fully coded, it was analysed to identify dominant themes within the literature. The analysis also explored views that were different to the dominant views held by the group. The analysis explored differences across the three specific areas of ENT, Diabetic Medicine and Corporate Services.

### **6.7 Validity and Reliability**

The quality of a study is determined by characteristics that determine the level of validity and reliability. Validity as a concept tries to assess how accurate and credible the results are (McNeill 1990, Schwandt 2007). Morse (1985) describes validity in qualitative research as the extent to which the research findings of the study represent reality. A common criticism of qualitative research is that it is merely a

collection of anecdotes and personal expressions that are strongly associated with the bias of the researcher (Mays and Pope 1995). A variety of methods exist that can ensure reliability and validity in qualitative research including a detailed illustration of the techniques used, the use of schematics coding with the aid of computer programmes and the use of transcription techniques (Seale and Silverman 1997).

A number of mechanisms were used to ensure that rigour was introduced in to the study. The research design was clearly identified as qualitative from the outset and in this case there was no expectation that the findings from this case could be directly transferred from one context to another. With this in mind the language used was careful in how the meanings were conveyed. All interviews were recorded using audio tapes which allowed the data to be recorded objectively and comprehensively. A computer programme was used to assist qualitative data analysis enabling systematics analysis of the data.

The sample selection was purposefully selected within the case to ensure that a number of perspectives within the case were represented. This use of theoretical sampling ensured that the selection of cases supported the theoretical assumptions. During the interviews the information provided by respondents was checked back with them for meaning to ensure that this had been captured as they intended. An inductive data analysis method was undertaken with constant comparison of the data with the emerging categories to ensure that data triangulation was taking place.

## 6.8 Reflexivity

Reflexivity is an approach that can be used to understand how the research process has contributed to knowledge construction and especially understand the role of the researcher within this process (Cohen et al 2006).

“Doing qualitative research is by nature a reflective and recursive process.”

(Ely et al, 1991)

Within qualitative research, it is impossible to eradicate subjectivity and bias given the role played by the researcher within this type of study. Cohen et al (2006) suggest that the bias and subjectivity should not be considered as undesirable but rather as a mechanism to capture further richness and depth in the area of study. They suggest that the position and perspectives of researchers can shape the outcomes of all types of research including qualitative, quantitative and laboratory methods.

For the purpose of this study the need to be reflexive was critical. The researcher had been employed by the case of study for more than 20 years. The researcher had developed an organisational memory throughout this period that could influence the researcher's perception of the organisation. This could potentially affect the results that were achieved from respondents. A number of steps were taken to manage this bias.

There are a number of advantages of researching your own organisation namely easier access in securing interviews with individuals and knowing how to contact them. Also, given that they know you they may be more incentivised to respond than if it was someone that they did not know. Also, the researcher has an understanding of the context of the organisation which can help in making sense and interpreting the findings. Alternatively, when approached they may have felt obligated to take part because of the pre-existing professional relationship. The following steps were taken by the researcher to manage the impact of this. Respondents were advised that all information shared within interviews would be anonymised and would be used for the purposes of the study only. Respondents were given the choice to participate in study via the introductory letter and if no response was received this was not pursued further and no reminder letters or phone calls were instigated. The information to respondents was clear that the researcher was employed within the organisation. This approach was taken purposefully and was explicit that in the interview situation the researcher was in the role of doctoral researcher. This approach was taken to ensure that there was openness and transparency throughout the process.

Another factor to consider when researching your own organisation is that respondents may be open to share information because they already know you or are able to commence the conversation at a deeper level because they make assumptions about the prior knowledge that you have. This may be problematic as they may assume that you have a shared understanding of the organisation. Alternatively, respondents may feel more able to speak to a stranger and consequently hold back on information that would ordinarily have shared with an

independent researcher. It is almost impossible to determine whether this has occurred in the study, however, it is important to have acknowledged it.

It was also acknowledged that the researcher might introduce their own bias to the research because of prior knowledge of the context of the organisation they have pre-conceived views that influence the way in which the findings are interpreted. Samples of coded transcripts were shared with the Supervisors to discuss emerging themes and compare them. This allowed the bias to be reduced and a wider perspective to be introduced when identifying themes in the data.

## **6.9 Ethical Considerations**

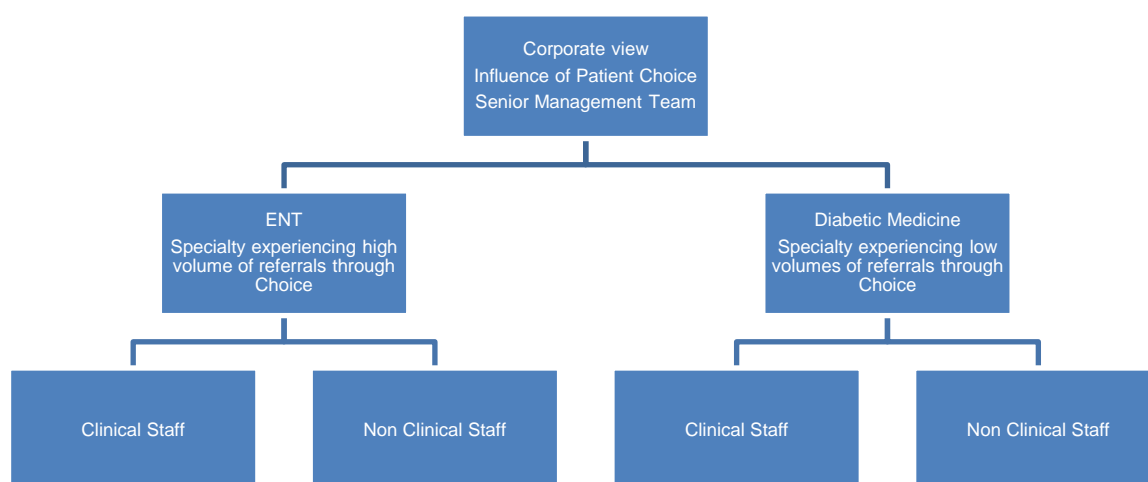
An application was made to the Research Governance department at the Trust and also the Regional Ethics Committee. The research was approved as Service Evaluation.

## **6.10 Summary**

The research design constructed for the study was based on an ideographic methodology. The case study approach was used to explore the research questions and assess the impact of PCP within a hospital. The case study design allowed rich detailed qualitative accounts to be gathered and a review of corporate documents to understand the ambition of the organisation in the context of PCP. The design used allowed the exploration of PCP as a deep level with a particular focus on understanding its meaning and impact on the respondents within the hospital. The

limitations of the case study are acknowledged, in particular, the ability to generalise the findings beyond the case itself. Using primarily qualitative methods the study explored the organisational perspective of the impact and consequence of PCP at a number of levels within the organisation. Focussing on two key specialties; a specialty that had received a high volume of Choose and Book referrals – ENT- and Diabetic Medicine that received a low volume of referrals through the national Choose and Book system the study explored both clinical and non-clinical perspectives on the impact of PCP within the hospital. The study also explored the views of the corporate team within the hospital to consider the impact of PCP on the organisation and its response to this cornerstone policy of the system wide reforms of the NHS. The figure below outlines the components of the case study.

Figure 6.10 – Outline of Research Case Study and core components of study



The next two chapters (Chapters 7 and 8) present the findings of the empirical study. Chapter 7 describes how PCP has been perceived by the different groups within the hospital. Chapter 8 discusses the impact that this might have had on the hospital and the consequence for PCP.



## **Chapter 7: Understanding patient choice and the culture of the hospital**

### **7.1 Introduction**

The purpose of this study is to explore the influence of patient choice on organisational behaviour in an NHS Teaching hospital with a particular focus upon how PCP has helped to shape organisational culture and cultural change. This chapter sets out the key findings derived from the qualitative interviews and a review of documents undertaken as part of the case study. This is achieved by providing a short outline of the case study context (a more detailed description of the case study is provided in chapter 6) and also an outline of the data sample used for the case study and the rationale supporting the approach used to sample staff.

The study is structured around a set of research questions (Appendix 6). This chapter focusses primarily on the first two questions and explores how patient choice has been perceived within the organisation and how the organisations culture has changed in response to PCP. The findings are set out in two sections. The first section explores the different views and meanings associated with patient choice. The second section explores the culture of the organisation to reveal whether this has changed as a result of the introduction of PCP. The findings are summarised in preparation for a discussion in chapter 9.

## **7.2 Case study background**

### ***7.2.1 Context to the Case Study***

A case study methodology was chosen for the research and the case chosen was a large teaching hospital located in the north of England providing health care provision for the local population and a range of regional and national services. The Trust is one of the largest hospitals in England with the clinical services delivered across a number of sites with over 1 million patients per year treated. As previously stated, whilst providing local services to the local population, the hospital provides regional and national clinical services e.g. Neurosurgery, Cardiac Services, and Oncology Services. The case is surrounded by a number of alternative local providers that patients can choose to be treated at as an alternative to the case. PCP programme theory proposes that competition is required for its impact to be felt by hospitals. The context of the case suggests that the opportunity for competition exists.

### ***7.2.2 Data Sample***

As outlined in Chapter 6, the approach taken to research the case was a set of semi structured interviews with staff from across the Trust. A topic guide was used to structure the discussion to address the research questions. The sampling methodology used was purposive. The sample was selected to draw on the specific experiences and views of different occupational groups of the organisation. The executive and corporate teams were selected as they are closer to the national policy agenda so would have strategic experience of PCP and would potentially have

knowledge of the policy, therefore, when looking for the impact of PCP it was proposed that the experience of this group would be useful to explore. ENT was selected as another group that potentially would have felt the impact of patient choice. The ENT service is a high volume specialty with a large proportion of simple cases. ENT services are regularly available in district general hospitals and also in a number of specialist GP practices and community services. Given the range of alternative providers for this service it was expected that ENT services within the Trust may have been influenced by patient choice policy. The final specialty selected was diabetic medicine. This is largely an acute service with patients with long term conditions. It was anticipated that this service would be less susceptible to the influence of patient choice given the nature of the patient population who tend to be long term condition patients with a limited volume of elective work. The table below outlines the staff interviewees selected for interview and details the criteria for used to select them.

Table 7.1 – Staff Interviewees

| Area           | Interviewees  | Criteria for Selection  |
|----------------|---|---|
| Executive Team | <ul style="list-style-type: none"> <li>Executive and Corporate staff members (x10)</li> </ul>   | <ul style="list-style-type: none"> <li>Close to Policy Makers</li> <li>Greater understanding of desired impact of choice</li> <li>Opportunity to direct and influence the organisation</li> </ul>   |
| ENT            | <ul style="list-style-type: none"> <li>Consultants, Doctors</li> <li>Nurses, matrons, ward sisters, staff nurses</li> <li>Administrative clerical staff</li> <li>Managerial staff (10 Interviews in total)</li> </ul> | <ul style="list-style-type: none"> <li>Staff closer to the patient may be more distant to patient choice policy therefore they might be expected to have experienced less impact of patient choice</li> <li>There may be a difference in clinical and non-clinical perspectives</li> <li>Staff within this specialty may show a greater understanding of patient choice policy given that this is a specialty within which the opportunity to exercise 'choice of provider' is more common</li> </ul> |
| Diabetic       | <ul style="list-style-type: none"> <li>Consultants, Doctors</li> </ul>  | <ul style="list-style-type: none"> <li>Staff closer to the patient may be more distant to</li> </ul>  |

|          |   |  |
|----------|---|--|
| Medicine | <ul style="list-style-type: none"> <li>• Nurses, matrons, ward sisters, staff nurses</li> <li>• Administrative clerical staff</li> <li>• Managerial staff (10 interviews in total)</li> </ul> | <p>patient choice policy therefore they may have experienced less impact of patient choice</p> <ul style="list-style-type: none"> <li>• There may be a difference in clinical and non-clinical perspectives</li> <li>• Staff within this specialty may show a lesser understanding of patient choice policy given that this is a specialty within which the opportunity to exercise 'choice of provider' is less common</li> </ul> |
|----------|---|--|

Appendix 7 outlines the background attributes of each of the interviewees participating in the study

### ***7.2.3 Data Analysis***

The analysis of the qualitative data collected was assisted by the use of a software package Nvivo 9. In addition to providing tools to support the coding of data, the software also assists in the provision of a number of outputs to support the presentation of the findings. The documents were reviewed to understand how PCP had been positioned in the organisation and whether it had any influence in shaping the future direction of the organisation.

## **7.3 Views and Perceptions of Patient Choice**

### ***7.3.1 Patient Choice of Provider and Appointment***

Whilst the programme theory underpinning PCP is clear that patient choice relates to patient choice of provider, the NHS itself has been less explicit when defining patient choice. Chapter 2 describes the evolution of patient choice in the NHS and reveals that patient choice has been described in many different ways and its scope has been expanded (Health and Social Care Bill, 2011). A review of Trust documents

revealed that one of the goals of the organisation was to be the ‘hospital of choice’ (Table 7.2 – Goals of the Hospital).

**Table 7.2 Goals of the Hospital**

|  |
|--|
| <ul style="list-style-type: none"><li>• <b>To be the hospital of choice for patients and staff;</b></li><li>• <b>To be a consistently high performing influential healthcare provider;</b></li><li>• <b>To achieve the best possible clinical outcomes for every patient, every time;</b></li><li>• <b>To achieve academic excellence and expand the boundaries of healthcare.</b></li></ul> |
|--|

**(Trust Integrated Business Plan 2010)**

A set of objectives underpinning this goal were found in a leadership document and were identified as;

“To continuously improve the experience of all patients and stakeholders.

To take a lead role in achieving better, simpler and cheaper local health care services”

(Managing for Success – Leading in Lean Organisation,2011)

From the corporate perspective patient choice was being defined in terms of both patient and stakeholder experience. The hospital also seemed to be setting its ambition to influence the local population rather than exploit the full opportunities presented by PCP.

The leadership document - Managing for Success - Leading in Lean Organisations, also set out further objectives on how it would achieve the best possible clinical outcomes for every patient, every time;

“To establish Middlechester as the partner of choice for those who purchase our services.”

(Managing for Success – Leading in Lean Organisation 2011)

From this it could be assumed that whilst acknowledging the role of patient in choice of hospital, the hospital felt that there was also a need to focus on the purchaser relationship and become the partner of choice with its commissioners. This suggests that the hospital felt that the commissioners were the influential stakeholders.

From the interviews, many interviewees described patient choice as a choice of hospital and choice of appointment, Choice of hospital and being able to have flexibility on the date and time of appointment were described as key elements of patient choice.

*I would say that if someone said to me what is patient choice, I would say choice of appointment times, choice of hospitals, and that's about all I would think. In reality I know that it is mostly around hospital times and not the hospitals because you don't really have a choice of where you are going to go. (14, Strategic, Clinical - Nursing)*

*Yes the way that people can book appointments, that they are given a choice of where to go, they don't always have to come to a big teaching hospital if they want to go somewhere nearer to home (16, Operational, Clinical- Nursing ENT)*

Interviewees described the convenience associated with being offered a choice of appointment. Patients being offered when, where and times when they could be seen was thought to be a core dimension of choice.

*To me patient choice means they want it quicker, specifically what hospital they want to go to, if they use a computer they usually look up the doctors on the Internet first nowadays. I think as well it's important that they are given options of days of clinics, you know different days, and they can look to see which Consultants have clinics on specific days. From my point of view if I was a patient it would literally be essential, we all like an early appointment or late afternoon, you need that flexibility. (1, Strategic, Non-clinical)*

For many of the interviewees, patient choice was seen simply as an alternative way of obtaining an appointment. This view was presented by the middle and more junior levels of the organisation. Despite patient choice and choose and book being very different concepts the terms were often used synonymously. The national Choose and Book system was regularly highlighted as the method by which patients would exercise their choice. One interviewee immediate response to defining choice was that it actually commenced with the Choose and Book system.

*Choose and Book initially because it is about patients choosing where their on-going care can be delivered for elective care. That is what I see as patient choice (15 Operational, Clinical – Nursing - ENT)*

It was the perceived improvement of the booking process and the ability to choose hospitals which led many of this group to define patient choice as a facility to improve access to health care both through waiting times and also through improved convenience. Many felt that because the national system allowed waiting times to be published explicitly this would enable patients to choose services where waiting times

were shorter if they wanted to be seen sooner. The parallel of the patient as a consumer in this context was noted and the requirements for patients to be able access health care quickly. An expectation that the delivery of health care should be comparative with other aspects of individual's lives was drawn here with the use of technology and speed enabling choice

*In this day and age I think people go to where they are going to get seen and get the fastest treatment because they want the answer now. Whether they are doing internet shopping and want it delivered tomorrow. You don't want to wait 6 weeks to find out if you have got cancer you want to know now. Choice is based on speed I think. (4, Operational, Clinical – Nursing – Diabetic Medicine)*

Only one interviewee made reference to the NHS constitution where patient choice is enshrined as an explicit right. This interviewee also made reference to the NHS Operating Framework and proposed that patient choice would support the delivery of choices in health care that would deliver timely and improved access.

*Well the NHS constitution obviously and the operating framework there are things in there regarding patient choices. For patients it is about where they want to be treated and when regarding the 18 week pathway and making sure that we deliver in that timeframe (6, Strategic, Non-Clinical)*

### **7.3.2 Patient involvement in health care**

A review of the Trust Annual Report (2010/11) makes reference to patient choice in a much broader sense. It describes patient choice as 'patient choice and involvement' and describes this as a means of engaging with patient population. The reference is made in the context of Trust's aspiration to become a Foundation Trust. The section



in the report describes how patient choice and involvement will aid the Trust in developing its services.

A few interviewees, one from the corporate team and another from the nursing team wanted to see patient choice described in much broader terms. They each commented that patient choice limiting itself to hospital or being able to choose an appointment did not constitute what patient choice should really cover. They wanted to see patient's choice as being something much broader than just choosing a hospital or an appointment. Here another glimpse of patient choice policy principles is seen where patient choice and quality of service are brought together. However, the context of this reference implies that patient choice as it is currently positioned in the organisation is limited and the reality of improvement to the quality of care has not yet been felt.

*I think patient choice needs to be set in a context of quality patients need. Patient choice to me should be in the context of how we provide a really high quality experience and quality of clinical outcome for our patients and actually to me about getting that right and allowing a patient to flow through the health system at whatever point is appropriate if where ever the patient feels appropriate the referring clinician and the receiving clinician feels appropriate, if we can get the patient experience right through patient choice then it actually follows through (8, Strategic, Non-clinical)*

Some senior managers were optimistic about PCP and how it could be linked to enhancing patient experience and outcome. It was felt that this would enable the hospital to improve health care delivery. The association between quality and PCP was made explicitly by a senior manager who reported that PCP could drive quality through improvements in patient experience and patient reported outcomes.

*Yes, effectively, I think it drives quality. It certainly provides quality for the individual, whether it provides quality overall, every other health system in the world would say that is does. It certainly drives quality in large, I only define quality by patient experience and outcome so you know it certainly drives them in both those arena's whether it drives quality and safety I don't know but in both those two areas it certainly does. (28, Strategic, Non-Clinical)*

Increased patient involvement was also seen as an important part of organisational strategy that would support PCP. It was suggested that this would be a useful mechanism in understanding what affected patients' choices so that the hospital could respond appropriately. One interviewee described a change in the hospital over the last three years that had led to greater involvement from patients and members of the public. The interviewee suggested that this was critical in moving the PCP agenda forward.

*I think historically it has been a top down orientated process telling people what governance should look like and we have got a responsibility now to be much more proactive in talking to service users and working with groups of patient representatives to influence things so I think it has changed quite a lot. I have been in this job for 3 years now and the emphasis on patient and public involvement particularly is key and this is an area that has developed more than anything else. (5, Strategic, Clinical – Nursing)*

A clinical perspective of choice was described as getting it right for patients, getting it right for the hospital and the patients. Within this definition, a much broader discussion of patient choice emerged that touched on the whole patient journey. This perspective suggested that patient choice embodied the whole health care experience and provided the opportunity for patients to be more involved in their health care.

*it is generally the right thing for patient's every time, and that's clearly the message that we are trying to give to the teams, you know that we can do this, that we can be the best, I want to be part of the organisation that's the best, that's what you should be thinking about. (21, Operational Clinical – Nursing – Diabetic Medicine)*

*I guess in a general term it implies patients having much more say in how and who delivers their health care. That has to be channelled to a degree because we have to listen to their various procedures of booking clinics and choosing ways of where you are referred to ranging from GPs suggesting people and through them patient choice systems, booking systems. (24, Operational, Clinical – Doctor - ENT)*

This perspective was supported by a number of interviewees and was widespread across clinical and non-clinical interviewees and by almost half the people interviewed. There was recognition from interviewees of the value of patients being involved in their health care.

*Some of it will be about, is it more local to them, there might be a hospital a lot more local to them where they would choose to go or they might have heard that a particular organisation did something particularly well, they have got low infection rates. I also think it's broader than that, it's from the moment that person is within your kind of environment, we should be giving them choices about everything, we should be asking them, we should be involving them, we should be communicating with them, getting their views about everything that we are going to do. Do you want a bath? so it goes back to that basic stuff about care requirements, Would you like a bath this morning? What would you like to do this morning? Would you like a drink? What drink would you like? All of that, do you feel that you have been involved in your care? Do you know what is going on? Where do you want to go when you leave hospital? It's those sorts of things to decide. For me it's taking it much further than perhaps that literal service of patient choice. (19, Operational, Clinical – Nursing – Diabetic Medicine)*

*There is a lot about patient experience, how they would choose to be looked after, medicine, have they had consultation in relation to their food, have they had consultation about how they want to maintain that from an older adult. What do they normally do, do they wear a pad, and are they toileted every hour so there is a lot on the essential care in patient choice (20, Operational, Clinical – Nursing – Diabetic Medicine)*

One of the corporate members of staff interviewed was the lead patient safety nurse. She articulated a vision for patient choice that outlined greater freedoms for patients in which they actually influenced the design and quality services that they were accessing. Her perception was that the current model for patient choice was focussed on the administrative components such as booking and waiting times and there was a strong clinical quality element that had a part to play in patient choice.

*It's people being able to exercise some discretion, something that makes them feel more involved, they are not a passive receiver of this you know when you start to feel that lump in your leg, as much as possible that fits into the way that you want to live your life and you want to live your life with this thing in addition to what is going on, health care has a small area of consumerism but it's only a tiny bit isn't it and where you can exercise that choice as a consumer then that's good because you can do that because that makes you feel you have more ownership over it, more responsibility you have your own personal responsibility. If you don't have that option or choice then it's even harder for the health care side of it to get people to engage in their own care, you can set up the administration element of it against the clinical element of it so the two aren't kind of working hand in hand. You see the best services don't you where the administration element and the clinical element of it you know are seamless; you can see it's just brilliant for people. (14, Strategic, Clinical - Nursing)*

There was a sense of frustration from those providing acute services that they could not influence the types of patients that they received and that perhaps they could use choice as an opportunity to be explicit about the types of patients that they could treat and use the available resource more efficiently. This was more a case of 'provider choice of patient' rather than 'patient choice of provider'. An important point is made here about the appropriate setting for care delivery and how this might have an impact of resource usage and efficiency.

*I think it is more than that. We focus our mind and effort on provider organisations such as reputation, income and business and we have got to*

*make sure that we attract the right type of patients for our business in terms of income and volume (5, Strategic, Clinical Nursing)*

There was one example where a junior non-clinical member of staff described patient choice as difficult to define given the breadth of patient choice and the fact that it could be different things to different people. Given that it could be anything to anyone, the interviewee felt unable to offer a definition.

*Patient choice means so many things to so many people. (10, Operational, Non-clinical, ENT)*

### **7.3.3 PCP and Service Quality**

Some interviewees were clear that the hospital had embraced PCP from a strategic perspective and reference to the hospital goals was used to illustrate this. Interviewees reported a lack of implementation of PCP across the hospital, which led to confusion when the policy was enacted in practice.

*I think the Trust overall from a strategic perspective has definitely put the right wheels into motion and that's why I said I don't think it's a strategic level but possibly operational level and that is sometimes down to people's interpretation of what choice actually means and how much choice do I offer a patient? (17, Strategic, Non-Clinical)*

In contrast a few of the operational managers reported that they felt remote from PCP. This was experienced by the operational staff in particular; one reported a lack of clarity from a strategic perspective and felt that in some cases PCP was being left to be defined locally within the area.

*I would have thought that I would be more focused on patient choice but it still feels remote I feel that it should be embedded but it feels as if it still sits outside the organisation (6, Operational, Non-Clinical - ENT)*

A number of interviewees viewed PCP as just one of many levers used by the government to introduce financial control in the NHS. There was a perception from them that PCP was not about quality in health care delivery but another mechanism to impose financial control.

*No I think there is a wider reform programme and I think the aspirations as to why as to behind the reform programme are probably quite noble, by the time it has been through a bureaucratic system I often wonder how honest some of those things are, some of those claims are, some of those designs are. As I say at the moment it is tough, I am not convinced that the current reforms are purely about delivering a closer to home led service and at the moment in an NHS hospital it feels like the reforms are purely about cutting costs. (24, Operational, Clinical - Doctor - ENT)*

Other members of the corporate team had approached patient choice with a degree of caution and expressed their cynicism towards it and were resentful of the political undertones associated with it. The clinical teams within operational areas have also challenged the reasons for the introduction of PCP and positioned it amongst a wider reform programme designed to achieve savings and efficiency and as a consequence may have been less optimistic about its potential and value to the organisation. Support for the principle of choice was evident across the organisation with many welcoming the opportunity for patients to be involved in health care decisions. The real challenge presented was the ability for this to be achieved given the way in which politics has influenced and shaped the NHS. It appeared that

although patient choice was seen as positive step forward, the policy as a vehicle of delivering this was not always supported. The emotions used to describe PCP included enthusiastic, cynical and frustration. PCP had generated an emotional response from the hospital.

For senior clinicians and some of the corporate executives, patient choice was seen as an example where the NHS is used by politicians as a means of influencing the voting population. The sentiment here was that patient choice was part of a political programme rather than genuinely facilitating patient involvement in health care appears throughout a number of interviews. Interviewees who shared these views expressed their cynicism towards the principles of patient choice and were generally less enthusiastic about it. These interviewees remained sceptical about patient choice and challenged the need for it.

*I am going to have to admit to being a bit of an old cynic here so you are going to have to forgive me on this, because what springs to me are the formal labour government buzz words. I feel I shouldn't feel like that but I am quite cynical about political parties who put up big banners about the NHS, and I think patient choice is still with us and has been picked up by the coalition but it's a new buzz word, about 10 years ago patients were going to have all the choice. I personally felt that there was a lot of nonsense around it and that they went about it in a cack handed way and if people had really wanted to give patient choice then they would have addressed it at some point, but they didn't. That is my reaction to patient choice. (8, Strategic, Non-clinical)*

One of the senior clinicians expressed mild concerns at the potential impact of patient choice in that it would be used to provide a reduced service. He described a scenario in which health care provision is rationed to a basic level with a 'top up' service offered to those that can afford to pay. This suggests a major redesign of the

NHS and challenges one of its founding principles which is health care free at the point of care. He was also reflective of the level of political intervention that the NHS had experienced and was almost fearful of the potential repercussions of patient choice. The context of the reform programme introducing the need for efficiency and savings is influencing how patient choice is perceived and what its purpose actually is.

*I think politics will never leave the NHS. My only slight worry is that actually in the end it is unaffordable. You would never believe that a labour government would bring in University fees and scrap grants; we might never believe that any government would scrap free at the point of delivery NHS but it could come. It might be the beginning of the process which might end up with people saying look here is your basic NHS, it will keep you safe and healthy if you want luxury you can pay more for it. (13, Operational, Clinical – Doctor – Diabetic Medicine)*

Frustration surrounding PCP was expressed by a number of senior managers. They felt that the organisation had positioned PCP as a threat. One of the managers described her frustration in that the emphasis of PCP was heavily focused upon the threat of losing patient referrals to other hospitals. She was clear that had PCP been implemented differently it could have presented as a real lever for opportunity for improving the quality of care through collaboration with patients. She felt that the way in which it had been implemented dis-incentivised hospitals from embracing it.

*I think patient choice needs to be set in a context of quality patient need. Patient choice to me should be in the context of how we provide a really high quality experience and quality of clinical outcome for our patients and actually to me about getting that right and allowing a patient to flow through the health system at whatever point is appropriate if where ever the patient feels appropriate the referring clinician and the receiving clinician feels appropriate, if we can get the patient experience right through patient choice then it actually follows through (30, Strategic, Clinical - Nursing)*



In summary, when determining how patient choice was being defined across the hospital it is clear that there were many different perceptions throughout the organisation. At its simplest level, it was seen a mechanism to access health care e.g. choose a hospital, book an appointment, or choose the date and time of your appointment. These facilities were perhaps not readily available in health care previously. At its most complex it was defined as a concept that should exist throughout the patients' health care journey allowing patients to participate in their health care, understand the options available to them so that they can shape and influence what happens to them. The broader definitions of patient choice were held by a wide range of professional groups and half of the interviewees wanted to see patient choice defined in these much broader terms. There was some understanding of patient choice as it was intended through PCP, however, this was proposed as a conceptual definition as many reporting this suggested that they were unclear on how the policy could be translated into practice. The differences in perceptions of patient choice could not be attributed to particular specialties or specific professional groups. This suggests that their views were not influenced by the types of patients that they were treating but rather the broader NHS context that they were working in.

Whilst there were a few interviewees that expressed optimism for PCP to be a lever for service improvement many of the senior managers and clinicians viewed it as a means of financial control. The policy was viewed in a highly political manner as governmental interference as and such was regarded by some with contempt. The concern from some was that it would lead to financial cuts and reduction in service provision.

The leadership in the hospital did not appear to have seen PCP as the opportunity to improve the way in which it delivered care. In some cases it was expressed that the threat of losing patients had dis-incentivised hospitals to embrace patient choice.

## **7.4 Organisational Behaviour**

### ***7.4.1 Describing the Culture of the Organisation***

The concept of organisational culture has been increasingly recognised as a lever for inducing improvement in quality and performance in health care systems (Department of Health 2000). A colloquial definition of culture is 'the way we do things around here' Schein 1985).

To explore the culture of the organisation and understand this in relation to the introduction of patient choice, the Competing Values Framework (CVF) was used in a qualitative way. The merits of using the CVF to understand the organisation's culture have been described in Chapter 6. Using the framework, interviewees were asked to define organisational culture as it was three years ago, the current position and where they expected to see the hospital in the future.

#### *Organisational Culture three years ago*

The overwhelming view from interviewees was that the culture across the hospital had been hierarchical three years ago. This view was shared by both clinical and non-clinical teams. Of the 30 interviewees, 28 described the culture of the

organisation from 3 years as hierarchical. See Table 7.3 Changing Culture of Hospital.

There were those that suggested the culture had been hierarchical for quite some time.

*I think three years ago we were probably quite hierarchical (6, Strategic – Non Clinical)*

*What we were like 3 years ago? I think we were more hierarchical 3 years ago, it maybe longer than 3 years ago (15, Operational, Clinical – Nursing ENT)*

*I think if I had to point us to a point on the grid where we were 3 years ago it would possibly, towers behind hierarchical clan like structure (17, Strategic, Non-Clinical)*

When describing this historical hierarchical structure, many associated this as a negative controlling culture. The lack of innovation and responsiveness to changes is reported once again. The culture was described in terms of a control that prevented innovation and did not allow individuals to be accountable or responsible for change.

*I think previously it was very hierarchal, previously in the past the perception from a local level was that it is punitive measures that you have to rather than follow policies because it's the right thing to do for the patient, it was policies were used more for, we were having to do that rather than that's the right thing to do because that's a good standard. I think also there was a hierarchical cohesive that we have always done it like that, there is a big emphasis on tradition, a big emphasis of how they think morale is poor but not accepting that it is their responsibility to be able to change that. (19, Operational, Clinical – Nursing – Diabetic Medicine)*

Those with negative views about the hospital culture were from clinical backgrounds. Some of the interviewees described the hospital culture not allowing developmental activities to take place such as changing pathways, seeking to expand service provision and developing a market strategy for the hospital. An interviewee described a scenario in which she was working with commissioners to redesign clinical pathways and develop innovative ways of working, however, when back in the workplace she was not able to authorise the recruitment of junior staff to deliver the basic standards of service.

*We have worked on a massive project across the city on urgent care and the front doors for urgent care. What choices do we have for patients and what choices do we have for services and what does it look like. What do patients want and how are we going to deliver it. Myself and the CD have been engaged in top level talks and really redesigned how it needs to look like and what the pathways need to look like. We have done all this stuff. Its innovative and exciting and it will change the face of our services and I believe it will happen and that freedom to be developmental but I come back and cannot employ a band 2 to a critical part of the service to run a clinic. (4, Operational, Clinical – Nursing – Diabetic Medicine)*

The Trust Annual Report (2010/2011) identified that there were a number of areas where the Trust had failed to meet national performance targets. Nursing staff commented that this focus on targets and the hierarchical culture had prevented them from delivering high standards of care.

*I think previously it was hierarchical, in the past the perception from a local level was that punitive measures were in place. You had to follow the policies rather do what you thought was the right standard of service for the patient.*

*Current culture of the Hospital*

In certain instances, parts of the hospital were still described as hierarchical, as individuals hadn't perceived any progress had been achieved in the organisation in recent years. There was particular reference to centralised hierarchical control and an emphasis on rules, policies and procedures. It was also suggested that the hospital was not proactive in embracing changes and that there was not very much innovation present. These views were largely represented by the senior doctors and some of the non-clinical teams.

*In some areas today hierarchical with a complete over reliance on order, rules and uniformities, I think you, better than anybody are better to see that effect on the service. I think its rules and policies and this emphasis on predictability, not doing anything new, doing the same and adversity to change. I can't see it as a clan that maybe different in some areas of the organisation. (8, Strategic, Non-Clinical)*

Clinical teams described the hierarchical culture of the organisation as a barrier to enable innovation. They expressed a desire to want to lead and innovate for the hospital but described an environment where they felt that they had been constrained by the hierarchical culture creating a culture of control.

*It is a frustrating culture especially for those of us that have been here a while who think we want leaders, developers and innovators it is really hard to be held in a hierarchy where you just want to break free (4, Operational, Clinical – Nursing – Diabetic Medicine)*

This culture was echoed by some of senior clinicians who described a gap between the top and bottom of the organisation. They also alluded to an environment that contained many cultures and that these cultures were not always cohesive. The dominant culture of hierarchical remained a key feature of the hospital. A senior clinician reported that the hospital was not clear on how it was going to create

change and he reflected his view that the hospital appeared to be obsessed with hierarchy. There was evidence to support orthogonal cultures existed within the organisation.

*No we are many cultures that is absolutely right, and it's not helped by how we divide everything out, so my view at the minute and my views are evolving as you do learn much more when you are doing this course. My view is that we have really quite clearly demarcated medical hierarchy, nursing hierarchy, management hierarchy and so that allows different cultures to permeate and to occur. Then we have got five layers between the worker and CEO and any given hierarchy, and that allows roles to be played out to a lot of people at different levels which are unhelpful, so those are my views on that. Everything is hierarchy, I don't see any new Trust venture that I see that has a front page that says this is how it is going to work, what do they call it a Trust structure, it's the same thing every time, it's always got three layers. This is an organisation that's obsessed with hierarchy because everything you see has this hierarchal structure. (22, Operational, Clinical – Doctor – Diabetic Medicine)*

In one instance, the hospital was described as arrogant and this seemed to affect its culture and also its inability to change.

*Why are we like that, because there is arrogance isn't there in the organisation sadly and it relates to our size in part. (22, Operational, Clinical – Doctor – Diabetic Medicine)*

The size of the hospital was noted as an important factor by some interviewees. They suggested that its large size not only affected the hospital's ability to change but also created a complex environment that contained many competing cultures and therefore affected its ability to be responsive. A member of the corporate team differentiated between the corporate cultures of the hospital and acknowledged that this was competing against the cultures that existed in the local clinical units across the hospital.

*I think the Trust, and when I talk about the Trust I suppose I mean at the very top. The Trust might have one singular culture because as an organisation you are meant to have and to promote a single culture. Because of the size of the organisation and the history of the organisation as well in terms of the merges that have taken place years back. I think what has happened is every business unit or every division as far as there is some culture in it has its own rules and its own interpretation of the rules. I think some are significantly better than others, they are certainly driven by the same principles, they are driven by the same needs that the Trust obviously drive staff but I think at maximum level they are very, very different. (17, Strategic, Non-Clinical)*

The concern raised by some of the clinicians was that the organisation was behind where it needed to be, therefore, change was even more difficult and that in many cases the organisation was still trying to catch up with others.

*We are so far behind with so many things but we are catching up, but it's difficult (22, Operational, Clinical – Doctor – Diabetic Medicine)*

An emerging culture of improving standards was reported across a few levels within the organisation. The change in culture seemed more prominent with the nursing and middle management layer. One of the nursing interviewees reported that the desire to change had existed for some time but there were now signs across that hospital that it was changing. She referenced the large scale programme currently underway across the hospital as an example of the way in which the organisation was changing.

*I think there is a new culture developing. I think as an organisation I think, we have been here quite a long time and have probably been trying to drive towards that change in culture and being really clear about what we are all about and everybody then knows what is expected of them. I don't think we have ever got to that point I don't think. But now we are really moving rapidly aren't we, in terms of the culture and the changes which can only benefit everybody, and it does feel that things will happen. Well things are happening aren't they; we have already made some quite complex changes. (16, Operational, Clinical – Nursing – ENT)*

There were some interviewees, however, that described a change in culture from hierarchical to rational. There was a view from the operational manager within ENT that cultures had changed and that departments were now more competitive both internally and externally. It was expected that ENT as a service would experience the consequence of alternative providers. This was not reflected by many others from ENT but was clearly the view from one of the operational managers.

*Gosh do I have to pick something from in here, partly it was in rational goal orientated, the emphasis was on winning, some things like patient choice have been very competitive like waiting times, I tend to look at other departments and see where they are. We are all as well now, competing with each other, or is that just me? (10, Operational, Non-Clinical ENT)*

#### *Aspirations for future Culture of Hospital*

Many senior clinicians described the desire to move towards a Developmental organisation (See CVF framework – Appendix 4) but articulated extreme frustration at the lack of autonomy and freedom that existed in the present day. These frustrations were exhibited through tight vacancy controls and an inability to recruit, train and manage junior staff. The example used to contrast the different levels that managers were being expected to operate at. On the one hand they were expected to innovate and redesign their services on the other hand; the current infrastructure was incapable of delivering the basic processes of ensuring that staff could be recruited, trained and remained competent in the workplace. This point had



previously been made by a senior nurse in the hospital but was clearly being felt across all disciplines and is reported by a senior clinician.

*I think people are so distracted by practical problems in the Trust that we haven't got time to stop and think about this, it should make us much more patient friendly and to be patient friendly you have to develop the positive sides of this grid here, whether we have succeeded or not I don't know. I don't know is the answer. I think the organisation is trying to develop a better culture; some of the blocks to this are not the organisation itself but the people in it. I think the senior management; I am going to sound awfully corporate, pathetically corporate. I think the senior management of the Trust are actually very, very well motivated to deliver all of this but there is a long way to go before they carry all workers with them. An example of that I always use is, I am kind of hung up about this but you only need one clerk in an outpatients who is unfriendly and the whole experience is destroyed for the patient, it is little things like that I think are really, really important. That is where we need to put a lot of time into it. (13, Operational, Clinical – Doctor Diabetic Medicine).*

A number of senior managers suggested that the organisational culture should become developmental in the future and that this is what would attract patients. The need for a unified culture where teams worked cohesively together was seen as an important factor that would affect patient choice. The need for the hospital to put the patient at the heart of service delivery was reported by one interviewee. She described an environment within which all staff across the hospital should be patient focused and the need to support the patient through their hospital journey should become our primary focus. She suggested that this purpose should be felt by staff from to the top to the bottom of the organisation and that it would be this environment that would enable the hospital to respond effectively to patient choice. Within this context she appears to reflect the broader definitions of patient choice within patients are involved in decision across the health care pathway.

*In terms of patient choice and organisational culture overall patient choice can only work when the organisation is willing to work for the patient as a whole and vice versa, patients also need to be made aware that organisations are made up of individuals it is not an inorganic system that doesn't understand typical patient problems there are individuals within the system, countless individuals that we need to drive through the organisation as a whole enough to make internal changes that we work cohesively as a team because, although we have our own little teams within departments, I think as an organisation we need to work as a team no matter what part of the hospital a patient comes in through whoever they see is the face of the hospital, the face of the Trust, so we need an organisation, a culture where we are much more responsible and made to feel much more responsible and made to feel more responsible for what we are doing whether you are at the bottom of the pile doing the cleaning or at the top, clinical lead, managing director, or right down at the bottom cleaner or porter at the end of the day you are wearing a uniform you are in the Trust you have got your badge on if a patient sees you, you are the face of the Trust for the duration of the time that they see you and I think one of the things we need to work on is changing culture sufficiently almost to have a sense of uniformity whoever the patient sees is going to respond in a relatively similar way and that we are all going to have the same attitude, we are all going to have different ways of dealing with different problems but we need a common attitude towards patients and patients choice and being able to deal with patients coming our way, (12, Operational, Non-Clinical - ENT)*

A number of interviewees indicated that patients were looking for innovation from the hospital and ways in which services would be improved and simplified. They were clear that hierarchical structures would not deliver the agility required to respond to patient choice requirements.

*It is doable; it is hard but a bit more creative. Words such as this can be adaptably created still feel a little way off from where we are. Still we are not innovative enough, our systems and processes, the lists, queues and red tape, in some areas we are starting to get through and saying we can make this happen but we still have to fill in forms to make this happen and it just does make it more difficult. We still have a way to go, we have started to be more risk takers and be able to do things without having to fill in lots of different things. We still have a long way to go before we call ourselves entrepreneurial. (11, Strategic, Non-Clinical)*

In summary, the hospital was described by almost all interviewees as having a hierarchical culture in the past. The current culture was described by some as still hierarchical and described this as a gap between the top and bottom of the organisation. For others, there was a feeling that the culture had changed and become rational. All interviewees reported a desire to move towards a more rational and developmental culture.

#### ***7.4.2 Organisational Cultural Change***

Mannion et al (2005) describe the relationship between organisational culture and change as an intimate one. A number of cultural change models have been set out in Chapter 4. Despite differences between these models, they all share some common elements. These include crisis as a trigger for change, leadership in detecting the need for change, success as a means of consolidating the new way of working and finally, re-learning and re-educating as a means of embedding the new ways of working (Mannion et al 2005). The previous section identified that whilst the dominant culture had historically been hierarchical that things in the organisation were definitely changing. The Trust Board Annual Report (2010/11) described the progress made on the transformation work underway in the organisation. The report highlights how the hospital had embarked upon a significant transformation programme to change the way in which services were delivered to patients. The annual report reiterated the goal to become the hospital of choice for patients. The reporting of achievement against national performance targets was the mechanism by which the hospital appeared to assess quality.

One of the nurse interviewees felt that a focus on infection rates and waiting times would help to attract patients. She described the focus on performance targets that were driving an improvement in service delivery.

*So I think there is a real focus on, we have the new strategy from the Trust board, the objectives, the vision, and I think that is going to help isn't it, I think we have been giving some clear direction with the Managing for Success stuff and the transformational change about where we want to be as an organisation. If you were a patient and you were going to choose a hospital, you would be looking at that wouldn't you? You would want to come to a hospital that delivers, that vision, that strategy I think. If it was me that is what I would be thinking. I think as an organisation we are doing a lot of work to improve our performance I guess, generally, generalise with far more infection rates aren't we that might impact on someone's choice, we are doing lots of work about our waiting times, clearly if you are going to have to wait longer you want to go somewhere that does things quicker. So I think as an organisation we are doing a lot of work, I think we are feeling or more aware of that, there is more information being cascaded down about where we need to be and the things we need to do to improve. (20, Operational, Clinical – Nursing Diabetic Medicine)*

The reported change in culture had been experienced in both the corporate and strategic functions of the hospital.

*That is why I said I think my answer now would be very different and while I would love us potentially to be on the developmental point I think we are somewhere on the rational point on the chart, that is largely because I have been exposed to things in this role that I haven't perhaps been exposed to as a business manager. So now it certainly feels a lot better, I have a better and a broader understanding of the Trust strategic agenda, not just in patient choice but in plenty of other areas. (17, Strategic, Non-Clinical)*

Some interviewees, particularly the nursing teams, reported small changes in the culture of the hospital. Whilst some had described this as reflection of the change in the national context others attributed the change to more local and internal organisational factors. For some the change in culture appeared to be closely

associated with the senior leadership team change and the arrival of the new chief executive and commitment from the senior team to become more patient focussed in service delivery.

*I think there is still an element of hierarchal clan but that is a cultural change and we are leading from the top with that. The chief nurse and certainly our chief executive is very clear that we are here for the patients and we expect yes there are big financial implications in relation to money balancing but we need to provide a lean service but the patient is at the centre of it and it's ensuring that it is cascaded down on a very local level to the practice nurses, HSW, domestics and that they play a very big part in that and it's not just that we are using these words to tick a box. (19, Operational, Clinical – Nursing – Diabetic Medicine)*

Some more junior members of staff described how the culture of the hospital had changed over the last few years. A clear message from many was that PCP principles would be far more achievable through a developmental culture and although the hospital had changed it was still not quite there yet.

*I would say previously we were there but now we are more at the developmental stage. I don't think the Trust has developed yet. We are looking at innovation in that perspective innovating the whole hospital just to look at different ways of doing things, that's the innovation, the winning we want to achieve, its more achievement of winning gold than actually racing to win but now I think we are going for more of the developmental block. I don't think we can complete in the external positioning but I think we just need to offer the same services, we don't want to say our services are better than yours we don't want to get into that wrangling we just want to say we have services as good as yours. (10, Operational, Non-Clinical ENT)*

Some of the administrative staff reported that change had taken place in the past two years and described an environment that had resulted in improvements in the way services were being delivered. One interviewee described a number of initiatives that

had taken place recently and reported that although implementing the changes had been difficult and staff were asked to take on new and additional responsibilities, this had resulted in the hospital becoming more attractive for patients. The improvement in communication across the hospital was noted and the improvement in staff engagement was also reported.

*Now as a Trust especially with PCTs holding the money especially in diabetes we can now see patients quickly, quicker in all the time scales and a lot more relaxed because now GPs have now been told that they can't just refer every single patient, and they don't need to be seen by a Consultant. I think things like that, and the Consultants then writing back to the GPs have improved things a lot. Staff seem to be more aware three years ago because I think it was just launched on them, a lot of people don't like change so I think it took quite a lot of time to adapt because literally everyone was told just take it all on, do all these extra things from the doctors to the nursing staff to the admin staff, there was no extra staff provided. I think now people have more open staff meetings especially about the managing for success programme and I think staff are being told more. As an organisation I think we have become more fast thinking for staff more viable for patients to come in and that's how I feel. (18, Operational Non Clinical – Diabetic Medicine)*

There were few signs to suggest that there had been any structural change in response to PCP other than the creation of a dedicated department to handle the workload from the national choose and book system. Some non-clinical staff commented on this and suggested that this could be related to the size of the hospital, as the hospital is very large. The size and complexity of the hospital is revealed here and although PCP is acknowledged as a potential driver for change translating this change into practice was seen as more difficult.

*I saw it from outside. It doesn't feel like it's any different to what I expected it to be. I think Middlechester is a really weird beast actually, as we all know. It is curious state of a place isn't it. I would describe it as the Balotelli of teaching hospitals, because we are capable of moments of extraordinary genius and*

*absolute horrible behaviours at the same time sometimes. We have an almost Schizophrenic personality, structurally I don't think that we relate in any different way to the patient in terms of allowing them to choose, than we did before, well I have seen a move towards that, I have seen a move towards us valuing patient choice as a driver. (28, Strategic, Non-Clinical)*

There was continued acknowledgement that organisational change was required to support PCP, but that this had not been experienced in the operational services of the hospital. The desire to ensure patients would choose the hospital remained a goal; however, once again, the mechanism to facilitate this in practice was less well understood.

*I think that people will say things like the choice is very important as we want patients to come to us. I don't think that's translated to the directorate and managing their capacity to maximise patient choice (30, Strategic, Clinical – Nursing)*

One of the reasons for lack of change in response to PCP was the incentive to change was not strong enough. This view was held by a senior clinician working in an operational area.

*Perhaps not as much as they should and then again in theory patient power is good and if we can get a really good structure for getting patient input that is powerful and very rewarding as well because they will be good propagators of good news about the Trust. I think that it needs a lot of work and there is very little incentive to do it at the moment. You know the Trust isn't setting up structures for involving patients as it could do. (13, Operational, Clinical-Doctor – Diabetic Medicine)*

In some cases it was felt that the hospital had not needed to change because it already offers a wide range of services and therefore would remain stable even if there were shifts in patient flows. One interviewee observed that other hospital's

responses to PCP had been to reduce the range of services that they could offer to patients. He suggested that this was not a challenge for the hospital as the range of services offered by the Trust was such that they had the infrastructure to cope with patients of all levels of complexity.

*Well I think we did it because we were a big provider. We didn't really have any issues about having to make particularly difficult decisions about what we should and shouldn't flag up, as to who do we want to see, we didn't have any exclusion issues unlike some other clients who opted to exclude. (25, Operational, Clinical – Doctor - ENT)*

From a service delivery point of view, the hospital's response demonstrated a degree of complacency in that they had the infrastructure to clinically treat any type of patient. In practice, clinical service delivery is only one component of PCP. This was acknowledged by a few interviewees who reported that the hospital's structures and processes would need to be able to respond to patient expectations.

*How that relates to patient choice I guess it is part of the processes and everything we do we need order and structure and make sure we can do what is being asked of us in a timely way (4, Operational, Clinical – Nursing – Diabetic Medicine)*

At the time the interviews took place, the structure was based on a Divisional model where the hospital was divided into four clinical units and one clinical support unit. Since the interviews were conducted, the hospital had conducted a review of its management structure and proposed to implement a radical change to move away from a divisional structure to clinically led units. This change would result in the hospital shifting from five business units to eighteen clinical service units. The proposed change was designed to introduce an earned autonomy model that allowed clinical units, devolved decision making and accountability if a number of key



performance, quality and financial metrics were satisfied. This change was significantly different from the hierarchical structure that many interviewees had previously described. There were a number of factors outlined as contributors to the change but PCP was not explicitly described as one of them. One of the primary drivers for the change was in response to an internal Consultant Survey which, for the second year in a row, described low clinician morale and lack of clinical engagement as reasons for the current failings in performance of the hospital. The Chief Executive described the proposed structural change as;

“The most radical structural change that the hospital has experienced in the last 20 years.”

(CEO Middlechester, 2012)

The recent structural change certainly presents a clear departure from the hierarchy that existed before. It is difficult to ascertain what role, if any, PCP played in effecting this change.

Table 7.3 – Changing Culture of Hospital

| Culture       | Three years ago | Current Culture | Desired Culture |
|---------------|-----------------|-----------------|-----------------|
| Hierarchical  | 28              | 12              | 13              |
| Clan          | 1               | 2               | 0               |
| Rational      | 1               | 15              | 0               |
| Developmental | 0               | 1               | 17              |

## **7.5 Summary of findings**

The purpose of this chapter was to understand the views and perceptions of different groups within the organisation regarding patient choice and how this related to PCP. The chapter also explored the culture of the hospital and how this may have changed over time.

A review of key documents and the interviews revealed that there was no clear objective and overarching definition for PCP. To become the hospital of choice as definitely one of the goals of the hospital but there was little underpinning this to describe what this might mean in practice. There were a wide range of definitions proposed for patient choice with many of the clinical teams and senior managers describing it in very broad terms as a necessary component of the entire care pathway. Many of the administrative teams recognised patient choice as choice of hospital and appointment date and time. This definition was closely associated with Choose and Book, the national system introduced to facilitate the booking of hospital appointments from GP practices.

An exploration of the culture of the hospital revealed a strong historical dominant culture of hierarchy that was expressed by the majority of interviewees. The historical culture was described in terms of negative and controlling and was used to explain why the hospital has not progressed. The current culture was described more variably with some managers and clinicians reflecting the hierarchy as still in place, whilst others, nursing and middle management in particular, described a shift to a more rational culture.

The future culture that interviewees aspired to range from rational to developmental with many interviewees expressing the desire to become more competitive with a focus on achievement.

A leadership change was described as one of the reasons for the cultural change. Associated with this leadership changes was the implementation of a transformational change programme that would focus the hospital on changing the way it was delivering its services.

It was difficult to directly attribute the organisational change to PCP. The documents reviewed reflected a need to improve current health care delivery with the hospital failing a number of key performance targets. Interviewees described an environment where decision making was controlled and innovation was stifled.

The next chapter explores in detail the organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers.

## **Chapter 8: Exploring how the Hospital has perceived PCP**

### **8.1 Introduction**

The study set out to explore three research questions (Table 8.1 – Research Questions). The previous chapter detailed the findings in relation to the views and perceptions of different staff groups within the organisation with regards to PCP and explored how the organisations culture had changed in response to PCP. The study set out a third question for exploration - What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers? The purpose of this chapter is to consider this question and understand what is happening within the hospital and what impact this had upon the intended outcome of PCP. The assumptions of the programme theory underpinning PCP are used to guide the analysis.

Table 8.1 Research Questions

- How is PCP viewed by different staff groups within the organisation?
- How has the organisation's culture changed in response to PCP?
- What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?

## 8.2 Organisational Factors and Processes Mediating the Impact of PCP

### 8.2.1 The role of GP in facilitating PCP

One of the underlying assumptions of PCP programme theory is that GPs would change role from decision maker to facilitator in supporting the implementation of PCP. A review of the hospital's Activity Enabling Strategy (2010) found that a survey of GPs had been conducted by the hospital. The title of the survey was 'Nice doing business with us?' The purpose of the survey was to understand what was influencing GPs when referring patients to secondary care. It is suggested that the hospital felt that the role of the GP is prominent in influencing patient choice of provider. In fact, the title of the survey suggests that the hospital viewed the GP as the customer rather than the patient.

Many interviewees, particularly the doctors, felt that GPs was heavily influencing patient choice of provider and in some cases still making choices on behalf of the patient. This view was based on what many interviewees believed to be a long standing relationship of trust between the patient and the GP. The hospital doctors recognised the trust that existed between patients and health care professionals.

*The GPs are bound to be looking out for patients, because the patients will request that of them. If I was a patient and the GP said where do you want to go, I would say where do you recommend but that doesn't happen. (25, Operational, Clinical – Doctor - ENT)*

*Yes, because for a lot of patients they are going to follow their GPs lead. Yes it is a patient's choice but they are probably going to ask their GP, where would you recommend I go to? (27, Operational, Non-Clinical)*

*The relationship between a doctor and a patient or parent is extremely strong that it's rare for an individual to choose something different. In my experience whilst they feel they like to be given a choice they want that person to decide*

*for them, so they say you could go here, you could go there, you could go to them, I suggest you go there because they are going to offer the comprehensive nature of what you need and that's in your best interest. I recognise it might not have X and Y but actually if you think about what you are going to get it might be better for you. (29, Strategic – Clinical Doctor)*

*In reality as a doctor when you are approached, people say you need this intervention or I want to refer you to there because that's what I think you need. They themselves, the advisors will be influenced by their knowledge and experience, the feedback mechanisms that they would have received. (29, Strategic, Clinical - Doctor)*

Certainly, it was the view of the clinicians interviewed that the relationship between the doctor and the patient was such that the patient trusted the expertise of the doctor and was happy to consider the options as presented by the GP. The role of GP as facilitator of choice was not recognised by many hospital clinicians who perceived the GP as having a much stronger role in patient choice of provider. This was reflected by the corporate team who felt that they were 'doing business' with the GPs.

Many interviewees suggested that they felt it was the GP who was influencing patient choice or even making choices on behalf of the patient but also acknowledged that in reality the time allowed to support patient choice was limited. It was reported that a 10 minute consultation would not always allow enough time for a choice discussion to take place and in these cases it was practical for GPs to make the choices for patients.

*The patient from my understanding as I am not very close to this GP practice should be given a choice of where they would prefer to be seen, GPs should then access that information from an IT system, going onto choose and book and choose with the patient where they would like to be seen. From what I have gleaned from my colleagues they look on the fact of where is the shortest waiting list, where is it accessible for the patient to get to and what does the patient wish. The only downside that I can see is that the GP only*

*has a 10 minute consultation and the GPs that I work with, I haven't mentioned that but they also work alongside us in the community. They are also GPs as well and they are saying that often there is not that time to talk to the patients a lot although they are making the choice it is sometimes passed to the secretarial staff to action. (23, Operational, Clinical – Nursing - ENT)*

Building on the notion that patient choice requires a time commitment and this might not always be available; the view from one of the nurses raised the potential for inequality. She referenced the differences between patients' groups and how this could affect patient choice.

*Yes that's the difficulty isn't it as you would always have that level of inequality and that level of understanding, knowledge, there is a mix; young people now are generally IT literate and even from a tiny age at school they are learning the IT side of it. Older people are but there is still a gap probably for people in the middle age group on how they achieve that best option. GPs have to get a lot of appointments through and there is not a lot of time set aside to help the patients in the choices either. (7, Operational, Clinical – Nursing - ENT)*

It was also suggested that GPs would suggest local providers rather than providers outside the local health community because they had well established networks with hospital doctors. It was accepted that were those better educated and more discerning patients who would be motivated to seek out alternative providers but the suggestion was that this was already happening even before PCP was introduced. One of the doctors interviewed suggested that patients knew that doctors would only do what was best for them and also suggested that travelling to other providers would not be something that patients would want to do.

*Well because I think although it is a very noble and open ambition to have completely free choice the reality is that it isn't like that, patients are confined by both their own logistical confines, you know they want to go to their local unit rather than travel miles, and also as always they rely on advice that is given to them and that's going to be given to them by their GPs, their GPs will*

*probably suggest going to somewhere where they know locally. There are of course also a few patients who are educated, motivated, have access to computers and information on the internet, have networks of friends that recognise the view that will presumably push quite aggressively for what they want, but you kind of think they would have probably got that anyway even in a non-patient choice system (24, Operational, Clinical – Doctor - ENT)*

The view that GPs were instrumental in choice of provider is perhaps one of the reasons why the corporate team focused on the GP perspective in the Activity Enabling Strategy (2010).

In summary, the corporate and clinical perception was that the GP had not changed their role in response to PCP. Clinicians reported that the GP would tend to recommend the local provider because of the clinical network that existed between GPs and hospital doctors and also the logistics of patients travelling to other hospitals was not something that patients would want to do. PCP programme theory assumed that the role of GP would change in response to PCP but the policy failed to recognise the context of the existing relationships that were already in place and the travel challenges for patients.

### ***8.2.2 Patient as a Consumer***

PCP programme theory is built on the notion that patients will behave as consumers. In neoclassical economic theories consumers are 'utility maximisers' and they make choices that enable them to achieve the maximum benefit (Kirzener 1973). A common view held by many interviewees and in particular people in the clinical teams was that not all patients would want to exercise choice and that in many cases they suggested that patients just wanted good quality local services. When a patient



was ill their primary focus would be on getting better and that they would use the simplest most accessible option to do this. In situations of acute illness it was suggested that the primary focus would not be that of acting as a consumer.

*Yes I guess the problem is the NHS is run on a national level as a national aspiration and that's great, there should be a national philosophy about how that's delivered but the reality is that the NHS is delivered in a very local level to a very local populace on the whole and the local population needs are often very pragmatic, it is not about grand aspirations it's not about national philosophy's it is about, I have hurt my head now I want someone to sort it out because I am worried about what it may mean to my health. And then again you want a good service locally; you accept that you are not going to have the world best quality service locally but you want a completely competent, safe, well run local service. These are hospitals that have existed for many years, well written in local populations and I think to sort of have a bit of a pin ball national overlay to this is unhelpful, although I say I do understand where some of that comes from. (24, Operational, Clinical – Doctor - ENT)*

Several interviewees from the clinical teams believed that patients would prefer to be directed and advised rather than to make choices themselves. These comments were often made in reference to older people but not exclusively. This is consistent with several previous studies related to patient choice that have identified similar findings. This view was consistent from the two different specialties and the corporate function

*I suppose this is probably influenced by my personal experience, from my parents. From speaking to them and relatives they just don't understand that concept. The majority of them want their appointment and want to be just given it and deal with it and they don't want to have that choice to make. They believe in going with the belief that the GP knows best and that they're going to refer them to the most appropriate place and they don't necessarily want to have that choice as the younger generation (16, Operational, Clinical – Nursing - ENT)*

*I think we have an ageing population where they want to be told by their doctors what is best for them and we have to handle that population sensitively (5, Strategic, Clinical – Nursing)*

*I don't think the public wants and I don't want that level of choice. (4, Operational, Clinical – Nursing – Diabetic Medicine)*

Further clinical perspectives described patients as largely passive and presenting themselves to the hospital in the expectation that the clinical staff would provide them with answers. It was this experience that was recounted and used to challenge the notion that patients would be able to exercise choice.

*Some of the older people that have come for years are still, they come in and sit and do what we say. It is more challenging by having people in clinics like that because you do have to have the answers don't you? (16, Operational, Clinical – Nursing, ENT)*

Some interviewees made the distinction between younger patients and older patients with the view that young people would want to make choices and that the older patients were less likely to want choice. A factor contributing to this perspective was technology. Interviewees referred to the level of IT literacy and knowledge of the internet patients had and suggested that as IT literacy increased the ability for patients to exercise choice would improve.

*I would say 75% would want a choice, 25% won't be that bothered because as long as they come to hospital and are seen by a doctor and can be made better. 75% will be more shall we say, almost the younger population, as in not young 20 year olds but maybe 65, I think maybe 25% of the population. I don't know unless they are very, I don't know maybe in 20 years' time everyone over 80 will be using the Internet but at the moment I think it's just a tool so I think it is important that I have a choice. (18, Operational, Non-Clinical – Diabetic Medicine)*

The clinical teams, particularly doctors, struggled to perceive patients as consumers. A clinician described the complexity of health care provision as another reason that

affects patient's abilities to make choices. He reported the need for patient choice to be considered as a two way process and for patients to understand that they also have responsibilities. It is this discussion that he suggested causes complexity and his concerns were that patients may focus on the simpler elements that they understand e.g. waiting times but the health care system is much wider than elective care access. He described a scenario where if not managed correctly clinicians would be waiting for patients but they have not been chosen by patients and in other settings popular consultants would not be able to cope with demand and will not meet waiting times standards. He suggested that free patient choice for all was not achievable and if pursued the consequence within health care could be far reaching.

*So this patient choice thing is two way, we want you to have much more input in deciding how your illness is managed once it's there, but the flip side is we want you to take much more responsibility for your own health. That's why the discussion is complicated and difficult because both sides are really important because you can't run the health service in the future giving people completely free choice because the system will just break down. You can't, it will have its faults, it will be hugely popular, with waiting lists that are regularly breaching targets, consultants sitting around doing nothing, and it's crazy so we have to find some way of making it work. It's a two way discussion. (22, Operational, Clinical – Doctor – Diabetic Medicine)*

A senior clinician made the distinction between social class and intimated that people from more deprived socio-economic areas would be less likely to want to and be able to behave as a consumer. He based his thoughts on the fact that he believed patients were heavily influenced by relatives, family and friends when exercising choice. His view was that those from more deprived areas were more likely to follow traditions and use local provision rather than exercise choice and travel to another area. This was an isolated view was not articulated by any other interviewee.

*The problem is patient choice tends to be social class driven, so those who are more likely to be a higher social class are more likely to think a lot more about where they want to go and what they want to do. Patients whose family and generations have always done it a certain way is more likely to do it the same way, so they are less likely to think differently. (29, Strategic, Clinical - Doctor)*

The clinicians remained sceptical about how patients could really take on the role of consumer. A senior clinician challenged the notion that patients could ask the right questions from the service and whether based on the answer they could actually determine where they want to be treated.

*The choice piece is I am now going to make a judgement and I am now going to ask you the right question that I think will allow me to judge whether I am going to go to you or go to you. I can't absolutely envisage that in healthcare maybe as much as I should. I fear it, (29, Strategic, Clinical - Doctor)*

The patient as a consumer was a perspective that a number of interviewees were struggling with. A number of interviewees described their nervousness in the patient may make the 'wrong choice'. A senior clinician described below a scenario in which a patient may make a choice in conflict with the health care professional. Patients may choose to wait for treatment because they want to go to the hospital just around the corner or where they can park outside. The GP, however, may not want to delay the referral because speed may be critical to resolving the underlying problem and commencing treatment. This presents an underlying tension between the patient and health care professional where the factors that influence ones set of choices are not congruent with the others. The clinician described with some irritation the factors influencing patients' choice and positions them as almost getting in the way of treatment.

*I am always struck by my wife's observation, she works in a GP practice, GPs refer patients and say to the patient , well you can go to St Middletown<sup>2</sup>, the week after next or it will be about six weeks to go to Smalldale<sup>3</sup>, they live in Small town<sup>4</sup> so say well I'll wait six weeks then. The GP goes, your condition is something that we want to get you seen quickly, no, no, I'll wait. That is a classic example of where you are presented with a choice and you may be choosing for the wrong reasons, whereas the clinician thinks you should be choosing because it's your health and the needs of your health but the patient says, well I've lived with it for a bit, I can live with it for a bit longer. The fact that I can then just go round the corner, walk there, park, it's a nice place and I don't have to get two buses. People are shaping their choices. (29, Strategic – Clinical - Doctor)*

The notion that patients may not make the right choice was echoed by another interviewee. One might have anticipated that this view would be held predominantly by staff with a clinical background but non-clinical staff were also concerned about patients making the wrong choice. The interviewee describes, with some frustration, the potential for patients to make wrong choice and that there was little one could do when this did occur.

*It doesn't feel right; it feels very very bad, very very wrong. People again make choices for all sorts of weird and wonderful ways and you are never going to get past that, you are never going to get that person to make the right choice. (27, Operational, Non-Clinical – Diabetic Medicine)*

The challenge of the patient as a consumer seemed to concern interviewees who felt that they were there to protect patients and the consumer role of the patient would be a hindrance.

The view from a senior manager was that commissioners should understand what their patients want and be able to commission appropriate choices on their behalf.

---

<sup>2</sup> Pseudonym

<sup>3</sup> Pseudonym

<sup>4</sup> Pseudonym

There was no detail provided to suggest how the commissioner might do this in practice. He suggested that the commissioner in this role would be a way in which patient choice could be used to influence the quality and efficiency of service provision. On a similar theme another manager suggested that there was a need to influence clinical commissioning groups if the impact of patient choice was to be effective.

*The commissioner should influence choice, the commissioner's job is to stand as close to the patient as they possibly can but get them the best quality service balancing that with the needs of the overall, so you know they have a duty to the NHS, which is fantastic a wonderful institution and they have a duty to protect the overall universal service obligation, but their real job is to make sure that every single one of their patients gets the best healthcare they possibly can because otherwise why do we have it (28, Strategic, Non-Clinical)*

All of the strategic documents reviewed emphasised the role of the commissioner as being important in influencing how patients would flow into hospitals. The Trust's Integrated Business Plan (2011) illustrates this point well;

“NHSXXX has confirmed its intent to support local services by re-investing the 1.5% tariff deflator in supporting demographic growth and other developments and pressures.”

(Trust Integrated Business Plan 2011 p50)

A key risk identified in the Integrated Business Plan was the growing competition through the stimulation of the market for both District General Hospital work and complex work. The proposed action described to mitigate against this risk was;

“a focus on quality, best use of capacity and relationships with commissioners.”

(Trust Integrated Business Plan 2011 p6)

The programme theory underpinning PCP seems to have largely ignored the role of the commissioner in health care and the context of commissioning for health care. In reality the hospital was focussing much of its attention on the role of the commissioner and the existing ways in which patient flows occurred. The consequence of this appeared to be the patient not being perceived as a consumer.

Interestingly, whilst recognising that many interviewees did not perceive the patient as a consumer, some interviewees reported that when electing to come to hospital they personally would want to be offered a choice. They talked about choice as a requirement and facilitated the decisions that patients should be able to make. They drew parallels from other parts of their life where they felt they were making decisions based on a number of options and supported the notion that choice should be applicable in health care. The principles of choice were recognised as important. These views tended to be held by the non-clinical teams.

*You wouldn't make a decision about anything else outside of your health care where actually you don't understand it and you have not had a chance to look at all of your options. In any other situation of your life you would expect those options so why not for your health care which is actually very important and I think patient should expect that and have the right to do that. (6, Strategic, Non-Clinical)*

*I have experienced healthcare where choice has been massively important and have the luxury in being able to choose where I was treated and that*

*made a massive difference in an emotional and physical way. (11, Strategic, Non-clinical)*

One interviewee recounted a personal experience of choose and book as her positive experience of patient choice. She described her experience in terms of being able to influence the date and time of her appointment. The experience was positive as there were no problems. There were no changes to her appointment and she felt that she was able to influence when she would be seen. Convenience and the ability to fit her appointment around her personal situation resulted in increased levels of satisfaction.

*It did go well I was really surprised. Obviously with being in RBS [Referral and Booking Service] as well we deal with the choose and book system and I feel quite protective of it at times. I went to my GP and was referred to Gynaecology. Although there wasn't any capacity there I was given the letter, I was told to wait I think 48 hours. I telephoned, a polite young man on the telephone gave me an appointment and that was it, it was great, he gave me an appointment, I attended that appointment and my whole pathway was fine, no complaints at all. It was a lot better because I actually chose when I had that appointment which was when I was at work, either at the beginning or at the end so I could fit it in. (26 Operational Non Clinical - ENT)*

One of the senior clinicians described patient choice as a way of moving the hospital away from its traditional paternalistic approach and stepping back to take account of what the patient might actually want. He described an environment where previously patients were expected to accept the level of service offered. He viewed patient choice as an opportunity for patients to be more involved and help shape service delivery.

*For the organisation, actually I see good and bad, the good is that it makes us feel that we have to provide a really good level of care so that patients choose us, and that is completely positive isn't it? I think the bad old days were that*



*people were expected to be grateful for what they were given, and to take what they were given without questioning it, patient choice is all part of an agenda to take us away from those dark days. So I completely sympathise and understand with that agenda. And so if you like it is completely positive for us. (13, Operational, Clinical Doctor – Diabetic Medicine)*

These perspectives were interesting in that they acknowledged the value of the role of patient as a consumer but in practice this was not happening.

In summary, many clinical teams across the hospital did not view the patient as a consumer for a number of reasons. A review of the corporate documents revealed that the commissioner was seen as the important relationship in determining choice of provider rather than patients so the corporate view of patient as consumer was not really being promoted by the leadership within the organisation

A few of the interviewees both clinical and non-clinical commented on the importance of patient choice and described the desire for patients to behave as consumers. They suggested that as they were experiencing this in other parts of their life health care should not be different.

Although PCP had been introduced for a number of years, staff in the organisation had not experienced patients acting as a classic consumer. Not only were some reticent that this could happen there were those that felt quite strongly that they were not sure that it was what patients really wanted. The evidence of the patient behaving as a consumer was limited but the traditional paternalistic values of the clinicians were demonstrated with many challenging the idea that patients could be effective in this role.

### ***8.2.3. The Incentives for Hospitals to Change***

The programme theory underpinning PCP suggested that hospitals would respond to PCP by improving the quality of its services. A number of interviewees echoed this perspective of PCP and felt that patient choice could be used as a lever for improvement and enhance the quality of care received by patients. In this case quality of care was defined in terms of patient experience and positive clinical outcomes. Interviewees responded enthusiastically to patient choice and much of their response was positive with regard to influence that patient choice could have could have in these specific areas.

*Yes, effectively, I think it drives quality. It certainly provides quality for the individual, whether it provides quality overall, every other health system in the world would say that is does. It certainly drives quality in large, I only define quality by patient experience and outcome so you know it certainly drives them in both those arenas whether it drives quality and safety I don't know but in both those two areas it certainly does. (30, Strategic, Clinical - Nursing)*

However, when interviewees were asked whether they could cite examples where they had seen choice work in this way, few were able to describe them. The administrative teams involved in the booking process talked about the speed of access and how the potential of being treated sooner may cause patients to go elsewhere.

*We want to be able to drive up quality. It will be a big piece of why patients choose us. The independent sector is taking the fast turnaround work and leaving us with the complex work. There is a danger that patients may not choose us in this situation. (11, Strategic, Non-clinical)*

The Trust's Market Assessment document (2009) identified that patients had chosen other providers because the waiting times at the hospital were too long. This was reiterated in the Activity Enabling Strategy (2010) which also identified a shift in patients from the hospital to other local providers. The document referred to a shortfall on available capacity as the reason for patients going elsewhere rather than it being viewed as a quality or safety issue.

Whilst the threat of patients moving to other providers had become a reality for the hospital, many interviewees did not perceive this as a strong threat. This view was compounded by a general belief that patients wanted to be treated locally. Loyalty of patients to the local provider was seen as one of key reasons why the threat was perceived not to be real. The view was reinforced as interviewees reported that they knew alternative providers were available but they had not seen fewer patients as a consequence of this.

*I don't think that has been the case, it may develop more but at the moment I don't think there is a big threat from other providers because we are the main providers in Middlechester. I think most patients I think come from Middlechester and have allegiance to stay in Middlechester rather than travelling out. Some of the community clinics of course are somewhat into that competition to keep their providers by external agencies but numerically that is not what it does. (25, Operational – Clinical Doctor - ENT)*

A few understood the principles of the PCP directive but for many this remained something that had not yet had an impact on the organisation and they speculated that perhaps its effects would possibly be felt in the future. The reality of competition in health care was yet to be felt across the organisation and a large degree of cynicism with regards to whether market mechanisms could function in health care.

This view was generally held by many interviewees but in particular the senior executive responsible for communications and external affairs was particularly explicit in his views with regard to the challenge of market principles within health care. The extract below outlines his summary of the key challenges for the market function with the local economy.

*When you take that policy and you apply it to a place like (Our area) and you apply it to a system which is governed in Middlestate<sup>5</sup> Area and which works in the way it works in Middle state, I do not believe it has had the impact I thought it should have. Now in any given market choice, if you take the gas market which you are familiar with, you used to work in, well for it, you only need a three per cent shift in consumer behaviour to change price, that's a similar kind of thing for groceries, you know anything. In the health service because of the way it is governed a three per cent shift in behaviour makes no difference, so It's not sensitive enough to react to patient choice and there is something about we kind of adopt the principal but are not prepared to live with the nasty consequences of choice so, and that has led to a whole series of things happening, and presumably this is something I might have to talk about something I don't particularly want the public to name, Middlechester without a doubt is a monopoly service. The way that we contract for our business is as a monopoly. We block contract things, we make sure that you know that we are going to be alright but we still play in the arena. Frankly because you are the monopolist we are always going to be alright, there is never not going to be a Middlechester it's always going to be at the centre of what's going on because it is the pinnacle really for most services, so it's kind of like we have the monopoly of power over the market. If choice was to take that away, so for example if we were in a place where we were threatened, like for an example over Orthopaedics the choice has been to go away from Middlechester, is that worsening the service for us or is that bettering the service for someone else, how does that react in the area. Well, it's keeping a hospital that arguably shouldn't be open, open, in terms of Shiregate because it's too small to be a proper hospital in my view and they know that because that's my view, I have told them that but that is a consequence of choice, we are keeping a small hospital, that's ok because patients are happy about that. I think that we as an institution are aware of choice and that it is an issue but it doesn't make any difference to us because at the end of the day we are governed by rules that allow us to do deals.(28, Strategic, Non-clinical)*

---

<sup>5</sup> Pseudonym

The interviewee described the hospital as a monopoly service provider and demonstrates an understanding on how he anticipates the market principle would operate in the Trust catchment area, however, he challenged the notion that this could happen in reality. His challenge stems from a number of different factors. First, current financial flows and commissioning arrangements are not aligned with true markets so the opportunity to negotiate with commissioners and work within agreed financial envelopes reduces the incentives for improving quality and efficiency, he makes clearly the point that the provider has the opportunity to bypass choice policy by making deals with commissioners. Second, he challenges whether failure regimes have been established to manage the impact of a failing provider. Whilst there is a broad understanding of 'money following the patient' and the need for efficiency, the practicalities of this are much less defined. Third, he discusses the political sensitivities associated with closing hospitals and suggests that the threat to non-performing hospitals may be not be as great as it needs to be if choice is to have the level of impact expected by policy makers. The interviewee demonstrates an understanding of the principles of patient choice policy but suggests the implementation of the policy in practice will be flawed given that true markets have not been established in health care and that the whole system has not been configured to allow patient choice to have the desired impact. The perspective of this interviewee has challenged much of the underpinning programme theory for PCP. He is claiming that the money does not follow that patient, alternative providers cannot provide what the hospital can provide in a clinically safe manner and that in reality hospitals do not close. Given that the mechanisms have been deemed to be

ineffective he suggests that the hospital is not incentivised to change and that PCP would not have the desired outcome.

Although there was general consensus that promoting services was something the Trust should be engaged in, there was also a sense of nervousness associated with this. In particular, being unable to cope with increased demand was a genuine fear articulated by many.

*Should we push it more, we should, I am absolutely convinced, we haven't promoted and sold our services in any way, shape or form or even as other acute providers do. We are miles away, if we promoted it more our theory is that we wouldn't be able to cope with the rush because our systems are not as robust, we are struggling all the time with demand management. We can't cope with the demand, because if you then offer choice you would fall down, if you say you are doing something and then you can't do it, you are giving false expectations. (29, Strategic, Clinical - Doctor)*

The hospital's marketing strategy made little reference to patient choice. There was an acknowledgement that the hospital had lost patients to local providers but this had been masked by an overall growth in activity. The Trust's strategy set out to halt and reverse this trend and this was to be achieved through improvements in access, quality and cost. The corporate teams had recognised the need to re-patriate patients that had been lost to providers but the mechanism to achieve this was not explicit. This view to attract these patients was reflected in the corporate business plan but was not reflected in any of the interviews that were undertaken. There was a genuine nervousness associated with marketing services as the need to manage demand and capacity was a core activity for the hospital. The prospect of attracting too many patients to the hospital and not being able to treat them within waiting time targets

was considered to be a real threat for the hospital, rather than losing patients to alternative providers.

There was a desire expressed by many interviewees of the need for the hospital to find ways of making itself more attractive to patients. It needed to consider ways in which it could market itself to patients. A senior nurse described the opportunity to showcase the skills and services being provided by the organisation and saw this as a mechanism for becoming the hospital of choice for patients.

*We are a Trust and we want to provide an excellent service, we want to be sort of one of the best places for care, we have got people who have excellent skills that we need to be able to use. I take that as being how we are competing against other areas really. We want to be that hospital of choice don't we? (15, Operational, Clinical – Nursing - ENT)*

Some interviewees discussed the notion of markets within their interviews and indicated that the hospital was not very good at publicising itself. A small proportion of these were from nursing backgrounds. The remainder of the interviewees were administrative or management staff. This group also expressed the need for the Trust to be able to market itself to attract patients. There was an acknowledgment from senior parts of the organisation that the hospital had perhaps not done enough to highlight the positive aspects of the organisation.

*I don't think we are proactive about saying we are a really good organisation. You can park your car here you can come and visit when you like we will tell you all about what is going to happen to you and all of these kind of things that really influence patient choice. (30, Strategic, Clinical - Nursing)*

In summary, patient choice as a lever for service improvement was recognised by some of the interviewees. In practice, the hospital was not incentivised to change in

response to PCP. A number of interviewees commented on the future and felt that the hospital should be more responsive and focus on marketing itself better to continue to attract patients.

#### ***8.2.4 Meaningful information to support patients making their choices***

One of the mechanisms of PCP was the introduction of information to support patients in making their choices. The programme theory was clear that information was required to support patients in making meaningful choices. A number of clinical interviewees described the complexity within health care and described an environment within which the information was difficult to collect, publish and then difficult for a lay person to interpret. There was a challenge at the stage choice was being offered. At the point of referral, in many cases the GP had not yet made a formal diagnosis and therefore the treatment plan was not clear. Given this situation the interviewee challenged the ability to make a choice at this point. The interviewee reported the need to consider when choice should be offered to ensure that the intervention occurs at a timely point. The final point made here is that choice should be limited to points where it can add value.

*Choice in health care is difficult. Patients want expert advice with their health and before you allow them access to expert you ask them to make choices. At this point they don't know what they are choosing. If they were told that they needed a hip replacement then they could make an informed decision. This is not the level of choice that I see we are at. We are at I am making a referral to orthopaedics where do you want to go. Well I don't know what to expect so how do I know how to make a choice I may need to look at their physio provision, arthroscopy rates, hip replacements treatments if I knew what was going to happen to me but this is rarely clear at the point of referral. Choice needs to be timely and there should not be too much of it (4, Operational, Clinical – Nursing – Diabetic Medicine)*



Information as a prerequisite to making choice was recognised as a critical deficiency in the current system. Many interviewees, mainly clinical, commented on the lack of robust information that would allow patients to make choices. Whilst recognising that there was some information available in the public domain designed to help patients it was felt that perhaps this was not enough to help make informed choices.

*I don't think patients have access to enough information to make informed choices about where they are being treated. Some organisations have got good examples of information that people can access through internets and things but I am not sure universally you could look at a directory of services nationally and say that there would be a good place to go. I don't think that has been developed as a product so that people can make informed choices. (5, Strategic, Clinical - Nursing)*

Interviewees were clear that information was the key to supporting choice and the decisions made. A few interviewees described an environment within which patients are expected to make particular choices regarding treatment and when they opt to decline treatment clinical staff struggle with the choices that are being made. This view was held by the nursing staff in particular.

*Sometimes patients choose not to have treatment and we struggle with that. They think that I have weighed up all benefits and risks and I would like to go home thank you very much and choose not to have any of that. Culturally we are not wired to accept that. (5, Strategic, Clinical - Nursing)*

The requirement for timely and credible information to support patient choice was recognised particularly by the clinicians and it was suggested that current provision was not yet fit for purpose. It was reported that perhaps patients were not exercising choice because the current set up does not allow them to do so.

*Patient choice as I understand it was to offer the patients a choice of provider, a range of people they could go and see but I think probably the overall factors that patients have to make that choice by haven't really been offered or the*

*information is not there really to use in the future, so I think it boils back down to where is it going to be this year. (25, Operational, Clinical – Doctor – ENT)*

Continuing with this theme, suggesting the need for information to support choice, one participant stated that the publishing of information about clinical quality was still perceived as a threat by clinicians. He reported that there was little confidence among clinicians in the way information had been constructed. He re-iterated the point that patients themselves would also find this type of data difficult to understand and therefore it would be difficult to use to help patients exercise choice. An important point was raised regarding information available for use across the NHS. This interviewee proposed that this remains lacking for both service providers and service users.

*Yes I think consultants probably feel very threatened by the idea of choice, consultants always feel threatened about data don't they because they always think it's poorly constructed and poorly put together, and actually I think patients find that sort of data very difficult to interpret as well. The narratives are much more important, so patients take a direct experience like, I saw so and so and he was like this to me, patient says great I am going to see him or her and that is the information that patients I suspect will often base judgements on, though the mortality figures are important but much more difficult to understand. (22, Operational, Clinical – Doctor – Diabetic Medicine)*

One of the mechanisms of PCP was the introduction of comparative information about providers made available through the internet. Interviewees challenged both the accessibility and the validity of this information in helping patients to choose their providers.

In the Activity Enabling Trust (2010), the corporate team had presented to the Board an analysis of its performance as it appears on public facing websites. Using this information this Trust rated its position as;

“only average in comparison to its competitors using these indicators”

(Activity Enabling Strategy 2010 p5)

The document also reflect the views of clinicians interviewed in that it reported that

“the information is poorly constructed and concentrates on a limited set of indicators so may not be a good indicator of quality. Further thought might be given on how the Trust might assess itself more accurately and manage its external perception”.

(Activity Enabling Strategy 2010 p5)

In summary, there was a challenge from many interviewees, in particular the clinical teams, that meaningful information was available to support patient choice.

### **8.3 Impact of Organisational Factors on Intended Outcome of PCP**

Many of the interviewees described PCP as having either little or no impact across the hospital. In particular, the doctors were notable for their unity in suggesting that there had been little or no impact of PCP across the hospital. Interviewees described the impact as being relatively unnoticeable in many places.

*No I think it's been relatively small (29, Strategic, Clinical - Doctor)*

There were others who reported that the impact of PCP had not been felt, as it was thought that it would have had more of an impact in primary care. The clinician below described the impact as creating a greater awareness on customer service and the need to be more thoughtful with communication.

*No, we are at the receiving end of it, not seeing the real impact of it, and the real impact on it is us worrying more what patients think of us. There are good things. Patient surveys are good, it does change the way you handle people if you know they are filling in a questionnaire about you. It doesn't necessarily mean you are going to bribe them with kindness but you might think a little bit more carefully about what you say and do and how you communicate with them. (13, Operational, Clinical – Doctor – Diabetic Medicine)*

There was an understanding across the hospital of the potential shift of patients from one hospital to another and the opportunity for patients to choose different hospitals. There was a view that the impact of PCP had been limited and the workload of the hospital had not been adversely affected.

*I don't think we will run out of work at the Trust (25, Operational, Clinical – Doctor – ENT)*

Although interviewees suggested that PCP had not had a huge impact, it was acknowledged that it may do so in the future. One interviewee reported that hospitals closing and other hospitals thriving had certainly not been experienced in the local health economy. There was almost relief that this had not been the case.

*Well probably nowhere near yet, it might do, it might do yet, it depends what you think patient choice is setting out to achieve. If you think it is setting out to achieve a more patient friendly NHS more focused on service to the patient than what is best for the patient I think we have probably gone a long way down that road, if you analyse patient choice in terms of money following the patient and some organisations going down and others surviving then it hasn't and maybe that is a good thing. 13, Operational, Clinical – Doctor, Diabetic Medicine)*

None of the doctors interviewed said that they had seen much difference in the patient population that they were treating. Interviewees reported that the patients they were treating were local patients and they believed strongly that patients were not really prepared to travel to access health care.

*No, no not really. When I started off as a junior doctor the big difference between now and then was about waiting lists. Now that has been driven by Department of Health reforms and Government political agendas rather than by patient choice agenda. You notice that patients who come to see you tend not to be from other ends of the country, there are your local population which is the way it has always been, again is a very pragmatic response by patients, they don't want to travel miles to see someone. If they do want to travel it is usually because they have heard someone has got a great reputation and want to pick that particular surgeon. I suspect in a lot of situations private patients can afford to make that choice probably get it privately because they want that surgeon to do it not the registrar or the right hand man whoever that is. So I am not sure it has made a massive difference. (24, Operational, Clinical - Doctor – ENT)*

When asked about the impact of choice, some of the interviewees from the nursing group suggested that there had been limited impact and they had not anticipated the impact would be significant. The area that they had noticed an impact was related to the booking of appointments where they perceived patients were now able to choose the date and time of their appointment. There were strong views that indicated they did not need PCP to help them improve the quality of their service. The threat of losing patients was met with contempt as they felt that this did not incentivise them to do the right thing in terms of health care delivery.

*Forget about whether patients are going to choose us or not it is important that we deliver a high standard of care and services are described appropriately and properly so that the quality is right. That is what should be important driver*

*for it rather than we want to make sure we don't lose patients (4, Operational, Clinical – Nursing Diabetic Medicine)*

There were parts of the organisation that felt no impact at all. A discussion with one of the matrons revealed that she knew very little about patient choice. During her interview she expressed discomfort that she was not engaged with patient choice and that if it had been introduced to improve health care delivery then she should have made efforts to have known more about it. She was clear that the interests of her patients were at the heart of what she did and she did not want to disadvantage them in any way. This view was expressed from a staff member from the ENT service. It had been anticipated that ENT would have experienced more of an impact of patient choice given the wide range of options available for patients when choosing an alternative provider. The information obtained from the nurse suggested this to not be the case. She suggested that her lack of awareness of patient choice attributed to it being an administrative initiative and that it did not affect her.

*Yes, I do feel uncomfortable a bit because I would like to know that I am doing the right thing and that my patients are getting the best, I don't want to be, I have been in the Trust for 30 years and I would hate to think somebody would think, you know she is a right stick in the mud she doesn't want to know anything about anything that is going on around here. If I don't know things I struggle sometimes, I need to know, I need to face it and know what..... I think it maybe comes out to a certain level and when you get further down, if I go to meetings or matrons meeting something like that then patient choice is mentioned. I might be wrong but it seems to be more prevalent in the clerical administrative side of patients than the actual nursing side of it I think. (16, Operational, Clinical – Nursing - ENT)*

The interviewees that were involved in activities related to appointment booking reported a significant impact of PCP within their work area. This staff group described the practicalities related to the deployment of a new system, the changes to existing

referral management processes and the need to review services with specialty teams to ensure that services would cope with the demand of bookings through the new system. This staff group were more concerned about the loss of patients to other providers. They perceived that the system had become a gateway for accessing secondary care and if the system was not used properly by the hospital and all services were not published fully then this would result in patients choosing other providers.

*I think it's about selling our services and we do that a lot more. I think from my point of view it's about looking at the relationship we have with the PCTs (Primary Care Trust) and GPs, and how you offer our services, so from a choose and book it's there, it's evident and you can see it. I think it's about communicating on a higher level which happens, working with the health authorities. To a patient it's readily available; it's on the Internet as well. I do think it's important from a Trust point of view to be able to carry it out; it's not just about selling it, it's being able to sustain it and being able to offer it to that patient, sometimes they don't fully understand what choice they make so maybe, they think they can choose anything, any time, any day they want to come so I think that knowledge needs to be there a little bit for the patient, but from the Trust it's about showing that we can deliver, we have this service available to the patient. (26, Operational, Non-Clinical – ENT)*

Those staff groups involved in the booking process commented on the need to be more competitive with other providers and ensure that services can attract patients to the hospital. The desire to be more competitive seemed to be more aspirational than recognition of the real impact of choice.

*I think that the real impact should have been that we have become more competitive. (1, Strategic, Non-Clinical)*

When asked for examples on how the hospital had responded to choice, there was a general feeling that there had been little response. The provision of services had not

changed dramatically; there was no evidence of extended clinics, weekend working or activities related to marketing the service. An interviewee described another reason for the limited impact of patient choice was because the organisation had not embraced the underlying philosophy correctly. She suggested that if the patient was at the centre of service delivery, then the organisation would have been more responsive to patient choice. She described a scenario in which the process of delivering health care did not take account of the patient's views and experience and because of this patient choice had not had the desired impact.

*If we are going to talk about patient choice it would sit right at the heart of what we do, it would be something that we would always think about, is this what the patient would want, how would I know this is what they want because I have asked them and they have told me and it doesn't sit at the heart of what we do, it just doesn't it's so far away from what we do, even when we talk about patient experience as a concept, which choice would be an element of experience wouldn't it, you know the stuff you talk about, we are not flexible enough in how we would use the tools we have got in order to make sure that whilst they are with us they get what they want and need and also when they go away they look back and , most of the time you know we do deal with nice things like people having babies or minor illnesses or treatments but a lot of the time we deal with really sick and traumatic events for people and if you can look back and say the event was horrible but the way I was handled was, made me feel confident so that if I was ever ill again I wouldn't be anxious. So that's why I don't think it has an impact we don't even think about it in the right way (14, Strategic, Non-Clinical).*

The lack of response from the hospital was echoed by a number of interviewees. Some of the non-clinical teams also expressed that there was more that could have been done in response to patient choice but that in real terms the impact had not been realised.

*So I think certainly from my experience as a business manager there is a lot more we could do or we could have done that might not have been done. (17, Strategic, Non-Clinical)*



When trying to explore the impact of PCP within the hospital, interviewees generally felt that the impact was not significant. Many reasons were offered and some of these have previously been touched upon. Lack of resource, shifting priorities and general lack of awareness of PCP were also identified as contributing to the lack of impact across the hospital. One interviewee described the organisation response as limited and doing the minimum with regard to implementing PCP. She reported that the competing priorities within the hospital meant that not much attention was given to supporting PCP and that its introduction to the hospital was limited to a superficial level.

*I don't think we have radically changed the way we deliver health care but I think we have an awareness of what the phrase actually entails and what we could or should be doing to actually deliver a service that meets that particular requirement. It wouldn't be appropriate to say that there hasn't been a shift because I think there has but I think because of where we find ourselves, not just as an organisation but generally in terms of difficult financial times and resources being tied, again I think rightly or wrongly that's probably one of the things where we would skirt round the edges to make sure that we do meet the requirement but probably not fulfil it quite to its full expectations. (17, Strategic, Non-Clinical)*

From a clinical perspective, doctors from both ENT and Diabetic Medicine reported little or no impact at all. They demonstrated an understating of the potential impact with regard to patients choosing alternative providers and the threat to them with regard to losing patients and reflected that in reality they had not seen this happen. They reported that the patients they were seeing continued to be from the local population and they had not seen a change in demand for services.

Many of the nurses felt that they had not felt the impact of PCP in the hospital; this was echoed both in ENT and Diabetic medicine. A few interviewees felt that they had not felt close to the impact of PCP at all and suggested that the impact was limited to the administrative functions.

In general impact of patient choice was limited to across the organisation and it had certainly created the significant change as intended by policy makers.

#### **8.4 Unintended Consequences of PCP**

When asked to comment on the unintended consequences of choice a number of interviewees particularly Managers, indicated that PCP could be costly. A senior manager reported the potential for health care to be less affordable as costs for complex in hospitals was currently off set against high volume simple cases. If this work moved to private hospitals it had the potential to de-stabilise large tertiary centres.

*I think there is a danger around what's in the press at the moment around independent and private sector are about is pulverising the fact that the big hospitals end up with the complex expensive difficult work and the private hospitals end up with a quick turnaround. Fast profit and I am not sure that's sustainable, so that is the responsibility of the choice and complications it would be a really difficult thing to work through. Yes I think it definitely has it's something we talk about in health care we often talk about patient choice the national agenda is making that less affordable. (11, Strategic, Non-Clinical)*

*Well, it's difficult isn't it as you wouldn't want to reward people who are chosen out of proportion as it would be unfair on the people who are not chosen through no fault of their own. If money follows the patient within an organisation like this and there are occasions then we need to cross subsidise because we need to provide a whole service, we can't withdraw service just because it is losing money. (13, Operational, Clinical - Doctor)*

There was a genuine fear that resource allocation would affect service provision because PCP would de-stabilise the flow of patients and consequently divert resources away from services that high cost but had low patient throughput.

The introduction of new additional processes was another example of unintended consequences. Many interviewees associated with the national Choose and Book system. The Choose and Book system introduced a new method of referral into the hospital and the hospital needed to invest time and energy with primary care to encourage them to use it effectively. A few interviewees commented on the increased bureaucracy that had been generated as a result of the introduction of this new system and its associated process.

*Did patients really see patient choice working in this way? If they could see the amount of administrative effort that went into facilitating the patient choice process I am not really sure that they would think that it was worth it. (1, Strategic, Non-Clinical)*

Hospitals being unable to meet patient expectations were cited as a consequence of PCP. It was felt that patients would expect more flexibility than the hospital was able to offer and that this would lead to greater levels of dissatisfaction. Interviewees reported that PCP had to operate within the finances available to the organisation and there may be cases where the most efficient service had been designed but that patients would want more from hospitals.

*I think delivery and expectations sometimes, delivery and expectations don't meet and that goes back to what we are able to deliver within a financially lean service. So I think there is some realism surrounding what patient choice and what we are able to offer. Especially with choose and book certainly when I speak to people (19, Operational, Clinical – Nursing – Diabetic Medicine)*

Finance was raised consistently by a number of interviewees. The need to evenly distribute resource was the focus of clinical teams. Some interviewees recognised that this may not always reflect what patients want. The nurses reflected their moral obligation to use the finances to deliver the greater good rather than individual needs and wants. There was a suggestion that PCP had created an environment for patients to make them think that they could have whatever they want.

*It's very easy as a patient when you don't appreciate the fact that there is a limited pot of money that has got to go round and sort everybody out and to think what about me and what about my particular case and how is the government going to help me, I have paid taxes all my life and of course everybody has and not everybody uses the health service quite to the same extent. You might only need it once in your life and maybe not get it or you might use it every week or every day. So I think because they don't quite understand that it's very easy to think that the only thing that should matter to that particular kind of patient is that it's a patient and that's absolutely right, but as an organisation just like the parent of a family when you have 10 mouths to feed, you need to feed them as much in a similar fashion as possible. It's very difficult to do that as I said because of financial constraints. (15, Operational, Clinical – Nursing - ENT).*

A number of the clinical teams were also concerned about the level of investment required in creating alternative hospitals. If these alternative facilities could not attract sufficient patients then they would not be viable but they would also have deflected critical investment away from the hospital.

*I think one of the drawbacks perhaps that we have seen is that there has been investment in other places, quite a high level of investment for a low number of patient population so if you were looking at the health economy, I don't know if you were spending £100,000 on X Y Z in hospital then 300 people might need it then the same amount of money in the community might take them three years for that same 300 patients, to them that is a drawback for a lot of investment. It's not necessarily the wrong thing but just a consequence that money has perhaps gone to areas where they have been less patients. I don't think that although this is changing although there have been more places for*

*people to go in a lot of areas within the trust I don't think that we are radically seeing less patients, maybe a bit less. (7, Operational, Clinical – Nursing – ENT)*

Resource distribution was identified by other interviewees who were not only concerned about investment in health care, but also touched on the impact a shift in resource may have on research based activities.

*I think some of the drawbacks to avoid is how many health care providers you can have in the market, if you can open that choice and widen it as you might. For all the right reasons a patient might want their care closer to home and in many effects it is a good thing but I think it might have a big knock on effect, it's a drawback for us personally and to a certain degree if you don't have that level of investment then you might not get that level of research and scientific development and from a financial perspective if you are not viable you won't be able to drive forward, there are huge scientific medical advances. (11, Strategic, Non-Clinical)*

These findings reveal that the teaching hospital recognised the role that it played in the research development agenda of health care and that health care delivery was not its only core activity. Interviewees reflected that perhaps PCP had not taken account of this. The challenges associated with PCP were noted evenly between the two chosen specialties of ENT and Diabetic Medicine. Many of the operational clinical teams reported difficulty in balancing patients' needs and wants with the finances available.

Some interviewees were concerned that too much choice would create confusion and complexity for patients.

*I think the vision for patient choice is a great one. I also sometimes do worry that there is something about us when people too much choice and that perhaps over complicates matters unnecessarily. I certainly think there is*

*potentially a lot more that we could try to do as an organisation. (17, Strategic, Non-Clinical)*

A senior nurse described a scenario using emergency care as an example to illustrate how complicated access to health care had become. She suggested that when patients are ill simple clear points of access were more helpful than a range of choices.

*We mapped this out for urgent care. How do people know about all the different types of services that are available to them A&E, walk in centres, pharmacists, Out of hours services. We bombard people with choice when we could have a really de-cluttered system if you are very sick go to A&E and if you are not that sick then you can go here. It does not have to be that complicated. We don't need minor injuries units all over the place. The location might be nice but if you are that ill then location should not be an issue. (4, Operational, Clinical – Nursing)*

In summary, it was felt by some that PCP reinforced the need to reduce waiting times and this was seen as an additional pressure in the system that was already under strain. The concern that doctors would be overworked and that clinics would be too full to cope with demand for services remained a concern for a number of interviewees. The distribution of resources was also a concern and it was felt by some interviewees that PCP had not taken account of the wider responsibilities of hospitals as teaching organisations and the advancement of healthcare through research in the way that patients could move across hospitals creating cost pressures on services that relied heavily on research activities.

It was proposed by some interviewees, that given the current financial constraints across the NHS it was difficult for hospitals to meet the competing demands of patients. Interviewees remained concerned with the underlying tension between

providing services within a financial envelope and developing services that would meet with patients' choices.

## **8.5 Summary of Findings**

The chapter explored the organisational factors and processes that mediate PCP and aligned this with the intended outcome of PCP.

The first section used the assumptions underpinning the programme theory to understand the impact of these on the hospital. It was noted that the role of the GP had not changed and that the hospital continued to view the GP as primary influence in the patient's choice of provider. Interviewees commented on the trusting relationship between patients and GPs as making patient choice being driven solely by patients much less likely. Clinical interviewees commented on the relationships they had with GPs and how this was likely to result on GPs continuing to refer locally.

The patient was not perceived as a consumer by many interviewees. There was a view from some of the doctors and nurses that patients did not want choice. Hospital doctors, in particular, were worried about patients making the wrong choices. The corporate documents revealed a reliance on the commissioner of services in influencing decisions about choice or provider and very little focus on the patient.

The incentives for the hospital to change were reported as weak. The senior leadership team had seen patients shift from one provider to another but was not considered to be a quality of service issue; rather it was seen as a capacity problem.

The lack of meaningful information available for patients to exercise choice was reported by the clinical teams. The corporate perspective echoed this view.

The impact of PCP across the hospital was minimal. Those involved in booking appointments felt that processes had been redesigned and new teams had been set up. In other parts of the hospital little or no impact had been felt. The operational clinical teams, both nurses and doctors felt that the types of patients being treated at the hospitals broadly remained the same with a firm view by many that local patients would want to be treated locally. There had been some movement of patients to other local providers and whilst this was of some concern to the corporate teams, staff closer to clinical delivery remained concerned with existing levels of high demand so was not particularly worried about the loss. Both ENT and Diabetic Medicine reported similar experiences with no significant variation in response.

The threat of losing patients was not a serious consideration for the clinical teams stating that they 'always having enough work to do'. The biggest concern for the hospital is losing investment for research and teaching activities as a result in the shift in simple cases.

The next chapter will discuss the findings in further detail and understand how these findings align with the existing theoretical and empirical literature.



## **Chapter 9: Discussion and Analysis of Findings**

### **9.1 Introduction**

As outlined in earlier chapters a qualitative case study approach was used to explore the influence of PCP on organisational culture in a large acute teaching hospital. Chapter 7 and 8 describe in detail the findings from the qualitative interviews and review the key organisational documents and reports. The purpose of this chapter is to discuss the key themes emerging from the findings and to reflect on how these link and relate to the theoretical literature and existing empirical evidence in this area.

The chapter is comprised of three sections. The first section begins by reminding the reader of the research questions. This section also restates the underlying programme theory of PCP to provide a context for the discussion. In this section it will be shown that PCP was designed to be a key lever for the modernisation of health care provision through incentivising hospitals to improve the quality of services. The second section focusses on the headline findings from the study, describing the impact of PCP in the hospital and draws on wider literature to provide an explanatory account for these findings. The final section considers what the findings uncover about the influence of PCP on organisational culture and cultural change in a large NHS Trust. This includes what the results from the study show about how the hospital is governed, how it operates and responds to change.

In this chapter it will be shown that PCP has had relatively little impact on the hospital. It will be argued that PCP has been naïve in its assumptions and has ignored the context that the policy is being implemented in. The culture of hospitals is

an important factor in stimulating change. PCP has failed to consider these organisational factors and as a result the intended outcomes of the policy have not been achieved. The chapter concludes by outlining the factors that have contributed to the resistance of PCP within the hospital setting.

## **9.2 Restatement of the research questions and an outline of the programme theory underpinning PCP.**

The aim of the case study was to explore the influence of patient choice on organisational behaviour in an NHS Teaching hospital with a particular focus upon culture and how this has been influenced or shaped in response to PCP. This aim was investigated through the research questions outlined in table 9.1 below.

Table 9.1 Research Questions

1. How is PCP viewed by different staff groups within the organisation?
2. How has the organisation's culture changed in response to PCP?
3. What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?

To facilitate PCP, a number of measures have been introduced to create the conditions to support choice in health care and encourage and enable the patient to adopt the required role of “a consumer”. The programme theory underpinning PCP has the following step wise logic:

- The Government asserts that the introduction of market elements into health care, in particular choice and competition will enhance efficiency and address non-responsiveness among provider organisations.
- Competition among providers for contracts will incentivise providers to review (and if necessary improve) the quality and efficiency of the services to ensure that they are responsive to patient needs, making them the most attractive option to potential patients.
- Payment by Results will generate standard tariffs for activity ensuring that price does not influence the market, and that providers compete principally on quality.
- Money will follow the patient so those providers not attracting patients stand to lose out financially.
- Increasing the number and diversity of eligible providers in “the marketplace” will allow patients to have a range of alternative providers to choose from.
- Patients will have access to a range of information about the quality of services ranging from health care outcomes to cleanliness ratings to access indicators (e.g. car parking, waiting times).
- Patients will use the information provided and act rationally to select the best performing hospitals.
- Those hospitals that do not achieve quality and efficiency standards will fail and potentially may go out of business (i.e. exit the market) because they will not be selected by patients and therefore, lose income.

The programme theory underpinning PCP is designed to challenge hospitals to respond by improving the quality of services they provide. The incentive for hospitals

is to attract patients. The intention of PCP is to challenge traditional referral patterns, with patients driving the change through the ability to exercise choice of hospital. The policy provides both challenge and opportunities to hospitals in that those that fail to attract patients may find that they will not be financial sustainable and will go out of business. For those that are successful in attracting more patients, they can increase their income and secure financial stability. The next section investigates the findings in detail to determine the degree to which the assumptions underpinning PCP are well founded.

### **9.3 Headline findings from the study**

#### ***9.3.1 Mapping the empirical findings to the research questions***

The overall finding detailed in Chapters 7 and 8 is that PCP has had relatively little impact on organisational behaviour in the case study hospital where this research took place. To illustrate this, Table 9.2 sets out the research findings and maps these against the research questions.

Table 9.2 - Mapping the empirical research findings against the research questions

| Research questions  | Key findings   |
|---|--|
| <p>How is PCP viewed by different staff groups within the organisation?</p> | <ul style="list-style-type: none"> <li>• Different perceptions of PCP existed within the organisation</li> <li>• Patient Choice of provider and appointment were described as examples of PCP</li> <li>• Patient choice and the booking of appointments were closely aligned views given the introduction of the National Choose and Book system. A view that was held by junior and middle managers in the main</li> <li>• Patient involvement in health care was another perception of patient choice. The Trust's Annual report described choice as the opportunity for patients to be involved in health care</li> <li>• Clinical teams, both nurses and doctors, wanted patient choice to be the vehicle by which they were involved in their health care and helped to shape and design services</li> <li>• A few members of the corporate team recognised PCP as a means of improving service quality</li> <li>• The operational teams felt more remote from the principles of patient choice and felt that it was not embedded in the work that they were involved with</li> <li>• For some corporate members and few of the hospital doctors, patient choice was seen as a means of cutting cost in the NHS rather than a lever for service improvement. They remained sceptical of the role of PCP in improving quality</li> </ul> |
| <p>How has the organisation's culture changed in response to PCP?</p>       | <ul style="list-style-type: none"> <li>• The historical corporate culture of the hospital was described as hierarchical. This was reported by 27 of the 30 interviewees</li> <li>• Many interviewees, particularly clinical and operational teams reported a frustration with</li> </ul>   |

|  |  |
|--|--|
|  | <p>the culture which they felt inhibited change and innovation</p> <ul style="list-style-type: none"> <li>• The culture of the organisation was reported to be changing by many across the organisation. The changed culture was moving to a more rational and developmental corporate culture</li> <li>• There was little indication that the change in culture was linked to the introduction of PCP. Many interviewees reported the change in culture as being attributed to the change in leadership</li> <li>• To become the hospital of choice was a goal of the hospital but had been for many years. The change of culture in the hospital was not being driven by this goal explicitly</li> <li>• ‘The hospital of choice’ goal was described as provision of local services for the local population with a significant focus on working with local GPs and the commissioner to secure this aim</li> </ul> |
| <p><b>What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?</b></p> | <ul style="list-style-type: none"> <li>• The view that the patient was a consumer was an important factor in mediating PCP. A review of corporate documents and findings from the interviews suggested that the hospital was not viewing the patient as a consumer</li> <li>• Many interviewees both clinical and non-clinical, felt that the GP was choosing the provider rather than the patient</li> <li>• The ‘Activity Enabling Strategy’ described a need to focus on influencing the GPs to ensure patient referrals continued to flow to the hospital</li> <li>• Clinical teams were clear that meaningful information did not exist to support choice of provider</li> <li>• Nursing and administrative teams reported that GP consultation did not allow sufficient time for</li> </ul>  |

|  |   |
|--|---|
|  | <p>a meaningful choice conversation to take place</p> <ul style="list-style-type: none"> <li>• The incentives for hospitals to change were not viewed by interviewees as strong</li> <li>• The Trust's 'Market Assessment document' identified a shift in patients to other providers. This was not identified as a significant risk to the hospital</li> <li>• Across the Trust, interviewees described that they had more patients than they could treat.</li> <li>• The risk of losing business and failing was not reported as a concern by any of those interviewed</li> <li>• PCP was not seen to be operating as intended by policymakers</li> <li>• The quasi-market model did not appear to be operating effectively because although patients were shifting to alternative providers, in practice this was not reducing the workload of the hospital. Excessive demand for health care and the need to meet performance targets meant that the shift in activity was not the incentive it was designed to be</li> </ul> |
|--|---|

The expectation that PCP will drive organisational change and service improvement has not been observed in the findings. These findings are consistent with previous studies in this area (Dixon et al 2010, Peckham et al 2011). Dixon et al (2010) in their study on 'How patients choose and how providers respond' found that NHS hospitals perceived patient choice to be of limited significance. Providers in the study were focused on providing a local system to their local population and had not developed an approach to broaden their markets. None of the providers interviewed were concerned about the financial impact of choice. The study did report that providers felt

that there may be an impact of PCP in the future as choice became more established and information to support choice became more accessible.

Many of the results of the Dixon et al (2010) study align with the current findings; clearly this position contests the intended programme theory that expects PCP to be a major lever for improvement and NHS modernisation. This next section explores the findings in detail to understand how PCP has been received by the organisation and how this might affect the hospital's response to it.

### ***9.3.2 Views and perceptions of PCP***

The results show that, in practice, patient choice was perceived in different ways across the organisation. The nurses and some of the doctors interviewed tended to define patient choice in very broad terms. For this group of staff, patient choice was viewed as a right allowing patients much more involvement and autonomy in their health care. The nurses were generally very supportive of this type of choice being available in health care and they felt that this would definitely help patients receive an improved quality of service. For others, particularly those working in the administrative teams, some of the middle management and operational teams defining patient choice was limited to the date and time of the appointment. Many of them associated choice with the introduction of the national Choose and Book system. The administrative team describes a new method for patients to book their hospital appointment in primary care with a change process for the hospital. This new booking process permits patients to choose the date and time of their appointment. Many administrative staff reported the consequence of this was that it introduced another layer of bureaucracy and administrative processes that created additional



pressure on the teams. Interviewees from the administrative team report patient expectations being raised and in some cases the hospital was not able to meet these expectations. There were only a few interviewees that recognised patient choice as an opportunity for patients to choose the hospital that they attend and described patient choice in the terms of PCP.

The extent to which each of the groups were supportive of patient choice – at least in part – depended on what ‘choice’ means to them. The administrative staff group saw choice principally as a technical process and one which was adding to the complexity of the patient journey and the management of patient flows. ‘Choice’ for this group was perceived as a burden and could influence the degree to which they were supportive of PCP. For the nursing staff, choice was linked to broader goals of involvement and engagement and this group tended to be more positive about it.

PCP as a concept was not well defined across the hospital. Corporate documents of the Trust did not provide clarity which permitted staff across the hospital to assign their own views. This contributed to a lack of focus on the actual intentions of PCP and potential dilution in its impact.

### ***9.3.3 Analysing the Programme Theory Assumptions***

For PCP to operate as intended it is necessary for patients to behave as consumers. The findings of the study indicated that this was not happening in practice. There were a numbers of reasons that shaped this view. Some interviewees felt that this was because patients did not want choice. The operational teams both administrative and clinical perceived that older people in particular did not want to exercise choice and that they would prefer to leave these types of choices to the GP. There is

significant empirical evidence to suggest that this may not be the case. A number of studies have demonstrated that choice is important to patients and that patients do want to exercise choice (Barnet et al 2008; Patiar 2006; Weir et al 2007, Caress 2005, Ogden et al 2008). A King's Fund study in 2010 (Dixon et al 2010) found that older people were significantly more likely than younger respondents to think that choice of hospital was important.

The view of interviewees was that patients were not exercising choice and felt that GPs were making choices on behalf of their patients. The findings indicated that interviewees felt that there was a relationship of trust between the patient and the GP and that is why they felt GPs continued to play a significant role in influencing patient choice. This finding is consistent with Lewin and Piper (2006) who found that almost 90% of the respondents were content to entrust their care exclusively to health professionals based on their confidence in the clinical expertise of the medical and nursing staff. The Lewin and Piper study noted that a number of participants indicated that they thought the role of patients would change over time and they would want choice in health care. There was little evidence to suggest that the referral making process had changed since PCP had been introduced so interviewees assumed that GPs continued to make referrals as they had done prior to the introduction of PCP.

In contrast, a recent study commissioned by NHS England and Monitor (Populus, 2014) offered further insight into why hospital doctors are not experiencing patients acting in the role of consumer. The study conducted by Populus was an on line survey of approximately 7,000 adults. The study included interviews with approximately 2,000 patients who had been referred for an outpatient appointment by

their GP within the last 12 months. The study found that whilst choice was important to patients, at the GP pre-referral stage, choice of hospital was not being offered to patients. 53% of respondents to the survey discussed which hospital or clinic that they might go for their first appointment but only 38% reported actually being offered a choice of hospital or clinic. This recent study suggests that it is not the patients that are not engaging with patient choice but rather that GPs are affecting the ability of patients to exercise choice.

The reaction from the doctors interviewed in the case study is comparable with the findings of the Populus study, in that it appears that doctors were reticent in accepting that perhaps patients do actually want choice. This situation presents an interesting conundrum for the hospital, as until the time when the broader health system allows patients to exercise choice it does not have cause to change the way in which it delivers its services. Whilst the programme theory of PCP has focused on engaging the patient as the driver of change, policy makers have underestimated the GP and patient relationship which is limiting the ability of the patient to exercise choice. The consequence of this on the hospital is that they do not believe that there is a need to change.

The quality of information available for patients to support them in making choices was identified as an issue by a number of interviewees. Interviewees felt that patient choice could only be effective if information is available to enable patients to understand different aspects of quality and how hospitals may vary on these, and to support them in making trade-offs between different aspects of quality. The clinicians interviewed, on the whole, felt quite strongly that the quality of information published is not 'fit for purpose' and challenged whether this could be used by patients as

indicators of quality and efficiency. The clinical teams remained sceptical of the ability of patients to understand and interpret published information as a means of determining hospital quality. Some of the clinicians interviewed express their discomfort with information currently available in the public domain and suggested that it was not adequate to support patients in exercising choice. Whilst there were a number of reasons that they- felt information was not 'fit for purpose', they felt that quality in health care was not well defined and that health care professionals had not yet agreed a definition amongst themselves so it was difficult to guide patients. Information and choice were contentious issues and Dixon et al (2010) demonstrated that the experience of family and friends and influence of GPs were amongst the most significant factors that influenced the choices that were made rather than the use of published information. Dixon et al (2010) found that only 4% of patients had used the NHS Choices website to support them in selecting a hospital. This supports the view that patients are more influenced by the experience of the people that they trust predominantly family and friends, rather than published performance data per se. This is consistent with similar studies. Coulter et al (1999) found that performance information did not influence the choices that patients make. They found that the locality of provider, experience of family and friends and influence of the GP were more important factors. Their study indicated that the hospital performance was not being used as explicitly as one might expect when assessing quality of service. This study concurs with the concerns raised by clinicians interviewed in the case study, who challenged whether quality information has been presented in a way for patients to make choices. It appears that the problem with information and choice is that the

information was not being provided in a way that is meaningful to patients and this was affecting the ability of patients to use it to exercise choice.

Similar studies have shown that the type and volume of information provided also causes difficulty for patients when trying to exercise choice, but the findings do not present a clear picture. For example, Barnett et al (2008) in a qualitative study found that information provided by GPs was inadequate, not because it was unavailable, rather that there was too much that made it difficult to understand and process. There was also a view from patients that information provided by hospitals would be partial and self-serving, which can lead patients to distrust the information. By contrast, a more recent study conducted on behalf of NHS England and Monitor (Populus 2014) found that 89% of respondents indicated that they had enough information to help them make their decision of choice of hospital. These findings challenge previous findings that indicated the information did not support patients making their choices (Magee 2003; Healthlink 2006). The previous studies had much smaller sample sizes and used face to face interviews and focus groups in contrast to this recent study that conducted interviews on line. The difference in the responses may be affected by the sample used by the studies. The Populus study had targeted people that were familiar with using computers and perhaps may be more familiar in using information through an electronic format such as web pages.

Interviewees in the case study, in particular the corporate and clinical teams, expressed a desire to share information about the quality of services with patients but acknowledged that this was difficult to achieve as defining quality was complicated.

The Trust's 'Marketing Strategy' made reference to limited comparative information published and the need for the hospital to consider a different set of information to define its services. In practice, there was no indication that this had been done. This view was reflected by one of the clinicians interviewed who felt that information that adequately described the quality of hospital services was not accessible for patients. The broader literature in the area has focused on how the information that is available is used to support choice rather than addressing the question on whether the information represents quality of services (Dixon et al 2010, Magee et al 2003, Healthlink 2006). Boyce et al (2010) found that decision making within health care was a complex process and supported the view of clinicians interviewed in the case study. The study proposed that the way that information is presented also influences the choices made.

A number of interviewees, in particular the corporate teams and doctors, perceived the hospital to be a monopoly provider. Within the city, the hospital was the primary provider of acute services for the local population. This is fairly unique for large cities that tend to have a number of separate hospitals. When asked about choice, many felt that patients did not want to travel and that their preference was to be treated by their local provider. Mahon et al (2004) also found that patients preferred their local provider but choose an alternative provider if waiting times are high or there is a need to access specialist health care.

The corporate team was aware that a proportion of referrals that had traditionally been received by the hospital, had been deflected to neighboring hospitals but this was attributed to long waiting times for certain services, where demand was greater

than available capacity. The corporate team did not feel that poor quality of service was driving this shift. The case study supported the empirical evidence that shows patients are willing to exercise where waiting times for treatment are excessive as was found in the London Patient Choice pilots (Dawson et al 2006). The case study also shows that the local provider's confidence in patient loyalty is so great that they do not perceive the threats associated with choice as real. Hirschman (1970) in his theory of loyalty indicated that there were instances where a user's loyalty to the organisation would present a barrier for choice being exercised. This is perhaps something that PCP had not given enough attention to. Patient loyalty appears in the empirical literature almost incidentally (Greener and Mannion, 2009). Greener and Mannion found that patients continued to choose their local hospital even when the quality of care was shown to be at a lower standard. The findings from this case study found that the hospital relied on this loyalty and was attributed to the hospital's perception that it provided the best quality health care. Loyalty appears to be combining with convenience to exert a very strong pull on patients to choose their local hospital. It would appear that PCP has not factored loyalty as a key variable for consideration in its programme theory and as a consequence failed to observe the way in which this could undermine the impact of patient choice.

Fotaki (2014) found that that whilst choice is important to patients, that they were willing to trade this for high quality local services. A study conducted by Mori (2010) supports Fotaki's proposition and that choice becomes less important to patients when positioned against fairness across public services. The perception that local provision of high quality services is more important than choice to patients is a view

that is held by many of the interviewees and a consequence PCP was deemed to have limited impact in the hospital.

The programme theory underpinning PCP describes patient choice as a lever for improvement in service delivery. It assumes that through the opportunity of alternative provision being made available for patients, hospitals will become more responsive to the needs of patients because they don't want to lose patients to other hospitals. It is also assumed that this responsiveness leads to the improved quality of service provision and efficiency. In reality, interviewees in the case study remained cynical that patient choice was designed to support the improvement of service delivery. Many interviewees reported that it was just another mechanism to rationalise health care provision. Interviewees described scenarios where the financial pressure is such that they felt they have to consider the type of service provision that they can continue to provide. There were examples cited where they quoted hospitals had re-defined the types of patients that they would accept. In this context Patient Choice was not viewed as a vehicle to drive quality and efficiency but was perceived as the mechanism by which the NHS will respond to the challenges of financial austerity. A report by the Nuffield Trust (Roberts et al 2012) reviewed the impact on financial austerity measures within the NHS. The report assessed the impact of choice and competition within the NHS between 2006 and 2008 and stated that there was very little evidence that this had any major impact on quality and efficiency in the NHS. However, choice appears to have made very little difference to the proportion of patients treated at an NHS hospital that was not the one closest to them. In 2006/07, 23 per cent of hernia patients were seen in an NHS trust which was not their local hospital and by 2010/11 this was 22 per cent. In emergency care,



where only NHS trusts provide services, there was hardly any significant change in where patients are treated.

Whilst the Nuffield Trust report indicates that private provision and choice has supported a change in the way health care is being delivered, the report found that there is little overall change in treatment patterns among NHS hospitals. The findings from the Nuffield Trust report are consistent of the views from interviewees in the case study. Interviewees noticed a shift in patients wishing to be treated in the private sector for low complexity procedures but this was only experienced at the margins. On the whole, the flow of patients and the types of patients referred to the hospital remained unchanged.

For some interviewees, in particular the corporate team and the doctors, the introduction of private providers and alternative health care provision coupled with financial stringencies, perceive patient choice as a mechanism to introduce plurality in health care provision. The need to reduce public spending and the introduction of alternative providers in the NHS market was viewed as the early steps to the reduction of the type of services that the NHS could provide in the future. The clinical teams associated choice and competition as a challenge to the fundamental principles of the NHS.

Operational staff within the case study hospital reported a number of competing priorities within the organisation. The need to deliver against challenging performance targets, deliver reduced infection rates and achieve financial balance was the areas that were occupying all staff groups. The operational teams, both

clinical and non-clinical reflected that perhaps they should have PCP more attention but that current competing priorities meant that PCP was just not prioritised. The teams reported that there were more significant priorities on the hospital agenda such as national performance and quality improvements targets that resulted in much less focus on PCP. This finding was consistent with Dixon et al (2010) who also found that providers were focussed on waiting times and financial pressures.

This section has summarised the apparent limited impact that PCP has had within the hospital. The findings contrast with the assumptions underpinning the programme theory that appear not to have been met in a number of instances. The next section will explore in more detail how these findings about PCP shed light on the hospitals response.

#### **9.4 Understanding the hospitals response to PCP**

A range of theoretical perspectives have been outlined in chapter 4 that describe hospitals as complex organisations. This section will consider what the findings about patient choice reveal about the hospital.

The findings reveal that many of the interviewees describe the past culture of the organisation as hierarchical. This is linked to a number of comments that suggest a prevailing negative controlling culture that has inhibited the development of the hospital. The hospital is large in size with more than 15,000 employees and is geographically spread across multiple sites and to manage an organisation of this size requires control. The structural control required to manage an organisation of this scale is substantial and reflective of Mintzberg's (1983) model of a professional bureaucracy. The findings of the organisational corporate culture compare with

Gerowitz et al (1996) that found that the culture of hospital management teams within the UK are frequently hierarchical or clan in nature. The implications for this for the hospital is whilst the hospital may perform well in terms of employee commitment and loyalty, it performs less well in terms of external stakeholder satisfaction, resource acquisition and competitiveness (Scott et al 2003). The programme theory of PCP relies on hospitals to engage with the market and compete with other hospitals to attract their patients; clearly, this may prove challenging for those organisations whose hierarchical cultures do not lend them to being competitive. Given the aim of PCP is to leverage change within hospitals a more effective way in influencing this may be to stimulate changes at organisational level within the hospital rather than external initiatives.

The existence of sub cultures within hospitals is widely acknowledged with the occupational sub culture within the NHS being a particular feature (Scott et al 2003), however, within the study this was not articulated explicitly. The cultural variances were subtle and noticeable through the way in which the different professional groups describe patient choice and its value in health care. The nurses and some doctors described patient choice as the patient being more involved in the care process and are something that should exist through the health care delivery process. The nurses indicated the need for patient choice as a right for patients that help them to be involved in their health care. For some doctors, patient choice was perceived more in terms of involvement. Some acknowledge that patients may want to be involved in making decisions but described this more as a joint activity with clinical teams that rather patients making their own choices per se. Doctors often confidently asserted what they thought patients wanted and were clear that it was difficult for patients to

be able to choose between different hospitals. There was a strong philosophical view from the doctors that quality was not well defined in health care consequently the opportunity for patients to exercise choice based on quality information was fundamentally flawed. The doctors were comfortable in suggesting that they knew what was best for the patient and worried about patients making the 'wrong' choices. The findings confirmed the ongoing existence of paternalism in health care particularly with the medical profession which has previously been recognised in the broader literature (Macdonald 2003). PCP introduces a model of health care that challenges the fundamental beliefs that clinical teams know what is right for the patient. The belief that information about hospitals will be enough to empower patients and engender this cultural change of patients making choices is flawed.

Many interviewees reported that a shift in organisational culture had been experienced and this is attributed to a change in senior management leadership that had taken place over recent years. Interviewees describe that the change in leadership has been accompanied by increased communication and a sense that the vision and purpose of the organisation has been clarified. Using the CVF as a culture assessment tool, many interviewees describe the desire to move towards more rational and developmental cultures. It was felt that these types of cultures would allow the hospital to perform more effectively in achieving high quality, safe care within a financial sustainable environment. There was a feeling from interviewees of not being able to exercise autonomy and expression in the previous hierarchical culture. Many interviewees describe being bound by rules and a lack of autonomy which created as a huge sense of frustration and they believed that this affected their ability to perform. A tool used to instigate change in culture across the hospital was

the introduction of a leadership behaviour framework (Figure 9.4 Hospital leadership behaviours). This framework outlines the behaviours expected of the leaders of the hospital.

Figure 9.3 Hospital leadership behaviours

| Behaviour           | Description  |
|---------------------|--|
| Respect people      | Leaders are expected to ensure that they interact in a professional way with all teams |
| Go and See          | Leaders are encouraged to undertake regular walkabouts and see their areas in action   |
| Ask why             | Leaders are encouraged to challenge the status quo                                     |
| Take responsibility | Leaders are required to recognise their responsibilities for their services            |
| Support teamwork    | Leaders are required to promote team working   |
| Solve problems      | Leaders are required to focus on solutions   |
| Make decisions      | Leaders need to ensure that timely decisions are made                                  |
| Deliver results     | Leaders need to be clear of their objectives and outputs required                      |

(Managing for Success – Leading in a Lean Organisation 2011)

Whilst the association between culture and organisational performance has been challenged with many critics suggesting that there is little evidence to suggest a linear relationship (Hitt and Ireland 2002), there are a number of empirical studies that appear to have discerned a relationship between performance and culture (Davies et al 2007, Jacobs et al 2013). Jacobs et al used the CVF to explore the

relationship between organisational culture and performance in NHS Hospital Trusts. They found that performing cultures were exhibiting a blend of cultures. They also found that dominant developmental cultures were associated with performing organisations.

The empirical findings of this study indicated that PCP had relatively little impact in the hospital, yet the vision, values and goals of the hospital have been reviewed in the last few years and the goal to become the hospital of choice was a clear ambition.

“To be the hospital of choice for staff and patients”

(Vision, purpose, goals and objectives, 2012)

When examining the detailed objectives underpinning this goal, the organisation identified that the strategy will be delivered through achieving, better, simpler and cheaper local health care services and by continuously improving the experience of all patients and stakeholders. The strategy provided a useful insight in the way in which the organisation has positioned itself within the NHS market place. The focus on local health care services seems to be the primary aim of the hospital. The hospital demonstrated some awareness of the importance of markets in health care with a marketing discussion taking place at Board level in October 2011 from which the Trusts marketing strategy has emerged. This was described as;

“Consolidate and improve our Market Share: More (Local) residents choosing to be treated (Locally), and consolidating on and expanding the opportunities for specialist and tertiary activity services.”

The marketing strategy of the case study Trust was defensive. Given the perceived limited competition to the hospital, it opted to safeguard its existing business rather than take an alternative approach. The hospital was not seen to behave as if it was operating in a quasi-market as intended by policy makers.

PCP was designed to operate as part of wider set of reforms within the NHS that created a competitive market environment within which hospitals would feel threatened and forced to change the way in which they operated to improve services (Le Grand 2007). The real context that PCP was introduced into is seen to be described very differently by the hospital. Many staff reported being overwhelmed with demand and constant pressure to deliver against the mandated waiting time standards for access to health e.g. Referral to treatment standard, cancer waiting time, emergency care standard. Demand exceeding supply meant that competition was not perceived as a threat. This sentiment was captured by one of the doctors who reported that 'the hospital will always have enough work'. The corporate ambition was not to operate competitively but to secure its existing market and appeared to be confident that local provision is what patients would continue to want particularly because of convenience factors such as travel and the ability for carers to visit. Many of the doctors interviewed feel that GPs were influencing or making choices and therefore, local service provision was likely to be offered as the first option to the patient. These combined factors of the hospital perceiving itself as a monopoly provider in addition to the hospital's view that patients prefer local convenient services and possibly exhibiting some loyalty to the hospital and finally,

the GPs acting as choosers continuing with traditional referral patterns had resulted in the behaviours within the hospital not changing in response to PCP.

There was limited reference by any of the interviewees to the hospital being part of a market system and many continued to describe a traditional public service model. The hospital corporate documents also continued to refer the GP and commissioners as the influential stakeholders rather than the patients. The Board discussion document from 2011 also outlined the need for the organisation to work closely with GPs and commissioners as a mechanism of securing market position. There was little reference in the document to the patient's role in influencing the market. This is consistent with research conducted Peckham et al (2011) who also found that hospitals focussed on the importance of the GP and commissioner relationship rather than the patient.

Chapter 4 outlined a number of theories that describe how organisational change can be achieved. The findings from this study suggest that whilst PCP is designed to be a catalyst for change in the hospital, in practice, this has not been the case. The previous sections on organisational strategy and organisational culture indicate that change has occurred in the hospital. The concept of the market has been noted by members of the corporate teams but in practice given little attention. There were steps taken by the leadership team to introduce a new style of leadership and leadership behaviours but it is difficult to link any of this change to PCP. There are a number of reasons why organisations try and resist change. Katz and Kahn (1978) described six key barriers to change. These included; structural inertia, limited focus of change, group inertia, threats to expertise, threats to power relations and threats to resource allocation. These areas are explored further in the section below to aid



understanding of whether these factors can explain the lack of response from the hospital towards PCP

- *Structural inertia*

Structural inertia can occur in organisational structures that are stable. The stability of the structure can often lead to organisations accepting the way things are (Stephenson 1985). It was not surprising to find that many interviewees described the hospital as hierarchical, as the literature traditionally recognises that hospital structures tend to be hierarchical in form, comprising of range of multi professional staff groups and non-qualified staff groups joined together to deliver a set of processes and services. Mintzberg (1983) describes the structure of a hospital as a professional bureaucracy. This is similar to functioning as a machine bureaucracy in which the work is stable leading to pre-determined or predictable behaviour. The hospital is recognised as complex so it is necessary for controls to be in place. A key point of difference between the professional bureaucracy and the machine bureaucracy is that the former relies on the skills and knowledge of individuals in the production of its services. These skilled individuals are highly trained in their discipline before they join an organisation and therefore can exert a great deal of power and influence.

Many corporate and clinical interviewees described the hospital as large and its size was frequently referenced as one of its unique features preventing it from behaving as other hospitals do and was often used to explain away the differences. The size of hospital was used as a proxy for complexity by many staff groups. One of the

clinicians described the hospital as 'arrogant' reflecting more a perspective of not wanting to change rather than not able to change.

- *Limited focus of change*

This type of resistance to change can occur if the proposed change is not understood well enough resulting in a lack of understanding and focus on the change. PCP has evolved over the last decade and continues to be refined (Health and Social Care Act, 2013). The study reveals that many interviewees have a varied understanding of the underpinning programme theory of PCP and the intentions of the policy. For the nursing teams interviewed being involved in health care and having a choice in what happens to them is considered to be very important. There were many interviewees that felt that PCP was perhaps not the best vehicle to achieve this goal. Broader change theories propose that a clear and shared view of the change is a vital factor in achieving large scale change (Kotter 1995). The case study appears to indicate that a shared vision and understanding did not exist in the hospital given the different perceptions of PCP.

- *Group inertia*

Group inertia can cause resistance to change where teams have established patterns of working and the proposed change challenges this (Rollinson 2008). The direct impact of PCP is designed to change the interaction between the GP and the patient. PCP requires the patient to drive the change, to become pro-active in

assuming the role of consumer. The programme theory underpinning PCP intended that this change would create an incentive for hospitals to reflect on the way they deliver services and change and improve. The findings of this case study reveal the hospital was comfortable in the quality of services that it delivered for its patients. Many clinical Interviewees reported that PCP was not required to stimulate service change as this is the core function of the hospital and this was part of the 'day job'.

- *Perceived threats to expertise*

Resistance to change can occur if the change planned, threatens the responsibility of a group or an individual (Kotter and Schlesinger 1979). The clinical interviewees reported that they were challenged by the concept of patient choice. They describe their concerns of patients making the wrong choices and in other situations not accepting clinical decisions. Some of the corporate interviewees describe this as a situation that staff were unfamiliar with and that perhaps they would struggle to know how to respond to it. The traditional model of decision making within health care has been clinician led where the doctor or nurse tells the patient what to do. The clinicians maintain that given their clinical expertise they know what is best for the patient. This is another factor that could contribute to the reduced impact of PCP in the hospital. On a practical note, clinicians are trained to be decision makers and have not been trained to be decision partners. This raises a number of issues including the attitude towards active patient involvement and the skills to be able to support active patient involvement. It has been proposed that patient involvement in choice can create tensions for doctors in their medical identity (O'Flynn and Britten, 2006).

- *Threats to power relations*

Hospitals have traditionally been at the centre of the NHS health care provision (Klein 1995). This role of the hospital is changing with the implementation of a latest set of reforms which require commissioners to challenge the effectiveness of outcomes and shape future service provision (King's fund 2014). PCP can be seen as a further erosion of the power of the hospital with the patient being given the opportunity to assess quality and make their own choices. The hospital as a powerful entity in health care has existed for many years (McKee and Healey 2000). The proposed set of wider reforms, of which PCP is a part, appears to be threatening this position and in turn creating resistance to change. Despite the desire to create powerful new commissioning bodies to challenge hospitals, providers continue to hold most of the power within the system due to the regular re-organisation of the systems around it (King's Fund, 2014).

- *Threats to resource allocation*

PCP is underpinned by a financial flows model that supports 'money following the patient'. Interviewees described their concern that resources may be unequally distributed across the health economy. Many interviewees reported how certain services currently subsidise others they felt that this was particularly the case between simple and complex patient casemix. There was a concern that patient choice may cause the flow of simple, high volume cases to be diverted to alternative providers leaving the acute teaching hospitals with overheads that could lead to financial difficulty. Interviewees also reported that it would make it hard for hospitals to sustain financial stability. There were genuine concerns that this could act as a

perverse incentive for some hospital who could decide to withdraw treatments and service provision because they are no longer financially viable. This concept of 'cherry picking' by alternative providers is recognised as a potential consequence of PCP (Chand 2014). Many interviewees perceive that PCP had the potential to affect the ability to provide academic and research facilities if the hospital became pre-occupied with the market model of health care. Many interviewees also reported genuine concerns about the negative consequences of patient choice and wider impact it could have on health care delivery. For some interviewees, PCP was perceived as a means of saving money by introducing competition and alternative providers of health care. It was felt by some interviewees that PCP could affect the NHS as an institution. PCP as a key component of market-based health care appeared to be the site of resistance rather than PCP per se. There was resistance to this as was seen as potentially deconstructing the NHS. PCP cannot be divorced from market thinking, and so any analysis of responses to it need to understand the various reasons why market logic is so contentious in the NHS.

There are a number of cultural change models including Gagliardi, Dyer and Schein (Scott et al 2003). A common element of these models is that strong leadership is required to deliver cultural change. The case study found that although the leadership was changing there was no indication that PCP was being driven by the leadership team. Cultural change also requires a threat to be identified to stimulate the change. PCP was not perceived as a threat by the hospital. The context of the organisation was that they had more work than they could cope with so losing business was not deemed to be a risk.

In summary, this section used organisation culture and cultural change theory to explore the hospitals response to PCP. The culture of the hospitals was changing and the leadership was prominent in driving change across the hospital. PCP was not positioned as a catalyst for change and was not being reflected as important in terms of the strategy of the hospital. The hospital used the language of markets such as market share, stakeholder and competition but in practice continued to behave as a service provider.

## **9.5 Summary**

The chapter began by setting out the research aim and the questions used to explore this in detail. The programme theory underpinning PCP was also set out, reminding the reader of the intention of PCP and how this might be achieved. PCP was designed to be a lever for service modernisation when in fact the findings reveal that this had not been the case in practice. The qualitative case study undertaken within a large teaching hospital within the NHS found that PCP has had relatively little impact on the hospital. Table 9.2 presents a mapping of the findings to the research questions and reveals how the impact has been limited to the redesign of process of booking appointments and the introduction of a new national system to support this.

The interviewees reported a number of reasons why they perceived that PCP had not had the intended impact on the hospital. These include a belief that patients did not want choice, despite evidence from the broader literature (Ipsos Mori 2010, Dixon et al 2010); the perception of many within the hospital was that this was not what patients wanted. Clinical and administrative teams observed that in many cases the

GP continued to make the choice of hospital on behalf of the patient. A recent survey commissioned by NHS England and Monitor (Populus 2014) supports this assertion as the survey reveals that only 4 in 10 patients are offered a choice of hospital by their GP. Many interviewees perceived the hospital to be a monopoly provider and remain confident that the clinical quality and the locality of provision would continue to influence GPs to refer patients to them.

The quality of information available to patients was reported by a number of interviewees as a barrier to patient choice. The doctors interviewed, reported that quality in health care was not well defined and in these circumstances it would be hard for patients to exercise choice.

The view that local patients want high quality local care is reported by many interviewees who report feel that the loyalty to the hospital and inconvenience of travel would deter patients from wanting to look elsewhere.

The strategy of the organisation described its focus on local provision for local residents and had set out to retain its patient population rather than expand it. The strategy of the hospital clearly set out its intention to be the 'hospital of choice' for patients but did not make reference to patient in the role of consumer. The strategy focused on managing the relationship with commissioners and GPs to secure its market position rather than marketing itself to the patient population.

The hierarchical corporate culture of the hospital was criticised by many as affecting the ability to develop services. The sub cultures revealed a range of different perceptions of patient choice. The interviewees from the nursing profession were committed to the concept of patient choice as a right. They were less swayed with

the notion that PCP can act as a level for service improvement. The doctors interviewed, on the other hand, remained concerned that choice can lead to patients making the wrong choices and perhaps affecting their health care outcomes.

The discussion highlights a number of reasons associated with the limited impact of PCP in the hospital. As many other studies have found, there was little evidence to suggest that PCP has improved the quality of services. This case study reveals a range of variables within the hospital that appear to be undermining the programme theory underpinning PCP and consequently affecting its ability to function as intended. The findings reveal that organisational cultural change is required for PCP to operate as intended. In practice, PCP has been viewed neither to be a threat nor an opportunity, the consequence of which was that it does not have the impact on hospitals as intended by policy makers. The policy makers have been naïve in the way in which they have constructed PCP and have neglected to consider the hospital as an organisation with its complex cultural composition.

The final chapter outlines the conclusion of the study and summarises the key findings. It also makes a number of policy and practice recommendations for future research.



## **Chapter 10: Conclusion**

### **10.1 Introduction**

Patient choice features prominently in debates on the future of health services provision (Fotaki 2013). For many it is viewed as a means of achieving strategic policy goals including greater efficiency and improved quality of care (Le Grand 2007). However, there is much debate about whether choice is the best mechanism for this. Patient choice is, therefore, designed to allow patients to act as choosers and shape service provision.

The aim of this thesis is to explore the influence of PCP on organisational behaviour in an NHS teaching hospital with a particular focus upon how this has influenced and shaped changes in organisational culture. This undertaking is important for the following reason, for PCP to be effective it is necessary for hospitals to recognise the challenge it represents and respond accordingly by improving performance or potentially face closure.

### **10.2 Overview of research and summary of key findings**

The thesis commenced with a review of PCP and an analysis of how this has developed over time and become increasingly significant in shaping health policy in the English NHS. The review found that the latest assumptions underpinning the policy conceive the role of the patient as changing from one of a service user to an empowered consumer of health care (Fotaki 2013).

A review of the empirical literature found that whilst choice was important to patients (Ipsos Mori 2010), in practice, patients were not often exercising choice. There are a number of reasons that contribute to this including, GPs not offering choice to their patient (Populus 2014) and the poor quality of information available to support choice (Magee 2003; Boyce et al 2010). The empirical literature also reveals that the impact of PCP in hospitals is limited (Dixon et al 2010; Peckham et al 2013). Certainly, the anticipated impact of PCP as a lever for driving efficiency improvements and better quality and responsiveness to users was not well founded.

A review of organisational culture and cultural change theory in Chapter 4 shows that hospitals are complex organisations comprising many different competing and overlapping cultures and sub cultures (Morgan 1992; Scott et al 2003). The myriad of cultures within hospitals manifest themselves most visibly in the need to balance clinical decisions within constrained resources. Hospitals in the NHS were viewed as long standing institutions that have not previously needed to consider competitive strategies as the flow of patients had been relatively unchanged for many years.

A qualitative case study design was used to explore the influence of PCP in an NHS teaching hospital. Thirty in depth interviews were conducted with a range of staff from within the hospital at various different levels of the hierarchy and came from both the clinical and administrative disciplines. The findings indicate that PCP has had relatively little impact on the hospital and contrary to the proposed programme theory which views it as a lever for change and modernisation in hospitals. Many interviewees perceived that patients did not want choice and that the GPs continued to influence these decisions on behalf of patients. A number of interviewees felt

strongly that the quality of information available to patients was not sufficient in helping patients make choices.

For many doctors interviewed they seemed less keen to engage with PCP remained as they were concerned that patients would make the wrong choices. Choice as a right was welcomed by the nurses interviewed who felt it was important in helping patients to be empowered and engaged. However, they did not view choice as a lever for service improvement. Their view was that quality of service was integrated in the way that they provided services.

For many interviewees PCP was defined as a new different way of booking appointments. The new computer system was seen as introducing further confusion in the appointment booking processes with teams within the hospital complaining about the additional bureaucracy created by it.

The corporate culture of the hospital was found to be one of hierarchy and control that was perceived by many of the interviewees as negative and limiting the ability of the hospital to develop new and innovative services. Members of the corporate team interviewed had not perceived PCP as either a challenge or an opportunity. The view by many of the interviewees across the hospital was that the hospital was a monopoly provider of many services in the city. The hospital was challenged by excessive demand and could not meet these so the threat of patients choosing other hospitals did not concern them.

Many interviewees perceived that although patients wanted high quality local service provision that they would not want the inconvenience of travelling to other hospitals.

Interviewees were therefore relying on the loyalty that they had from their patients and therefore, PCP appeared not to be having the desired impact in changing organisational behaviour to become more entrepreneurial and consumer focused.

The findings indicate that organisational cultural change in a hospital setting is difficult to achieve and is affected by a range of internal and external factors. Where the reason for change is unclear or not supported it is highly likely that the change will meet with resistance. For some interviewees PCP was perceived as a vehicle to rationalise health care provision in the current climate of financial austerity. Inevitably, PCP would be met with resistance under these conditions. For cultural change to occur in the organisation there were a number of factors required to stimulate this. A trigger or crisis is often required to commence cultural change, within the hospital, the threat of losing patients to other providers was not perceived as significant. Leadership also plays a significant part in driving forward cultural change. Findings from corporate documents did not demonstrate a significant awareness of PCP, nor a commitment to drive forward its ambition to extend its patient population. The hospital goal to be the hospital of choice for its patients was to be achieved through nurturing close working relationships with GPs and commissioners with a particular focus on local service provision for the local population.

The culture of the hospital was reported as moving from a hierarchical organisation to becoming more rational and developmental organisation. The change in the organisation was attributed by many to changes in the senior leadership team, but PCP did not seem to directly contributing to this change.

A few interviewees expressed the desire to see greater patient choice in health care and how this could improve the way in which services could be improved. However, in practice, this was not seen to happen.

### **10.3 Research contribution**

Previous empirical research into PCP has focused primarily on the relationship between the patient, the GP and the information sources available to enable patient choice to occur. An exploration of the underpinning programme theory proposed that the impact of PCP should be to stimulate hospitals to change their behaviour. A review of the empirical research reveals a limited number of studies exploring the impact of PCP on hospitals and those that have reported a limited response from hospitals (Dixon et al 2010; Peckham et al 2013). These studies typically provide rather cursory explanations of these findings and had not examined the hospital in the context of organisational behaviour to seek further explanations for the limited responses.

By examining the organisational culture of a hospital this study provides a deeper insight and evidence as to why PCP has not delivered the desired outcomes as set out by policymakers. The exploration of the hospital cultures reveals how the hospital has perceived PCP and how its behaviours have challenged a number of the assumptions underlying PCP programme theory. This study found the organisational context within which change is implemented is critical to the success of its outcome and how policymakers have underestimated this for PCP.

#### **10.4 Limitations of the Study**

Several limitations of the study should be noted. As with many case study methodologies the challenge is to ensure that the findings from the study are generalisable and applicable to other contexts. The general findings of multiple hospital cultures are recognised in the wider literature on organisations. The definitions of PCP may vary from organisation to organisation depending on the blend of cultures that exist with them and also, will be dependent on which cultures dominate.

The study was focused on hospitals as much of the previous research in this area had focussed upon primary care and GPs. The findings from this study provide some insight into how hospitals behave as organisations and expose the considerable degree of complexity found within them. A number of key stakeholders are impacted by PCP, namely patients, GPs commissioners and alternative service providers. The case study focused deliberately on the perspective of hospitals only. The interviewees in the study presented their view on how PCP had been perceived. These views were not triangulated with the other key stakeholders impacted by PCP to test for validity in any way.

PCP is a broad concept embracing a wide range of theoretical domains, in choosing to focus specifically on the impact in the hospital, related to concepts such as decision making; relationships between health care professionals have not been considered in detail.

## **10.5 Implications for future research**

The findings from this study align with much of the previous evidence which indicates a limited impact of PCP on hospital quality and efficiency (Dixon et al 2010; Peckham et al 2013; Fotaki 2013). The threat or opportunity proposed by PCP is therefore not having the intended impact on hospitals. The aim of the next section is to highlight the key areas that the findings of the thesis indicate need to be addressed.

### ***10.5.1 Recommendations for future research***

- Many interviewees perceived the hospital as a monopoly provider and proposed, with confidence, the loyalty that the patients had to the organisation. A consideration for future research is the exploration of loyalty within quasi markets. Does it exist? Is it actually loyalty or does it relate more to access to health care? Loyalty has not featured explicitly in the empirical literature and given the hospital's reliance on this it is an important aspect to explore further.
- A number of interviewees remained convinced that patients did not want choice. They felt that the GP remained the influential factor in determining whether choice was offered and whether patients were able to exercise it. Further and more sustained research is required to understand the patient-GP interaction in relation to PCP. Are GPs prohibiting the choice conversation? Is the patient relying on the GP to make the choice? If patients are to drive forward this change it is important to see them act as consumers.

- There are many rival, competing and overlapping cultures and sub cultures within the hospital. The findings reveal that whilst many interviewees supported patient choice as a right that PCP was not perceived as the best vehicle to deliver this. There is a need to explore these cultures and sub cultures in more detail to understand their influence on mediating responses to PCP in hospital settings
- Further and more sustained research is required to understand how hospitals can develop effective strategies around PCP. Will hospitals need to consider the needs of the local population when developing these strategies or are there other factors that will need to be considered
- Patient choice as a right for patients was welcomed by many interviewees. It was also suggested that patients being involved in decisions about their health care was a positive mechanism in helping to shape health care provision. There is an opportunity to re-visit PCP and consider how patient choice is better defined to meet with this perception. Is choice of hospital the right definition of PCP? Can PCP offer different types of choice that can influence the quality and efficiency of health care delivery?

#### ***10.5.2 Recommendations for policy***

- The findings from the thesis indicate that many staff did not fully understand the logic of PCP and how it was designed to work in practice. For many it was linked closely to the function of booking appointments rather than the more fundamental principle of facilitating patients to choose a hospital for treatment. There is



therefore a need for policy makers to consider how policy is disseminated once it is approved and offer more explicit guidance on how the policy should be implemented.

- The findings from the study also show that some hospitals provide additional functions such as teaching and research facilities. PCP proposes financial flows of the money following the patient as a means of determining success or failure for hospitals. There was a concern raised by some interviewees that this shift in resource may de-stabilise hospitals and their ability to fulfil these additional responsibilities. Policy makers should therefore consider how research and teaching functions can continue to be supported in the context of the PCP model.
- The findings indicate that quality and accessibility of information to support patients in making meaningful choices was not readily available. There is a need for policy makers to consider the quality of information provision and how it supports patient choice. This may require policy makers to be more explicit about how the information can be used to support choice.
- The incentives and threats of PCP were deemed to be too weak to trigger a change in organisation behaviour within the hospital. Policy makers need therefore to consider how the incentives associated with PCP that would be more powerful in stimulating hospitals to respond in a beneficial manner for staff, patients and local health economies.

**Appendix 1 - Choose and Book Bookings  
by Specialty**

Bookings by Specialty and SHA

| Specialty                        | Bookings during AUG 2010 |                |               |               |               |               |               |               |               |               |                |
|----------------------------------|--------------------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
|                                  | NE                       | NW             | YH            | EM            | WM            | EoE           | Lon           | SEC           | SC            | SW            | Total          |
| <b>Total</b>                     | <b>32,483</b>            | <b>101,059</b> | <b>65,063</b> | <b>51,225</b> | <b>55,166</b> | <b>63,825</b> | <b>74,870</b> | <b>40,794</b> | <b>34,007</b> | <b>82,242</b> | <b>600,734</b> |
| 2WW                              | 777                      | 2,113          | 2,681         | 5,511         | 1,814         | 2,538         | 362           | 197           | 338           | 6,326         | <b>22,657</b>  |
| Allergy                          | 0                        | 47             | 117           | 107           | 48            | 126           | 357           | 115           | 135           | 72            | <b>1,124</b>   |
| Cardiology                       | 979                      | 2,778          | 2,129         | 1,787         | 1,992         | 2,001         | 2,434         | 1,347         | 1,335         | 3,150         | <b>19,932</b>  |
| Children's & Adolescent Services | 2,112                    | 5,555          | 4,443         | 2,957         | 3,769         | 3,438         | 5,598         | 1,974         | 2,228         | 3,658         | <b>35,732</b>  |
| Complementary Medicine           | 0                        | 0              | 0             | 0             | 0             | 0             | 17            | 0             | 0             | 21            | <b>38</b>      |
| Dental Medicine                  | 0                        | 0              | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | <b>0</b>       |
| Dentistry and Orthodontics       | 0                        | 19             | 7             | 1             | 4             | 13            | 11            | 1             | 20            | 128           | <b>204</b>     |
| Dermatology                      | 2,623                    | 7,848          | 5,382         | 2,959         | 4,277         | 6,030         | 7,118         | 3,805         | 2,575         | 6,080         | <b>48,697</b>  |
| Diabetic Medicine                | 104                      | 412            | 238           | 139           | 159           | 289           | 274           | 78            | 120           | 405           | <b>2,218</b>   |
| Diagnostic Endoscopy             | 243                      | 818            | 294           | 228           | 149           | 176           | 65            | 173           | 250           | 410           | <b>2,806</b>   |

|  |       |       |       |       |       |       |       |       |       |       |               |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|---------------|
| Diagnostic Imaging                     | 162   | 700   | 377   | 19    | 325   | 782   | 246   | 13    | 0     | 492   | <b>3,116</b>  |
| Diagnostic Pathology                   | 8     | 39    | 0     | 0     | 0     | 7     | 0     | 0     | 0     | 0     | <b>54</b>     |
| Diagnostic Physiological Measurement   | 515   | 1,600 | 998   | 816   | 764   | 701   | 326   | 566   | 406   | 1,768 | <b>8,460</b>  |
| Dietetics                              | 0     | 105   | 8     | 0     | 25    | 9     | 2     | 13    | 21    | 14    | <b>197</b>    |
| Ear Nose and Throat                    | 2,889 | 7,978 | 5,233 | 3,262 | 4,747 | 5,331 | 6,046 | 3,713 | 2,419 | 5,568 | <b>47,186</b> |
| Endocrinology                          | 271   | 845   | 620   | 461   | 626   | 580   | 1,106 | 423   | 361   | 614   | <b>5,907</b>  |
| General Medicine                       | 175   | 508   | 241   | 58    | 254   | 186   | 356   | 196   | 127   | 1,868 | <b>3,969</b>  |
| Genetics                               | 0     | 28    | 60    | 30    | 2     | 0     | 43    | 2     | 8     | 3     | <b>176</b>    |
| Genito-Urinary Medicine                | 0     | 0     | 3     | 0     | 0     | 0     | 1     | 0     | 0     | 0     | <b>4</b>      |
| Geriatric Medicine                     | 306   | 453   | 308   | 239   | 241   | 331   | 251   | 231   | 128   | 492   | <b>2,980</b>  |
| GI and Liver (Medicine and Surgery)    | 2,402 | 6,812 | 4,757 | 3,197 | 4,022 | 4,143 | 5,856 | 3,096 | 3,064 | 5,017 | <b>42,366</b> |
| Gynaecology                            | 2,242 | 6,366 | 4,146 | 3,351 | 3,858 | 4,236 | 5,490 | 2,929 | 2,525 | 4,252 | <b>39,395</b> |
| Haematology                            | 197   | 621   | 487   | 277   | 389   | 246   | 631   | 184   | 165   | 393   | <b>3,590</b>  |
| Health Promotion                       | 0     | 30    | 3     | 12    | 0     | 0     | 2     | 0     | 0     | 0     | <b>47</b>     |
| Hepato-Gastroenterology (Surg and Med) | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | <b>0</b>      |
| Immunology                             | 0     | 84    | 82    | 31    | 21    | 3     | 15    | 17    | 21    | 43    | <b>317</b>    |

|                                    |       |        |        |       |        |        |       |       |       |        |                |
|------------------------------------|-------|--------|--------|-------|--------|--------|-------|-------|-------|--------|----------------|
| Infectious Diseases                | 13    | 23     | 39     | 14    | 19     | 11     | 42    | 0     | 14    | 5      | <b>180</b>     |
| Learning Disabilities              | 0     | 1      | 0      | 3     | 0      | 2      | 0     | 0     | 0     | 1      | <b>7</b>       |
| Mental Health - Adults of all ages | 4     | 682    | 325    | 1,651 | 59     | 70     | 35    | 442   | 0     | 732    | <b>4,000</b>   |
| Mental Health - Child & Adolescent | 11    | 60     | 0      | 161   | 0      | 3      | 2     | 0     | 0     | 11     | <b>248</b>     |
| Nephrology                         | 132   | 361    | 206    | 156   | 277    | 293    | 505   | 151   | 186   | 285    | <b>2,552</b>   |
| Neurology                          | 935   | 1,950  | 1,556  | 1,136 | 1,873  | 1,992  | 2,899 | 1,105 | 1,182 | 1,795  | <b>16,423</b>  |
| Neurosurgery                       | 199   | 578    | 366    | 35    | 165    | 29     | 458   | 17    | 115   | 352    | <b>2,314</b>   |
| Obstetrics                         | 0     | 1,379  | 3      | 105   | 450    | 0      | 303   | 0     | 0     | 102    | <b>2,342</b>   |
| Occupational Therapy               | 0     | 12     | 0      | 0     | 0      | 0      | 0     | 0     | 0     | 0      | <b>12</b>      |
| Oncology (phasing out)             | 0     | 0      | 0      | 0     | 0      | 0      | 0     | 0     | 0     | 0      | <b>0</b>       |
| Ophthalmology                      | 2,827 | 6,889  | 5,338  | 4,658 | 4,439  | 5,797  | 7,215 | 3,822 | 3,161 | 8,082  | <b>52,228</b>  |
| Oral and Maxillo-Facial Surgery    | 205   | 678    | 390    | 372   | 337    | 501    | 581   | 440   | 341   | 1,069  | <b>4,914</b>   |
| Orthopaedics                       | 5,709 | 22,731 | 10,079 | 9,304 | 10,330 | 12,085 | 9,669 | 8,099 | 6,474 | 15,363 | <b>109,843</b> |
| Orthotics and Prosthetics          | 0     | 0      | 0      | 77    | 57     | 0      | 0     | 0     | 0     | 0      | <b>134</b>     |
| Pain Management                    | 274   | 866    | 902    | 643   | 492    | 617    | 758   | 422   | 400   | 1,150  | <b>6,524</b>   |
| Palliative Medicine                | 0     | 1      | 0      | 12    | 0      | 0      | 2     | 0     | 0     | 0      | <b>15</b>      |

|                                   |       |       |       |       |       |       |       |       |       |       |               |
|-----------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|---------------|
| Physiotherapy                     | 1     | 2,183 | 1,981 | 433   | 202   | 761   | 2,968 | 549   | 10    | 509   | <b>9,597</b>  |
| Podiatry                          | 22    | 491   | 379   | 219   | 95    | 13    | 762   | 265   | 1     | 379   | <b>2,626</b>  |
| Rehabilitation                    | 3     | 3     | 584   | 23    | 13    | 0     | 2     | 0     | 8     | 4     | <b>640</b>    |
| Respiratory Medicine              | 419   | 1,018 | 769   | 512   | 752   | 734   | 883   | 471   | 431   | 861   | <b>6,850</b>  |
| Rheumatology                      | 1,035 | 2,413 | 1,403 | 1,021 | 1,534 | 2,074 | 2,629 | 1,129 | 838   | 2,045 | <b>16,121</b> |
| Sleep Studies                     | 160   | 176   | 130   | 179   | 164   | 218   | 133   | 109   | 133   | 161   | <b>1,563</b>  |
| Surgery - Breast                  | 635   | 1,772 | 1,061 | 806   | 368   | 1,037 | 705   | 363   | 320   | 989   | <b>8,056</b>  |
| Surgery - Cardiothoracic          | 5     | 5     | 7     | 3     | 14    | 7     | 7     | 0     | 0     | 7     | <b>55</b>     |
| Surgery - Not Otherwise Specified | 1,084 | 4,131 | 2,105 | 1,458 | 2,074 | 2,035 | 2,916 | 1,486 | 1,225 | 2,662 | <b>21,176</b> |
| Surgery - Plastic                 | 623   | 858   | 877   | 327   | 613   | 883   | 569   | 334   | 863   | 900   | <b>6,847</b>  |
| Surgery - Vascular                | 638   | 1,619 | 1,327 | 715   | 1,097 | 946   | 1,269 | 587   | 437   | 1,088 | <b>9,723</b>  |
| Urology                           | 1,544 | 4,420 | 2,622 | 1,760 | 2,256 | 2,551 | 2,951 | 1,930 | 1,622 | 2,916 | <b>24,572</b> |

## Appendix 2 - Percentage of patients offered choice by SHA, surveys to date

|                  | May/June<br>2006 <sup>1</sup>        | March 2008                           | May 2008                             | July 2008                            | September 2008                       | December 2008                        | March 2009                           | February 2010                        |
|------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
|                  | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> | Total <sup>2</sup> %Yes <sup>3</sup> |
|                  | 78,773 30%                           | 109,331 47%                          | 89,903 45%                           | 93,528 46%                           | 93,003 46%                           | 75,878 46%                           | 93,217 47%                           | 69,040 49%                           |
|                  | 4,238 28%                            | 6,824 51%                            | 5,587 47%                            | 3,922 52%                            | 5,577 50%                            | 4,958 50%                            | 5,235 50%                            | 3,334 57%                            |
|                  | 11,252 39%                           | 14,117 52%                           | 12,751 51%                           | 13,139 52%                           | 13,084 52%                           | 10,447 51%                           | 13,002 52%                           | 11,805 54%                           |
|                  | 9,321 26%                            | 12,486 44%                           | 9,831 41%                            | 10,699 41%                           | 12,165 43%                           | 9,083 42%                            | 12,253 44%                           | 9,340 45%                            |
| <b>England</b>   | 7,240 38%                            | 10,269 56%                           | 8,514 52%                            | 9,701 52%                            | 10,113 52%                           | 8,489 51%                            | 8,937 50%                            | 6,181 50%                            |
| North East       | 7,355 30%                            | 8,605 45%                            | 8,208 43%                            | 8,002 43%                            | 7,119 44%                            | 4,840 46%                            | 6,964 47%                            | 5,747 49%                            |
| North West       | 8,580 24%                            | 11,442 40%                           | 8,976 37%                            | 8,295 39%                            | 8,764 40%                            | 7,252 42%                            | 8,959 43%                            | 5,951 46%                            |
| Yorks & Humber   | 9,350 30%                            | 11,563 45%                           | 10,433 45%                           | 10,318 45%                           | 8,634 43%                            | 7,224 45%                            | 9,180 46%                            | 5,864 48%                            |
| East Midlands    | 7,490 20%                            | 8,642 44%                            | 7,530 44%                            | 6,880 43%                            | 7,797 44%                            | 5,950 44%                            | 7,712 45%                            | 5,601 44%                            |
| West Midlands    | 5,204 34%                            | 6,486 47%                            | 6,051 44%                            | 7,001 46%                            | 6,150 45%                            | 5,756 42%                            | 7,326 41%                            | 5,841 41%                            |
| East of England  | 8,747 27%                            | 10,690 49%                           | 8,455 48%                            | 11,177 50%                           | 8,274 49%                            | 8,397 49%                            | 10,690 49%                           | 8,366 51%                            |
| London           |                                      |                                      |                                      |                                      |                                      |                                      |                                      |                                      |
| South East Coast |                                      |                                      |                                      |                                      |                                      |                                      |                                      |                                      |
| South Central    |                                      |                                      |                                      |                                      |                                      |                                      |                                      |                                      |
| South West       |                                      |                                      |                                      |                                      |                                      |                                      |                                      |                                      |

1. For results of the July 2006 to January 2008 surveys, see previous reports.
2. Total valid responses. From November 2006, total includes cases not identifiable by SHA (see Annex B).
3. Percentage of patients who said Yes to: 'Were you offered a choice of hospital for your first hospital appointment?'
4. SHA results are not weighted for any age or sex bias among respondents.

### ***Appendix 3 – Documents Reviewed***

Market Assessment – Overview – Board Discussion Day –December 2009

Activity Enabling Strategy 2010/11-2015/16

Integrated Business Plan - Board Workshop December 2011

Managing for Success – Leading in a Lean Organisation - 2011

Trust Annual Report 2020/11

## ***Appendix 4 – Information for Participants***

### **IMPACT OF PATIENT CHOICE IN THE NHS: INFORMATION FOR PARTICIPANTS**

This project aims to understand the impact that patient choice policy has had upon health care delivery within a secondary care setting. The research is being conducted by a doctoral researcher, Mrs Balbir Bhogal through the Health Services Management Centre at the University of Birmingham

#### **Background to the research**

Patient Choice has been a dominant theme through recent Government policy and the current White Paper: Liberating the NHS reinforces this commitment. This focus on the role of the patient choice in the health care delivery process is an interesting dimension that requires further investigation to assess its impact and potential in shaping health care services.

#### **The aims and focus of the study**

An assessment of the patient choice policy within the NHS and an understanding of the impact that it has had upon a hospital

The study is interested in exploring:

- Has patient choice caused a change in the way services are marketed/delivered.
- How is patient choice is defined by clinicians, managers and staff groups in a hospital
- What do clinicians and managers anticipate the impact of patient choice will be



## **The nature of the research**

Two main methods will be used to collect data:

- In-depth face-to-face semi-structured interviews with managers, clinicians and Directorate team members
  
- Analysis of documents e.g. IT strategies, minutes of meetings.

The research will not involve talking to patients or viewing individual patient records.

## **What I am requesting from you?**

The Trust has kindly agreed for me to undertake my research study within the organisation and you are one of thirty professionals and managers that I wish to include in the interview stage of the project. I would be grateful if you would be willing to be interviewed in depth about your work relating to patient choice and its impact on you/ practice/ in the hospital. The interviews will last for no more than an hour and take place at a time and work location convenient to you. With your permission, I would like to audio record the interview as it makes analysis more reliable. It is up to you to decide whether to take part. If you agree to be interviewed you will be asked to sign a consent form, but you will be free to withdraw at any time without giving reason.

## **What will happen to the information?**

All the information collected during the course of the research will be kept confidential and personal details will be anonymised. The anonymised data will be stored on a secure University server, password and firewall protected and accessible only to the research team and at the end of the project will be securely archived to a maximum of seven years and then destroyed.

I will write my thesis based on the findings of the study and submit it to the University of Birmingham.

**Who has reviewed the study?**

The design of the study has been reviewed by the Trust Research Governance Committee.

**Complaints**

If you have a concern about any aspect of this study, please speak to myself (see numbers below) and I will do my best to answer your questions.

Thank you for taking time to read this leaflet. If you have any further questions about the

study please contact:

**Balbir Bhogal**



## Appendix 5 – Topic Guide

### Topic Guide for Patient Choice in an NHS Teaching Hospital Trust

#### Key Question

The Impact of Patient Choice on organisational behaviour in particular, strategy, structure and culture.

**Introduction**  
**Ensure consent is obtained**  
**Turn on the recorder**

#### I. Warm Up

Purpose: To understand the individual's role, background and understanding of the NHS.

- So, how long have you been working at the Trust
- Can you tell me a little bit about your role

Ensure to tease out type of role i.e. clinical, non-clinical  
Level of interface with patients  
Identify budget holders vs non budget holders

#### II. Views and Perceptions on Patient Choice

Purpose: To get the individual to speak broadly about patient choice without strong directional lead from the researcher.

- What springs to mind when you think about patient choice?

Can prompt with choice as;

- Concept
- Policy
- In the organisation
- Locally
- Nationally
- Different types of choice e.g. provider, treatment, appointment

### III. The impact of Patient Choice.

Purpose: To understand the impact of patient choice as experienced by the individual. What impact would you say Patient Choice has had within the organisation?

- Your practice
  - Team – relationships with staff/ between patients
  - Directorate
  - Organisation
  - Service delivery
  - Patients
- If patient choice has had an impact then what has caused it?
  - If patient choice has not had an impact then why not?
  - What have been the incentives/drivers for change in relation to patient choice?

Use programme logic to deconstruct choice policy

Explore values, beliefs, culture and the work strategies

Use cultural matrix prompt (See Appendix 1) and ask participant to map out culture 3 years ago, now, a view on how it should manage in the future

- To what extent has the Trust changed the way it delivers healthcare in response to patient choice?

### IV. Understanding the Consequences

Purpose: Assessing the consequences of patient choice

- Has it delivered what it set out to achieve?
- Can you think of any drawbacks or unintended consequences of patient choice?

### V. Future of Patient Choice

Purpose: To understand from the participant's views/ thoughts regarding future of patient choice.

- What do you see as the future for patient choice?

If you were going to advise Andrew Lansley on how he could develop patient choice policy what would you suggest? Ensure to tease out type of role i.e. clinical, non-clinical

- Level of interface with patients

### VI. Wrap Up

Is there anything else you would like to add that we have not covered in the session?

**Turn off Recorder**

**Thank You**

Characteristics of Cultures in Organisations

**Organic processes:**

Flexibility, spontaneity, individuality

|  |  |   |  |
|--|--|---|--|
|  | <b>Clan:</b>   | <b>Developmental:</b>   |  |
|  | Cohesive,<br>participative<br><br>Leader as a<br>mentor<br><br>Bonded by loyalty,<br>tradition<br><br>Emphasis on<br>morale            | Creative, adaptive<br><br>Leader as risk taker,<br>innovator<br><br>Bonded by<br>entrepreneurship<br><br>Emphasis on innovation |  |
| <b>Internal</b>  |  |   | <b>External</b>  |
| <b>Maintenance;</b><br><br>Smoothing,<br><br>Integration | <b>Hierarchical:</b>   | <b>Rational:</b>  | <b>Positioning;</b><br><br>Competition,<br><br>Differentiation |
|  | Order, rules,<br>uniformity<br><br>Leader as<br>administrator<br><br>Bonded by rules,<br>policies<br><br>Emphasis on<br>predictability | Competitiveness<br><br>Leader as goal-<br>orientated<br><br>Bonded by competition<br><br>Emphasis on winning                    |  |

**Mechanistic processes;**

Control, Order, Stability

What did it feel like 3 years ago?

What does it feel like now?

What should it feel like in the future?

## ***Appendix 6 - Research Questions***

- How is PCP viewed by different staff groups within the organisation?
- How has the organisation's culture changed in response to PCP?
- What organisational factors and processes mediate the impact of PCP within the hospital and how does this align with the intended outcomes assumed by policy makers?

**Appendix 7 - Attributes of Interviewees**

| Interview | Role        | Clinical/Non Clinical         | Patient facing | Length of time in Trust  | Budget  |
|-----------|-------------|-------------------------------|----------------|--------------------------|---------|
| 1         | Strategic   | Non clinical                  | Infrequent     | More than 3 less than 10 | Monitor |
| 2         | Operational | Non clinical - ENT            | Infrequent     | More than 3 less than 10 | Holder  |
| 3         | Operational | Non clinical - Diabetes       | Frequent       | More than 3 less than 10 | None    |
| 4         | Operational | Clinical – Nursing - Diabetes | Frequent       | More than 10             | Holder  |
| 5         | Strategic   | Clinical - Nursing            | Infrequent     | More than 10             | Holder  |
| 6         | Strategic   | Non clinical                  | Frequent       | More than 10             | Monitor |
| 7         | Operational | Clinical - Nursing - ENT      | Frequent       | More than 3 less than 10 | Holder  |
| 8         | Strategic   | Non clinical                  | Infrequent     | Less than 3              | Holder  |
| 9         | Operational | Non clinical – Diabetes       | Frequent       | More than 3 less than 10 | Monitor |
| 10        | Operational | Non clinical - ENT            | Frequent       | More than 10             | None    |
| 11        | Strategic   | Non clinical                  | Infrequent     | More than 3 less than 10 | Monitor |
| 12        | Operational | Non clinical - ENT            | Frequent       | More than 3 less than 10 | None    |
| 13        | Operational | Clinical – Doctor - Diabetes  | Frequent       | More than 10             | Monitor |
| 14        | Strategic   | Clinical - Nursing            | Infrequent     | More than 3 less than 10 | Holder  |
| 15        | Operational | Clinical – Nursing - ENT      | Frequent       | More than 10             | None    |

|    |             |                              |            |                          |         |
|----|-------------|------------------------------|------------|--------------------------|---------|
| 16 | Operational | Clinical – Nursing - ENT     | Frequent   | More than 10             | Monitor |
| 17 | Strategic   | Non clinical                 | Infrequent | More than 3 less than 10 | Monitor |
| 18 | Operational | Non Clinical - Diabetes      | Infrequent | More than 10             | None    |
| 19 | Operational | Clinical Nursing - Diabetes  | Frequent   | More than 3 less than 10 | Monitor |
| 20 | Operational | Clinical –Nursing - Diabetes | Frequent   | More than 10             | Monitor |
| 21 | Operational | Clinical –Nursing - Diabetes | Frequent   | More than 3 less than 10 | Monitor |
| 22 | Operational | Clinical – Doctor - Diabetes | Frequent   | More than 10             | Monitor |
| 23 | Operational | Clinical –Nursing - ENT      | Frequent   | More than 10             | None    |
| 24 | Operational | Clinical –Doctor - ENT       | Frequent   | Less than 3              | Monitor |
| 25 | Operational | Clinical – Doctor - ENT      | Frequent   | More than 10             | Monitor |
| 26 | Operational | Non clinical – ENT           | Infrequent | More than 10             | None    |
| 27 | Operational | Non clinical - Diabetes      | Infrequent | More than 3 less than 10 | None    |
| 28 | Strategic   | Non clinical                 | Infrequent | Less than 3              | Holder  |
| 29 | Strategic   | Clinical - Doctor            | Frequent   | More than 10             | Holder  |
| 30 | Strategic   | Clinical - Nursing           | Infrequent | More than 3 less than 10 | Holder  |



## ***Bibliography***

Abbot, S. & Meyer, J. & Bentley, J. & Lanceley, A. (2006), Patient advice and liaison services: strengthening the voices of individual service users in health-care organisations, *Health Expectations* 9, 138-147

Alvesson, M. (2002), *Understanding Organisational Culture*, London: Sage

Appleby, J., Harrison, A. and Dewar, S. (2003). 'Patients choosing their hospital', *BMJ*, 326: 407-8.

Appleby, J. & Harrison, A. & Devlin, A. (2003) *What is the real cost of more patient choice?* London: Kings Fund. Available from [http://www.kingsfund.org.uk/publications/what\\_is\\_the\\_real.html](http://www.kingsfund.org.uk/publications/what_is_the_real.html) [last accessed on 17th May 2010]

Argyris, C., and Schon., D.A., (1978), *Theory in Practice*, San Francisco: Jossey Bass

Armstrong, M (2009), *Armstrong's Handbook of Performance Management: An Evidence-Based Guide to Delivering High Performance*, Kogan-Page

Baldrige, J. V., Curtis, D. V., Ecker, G. P., & Riley, G. (1977). Alternative models of governance in higher education. In G. Riley and J. V. Baldrige (Eds.), *Governing academic organizations*. Berkeley, CA: McCutchan Publishing.

Barnett J, Ogden J, Daniells E. (2008) The value of choice: a qualitative study. *Br J Gen Pract.* 58(554):609–613.

Barr, D.A. & Fenton, L. & Blane, D. (2008) The claim for patient choice and equity, *Journal of Medical Ethics*, 34: 271 – 274

Bate, P., Khan, R., & Pye, A. (2000). Towards a culturally sensitive approach to organization structuring. *Organization Science*, 11, 197-211.

Bellot, J. (2011), Defining and assessing organisational culture, *Nursing Forum*, 46 (1) 29-37

Bennis, WG. (1969), *Organization Development, its nature, origins and prospects*, Reading, Mass: Addison-Wesley Pub Co.

Besley, T. and Ghatak, M. (2003) Incentives, choice and accountability in the provision of public services. London: Institute for Fiscal Studies.

Bevan, G. & Hood, C. (2006) What's measured is what matters: Targets and gaming in the English Public Health Care system, *Public Administration*, 84(3), 517- 538

- Black, N. (2010), Liberating the NHS – Another attempt to implement market forces in English Health care, *New England Journal of Medicine*, vol 363 no12 1103-5
- Blaikie, N. (2000), *Designing Social Research*, Cambridge: Polity Press
- Blaikie, N. (2007), *Approaches to Social Enquiry*, 2<sup>nd</sup> ed Cambridge: Polity Press
- Boak, G. & Jones, H. (2002), *Leading Innovation and Change in the Health Service*, Kings ham Press
- Bolman, L. G. and Deal, T. E. "Leadership and Management Effectiveness: a Multi-Frame, Multi-Sector Analysis." *Human Resource Management*, 1991, 30, 509-534
- Boundless (2014). "The Origins of Culture." *Boundless Sociology*. [on line]. Available from <https://www.boundless.com/sociology/textbooks/boundless-sociology-textbook/culture-3/culture-and-adaptation-31/the-origins-of-culture-199-3031/> [last accesses 4<sup>th</sup> May 2015
- Boyce, T. & Dixon, A. & Fasolo, B. & Reutskaja E. (2010) *Choosing High Quality Hospital – The role of nudges, scorecard design and information*, Kings Fund
- Brereton, L. & Vasoodaven, V. (2010), *The impact of the NHS market*, [online] Available from [http://www.civitas.org.uk/nhs/download/Civitas\\_LiteratureReview\\_NHS\\_market\\_Feb10.pdf](http://www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf) [last accessed 15th January 2012]
- Brown, A., (1995), *Organisational Culture*, London: Pitman
- Bryman, A. (1984), *The Debate about Quantitative and Qualitative Research; A Question Method or Epistemology?* The Journal of British Sociology, 35 (1):75-92
- Bryman, A. (1988), *Quantity and Quality in Social Research*, London: Routledge.
- Bryman, A. (2004), *Social Research Methods.*, 2<sup>nd</sup> ed Oxford: Oxford University Press
- Burrell, G. & Morgan, G. (1979), *Sociological Paradigms and Organisational Analysis: Elements of the Sociology of Corporate Life*, London: Heinemann Educational Books Ltd.
- Cameron, K., and Freeman, S., (1991) "Culture, congruence, strength and type, relationship to effectiveness," *Res Organizational Change Development*, 5, 23-58
- Campbell, D. (1975), *Degrees of Freedom and the Case Study*, Comparative Political Studies, 8(1): 178-91

Caress, A. & Beaver, K. & Luker, K. & Campbell, M. & Woodcock, (2005), Involvement in treatment decisions: what do adults with asthma want and what do they get? Results of a cross sectional survey, *Thorax*,<sub>60</sub>, 199-205

Carey, A Carlin, M. in Granshaw, L. & Porter, R. (1989), *The Hospital in History*, Routledge

<http://campus.murraystate.edu/academic/faculty/mark.wattier/Carey1967.PDF>

Chakraborty, A. (2010) 'Cameron's hijacking of Nudge theory is a classic example of how big ideas get corrupted', *Guardian*, 7 December.

Chand, K. (2014), Privatisation is ripping the NHS from our hands, *Guardian Professional*, [on line] Available from

<https://dub110.mail.live.com/default.aspx?id=64855#tid=cm0E8-f2Ug5BGSmgAjfeRhjg2&fid=flinbox> [Accessed 16<sup>th</sup> August 2014]

Cialdini, R. (2009). *Influence: Science and Practice*, ePub (5th Edition). Pearson HE

Cohen D, Crabtree B. "Qualitative Research Guidelines Project." July 2006. available on line at <http://www.qualres.org/HomeRefl-3703.htm> [last accessed 9th January 2011]

Coleman, J. (1973). *The Mathematics of Collective Action*, London; Heinemann

Cooper, R.(1987) 'Information, communication and organization: a post-structural revision'. *Journal of Mind and Behaviour* 8/3: 395-416.

Cooper, Z. McGuire, A. Jones, S. & Le Grand, J. (2009) Equity, Waiting Times and NHS Reforms: Retrospective study, *British Medical Journal*,<sub>339</sub>, b3264

Cooper, Z. & Gibbons, S. & Jones, S. & McGuire, A (2011), Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms, *The Economic Journal*, 121: 228-260 [on line], available at

[http://image.guardian.co.uk/sys-files/Guardian/documents/2011/07/28/Cooper\\_et\\_al\\_Competition\\_EJ-1.pdf](http://image.guardian.co.uk/sys-files/Guardian/documents/2011/07/28/Cooper_et_al_Competition_EJ-1.pdf) [last accessed 30th August 2014]

Coulter, A. (1999), Paternalism or Partnership? *British Medical Journal*,<sub>319</sub>:719

Coulter, A. & Entwistle, V. & Gilbert, D. (1999), Sharing decisions with patients: Is the information good enough, *British medical Journal*, 318, 7179, 318-22

Coulter, A. et al (2005) Patients' experience of choosing where to undergo surgical treatment. Evaluation of the London Patient Choice Scheme, Oxford: Picker Institute

Creteur, M. & Pochet, Y. (2000) *Organisational Design and Hospital Performance*, [On line], Available at <http://deazone.com/en/creteur-m-y-pochet-i-pouplier-and-mc-closon-2002-organisational-performance-evaluation-application-to-belgian-hospitals-int-j-healthcare-technology-and-management-41-2-148-179> [Last accessed 12th September 2013]

Crombie, I.K. & Davies, H.T.O. (1996), *Research in Health Care – Design Conduct and Interpretation of Health Services Research*, Chichester: John Wiley and Sons.

Darzi, A (2008), *High Quality for All: NHS Next Stage Review*, [on line] Department of Health Available from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825) [last accessed 31st October 2011]

Datta, Y. & Emeritus, A (2009), *A Critique of Porter's Cost Leadership and Differentiation Strategies*, [On Line] Available at [http://www2.warwick.ac.uk/fac/soc/economics/staff/academic/ohene-asare/michael\\_porter\\_a\\_redifinition\\_of\\_product\\_differential\\_y.\\_datta\\_emeritus\\_2009.pdf](http://www2.warwick.ac.uk/fac/soc/economics/staff/academic/ohene-asare/michael_porter_a_redifinition_of_product_differential_y._datta_emeritus_2009.pdf) [Last accessed 12th September 2013]

Davies, H. & Nutley, S. & Mannion, R. (2000), Organisational culture and quality of health care, *British Medical Journal*, 9: 111-119

Davies, H. & Mannion, R. & Jacobs, R. & Powell, M. & Marshall, M. (2007), Exploring the relationship between senior management team culture and hospital performance, *Medical Care Research*, 64(1):46-65

Davies, H. & Mannion, R. (2013), Will prescriptions for cultural change improve the NHS? *British Medical Journal*, 346:f1305

Dawson, S. 1999. Managing, organising and performing in health care: what do we know and how can we learn? In *Organisational Behaviour in Health Care*, eds A. Mark and S. Dopson. London: Macmillan

Dawson, D. & Jacobs, R. & Martin, S. & Smith, P (2004) Evaluation of the London Patient Choice Project: system wide impacts. [On line] available from <http://www.york.ac.uk/che/pdf/london.pdf> [accessed December 2010]

Dawson, D. & Jacobs, R. & Martin, S. & Smith, P. (2006), The impact of patient choice and waiting time on the demand for health care: results from the London Patient Choice Project, *Applied Economics*, 38, 1363 – 1370

Deal, TE & Kennedy, AA (1982), *Corporate Culture, The Rites and Rituals of Corporate Life*, Reading, MA: Addison - Wesley

Dealey, C. (2005), the factors that influence patients' choice of hospital and treatment, *British Journal of Nursing*,\_vol14, No 10 576- 579

Degeling, P. & Winters, M. & Kennedy, J & Carr, A. & Maxwell, S. & Ricci, L. & Telfer, B. & Coyle, B (2003) *A project to map the cultural and psycho-social predispositions of staff in an Australian Hospital and to assess the implications for reform*, Durham: Centre for Clinical Management Development, University of Durham

Demers, C. (2007), *Organisational Change Theories – A synthesis*, [on line] Available from

<https://books.google.co.uk/books?id=zeo6QMZjahEC&pg=PA75&lpg=PA75&dq=On+both+sides+of+the+Atlantic,+the+cultural+approach+to+organizational+...+mid-1980s,+the+majority+of+writings+associated+with+the+cultural+approach.&source=bl&ots=yduvfUOtJs&sig=0krcDaYZQgQv-g69OF8gv3h18lg&hl=en&sa=X&ei=V7BhVaTGEYOMsgGf-YDQDQ&ved=0CCkQ6AEwAQ#v=onepage&q=On%20both%20sides%20of%20the%20Atlantic%2C%20the%20cultural%20approach%20to%20organizational%20...%20mid-1980s%2C%20the%20majority%20of%20writings%20associated%20with%20the%20cultural%20approach.&f=false> [Last accessed 23<sup>rd</sup> May 2015]

Department of Health and Social Security (DHSS) (1979) *Patients first: consultative paper on the structure and management of the National Health Service in England and Wales*. London:

Department of Health, (1989), *Working for Patients*, [on line] Available from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_4122399](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_4122399) [Accessed 1<sup>st</sup> December 2010]

Department of Health, (1991) *The Patients Charter*, HMSC

Department of Health (1996), *NHS: A service with ambitions*. London, Department of Health

Department of Health, (1997), *The NHS Modern and Dependable* [on line] Available from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008869](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008869) [accessed 1 December 2010]

Department of Health, (2000), *Shifting the Balance of Power within the NHS: Securing Delivery*. London

Department of Health (2001) *Extending choice for patients*. London: Department of Health.

Department of Health (2003). *Building on the best: Choice, responsiveness and equity in the NHS*: Department of Health.

Department of Health, (2004), *Payment by Results*, [on line] Available from [http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH\\_900](http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_900) [accessed 3 March 2010]

Department of Health (2004a) *Choosing health. Making healthy choices easier*. London: Department of Health.

Department of Health (2004b). *The NHS Improvement Plan: Putting people at the heart of public services*. London: Department of Health.

Department of Health (2005) *Health reform in England: update and next steps*. London: Department of Health.

Department of Health (2006). *Our health, our care, our say*. London: Department of Health.

Department of Health (2008), *NHS Next Stage Review, High Quality Care for All*, [on line], Available from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228836/7432.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf)

Department of Health, (2009), *The NHS Plan* [on line]. London, The Stationery Office. Available from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH\\_4002960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960). [Accessed 1 December 2010]

Department of Health (2009), *The NHS Constitution* [on line] London Available from [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613) [Last accessed 31st October 2011]

Department of Health (2010b), *Equity and Excellence – Liberating the NHS* [on line] Department of Health Available from <http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm> [Last accessed on 31st October 2011]

Department of Health (2010c), *Liberating the NHS – An Information Revolution*, [on line] Department of Health Available from [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_120080](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_120080) [Last accessed on 31st October 2011]

Department of Health (2011), *The Health and Social Care Bill*, [on line] Available from [http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_123618](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_123618) [Accessed on 30<sup>th</sup> October 2011]

Department of Health (2012), *2013/14 Choice Framework* [on line], Available from [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications) [Last accessed 2nd April 2014]



Department of Health (2013), *The Mandate, A Mandate from the Government to NHS England*, [on line] Available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/256406/Mandate\\_14\\_15.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf) [Accessed 2nd April 2014]

Department of Health and Children. National Health Information Strategy. Dublin: The Department of Health and Children; 2004. Available online from: <http://www.dohc.ie/publications/nhis.html>.

Dess, G. & Davis, P (1984), Porter's (1980) Generic Strategies as Determinants of Strategic Group Membership and Organizational Performance, *The Academy of Management Journal*,\_vol 27, no 3: 467- 488

Dillon SM. 1998. Descriptive decision making: Comparing theory with practice, Proceedings of the 33rd Annual Conference of the New Zealand Operational Research Society, August 31 - September 1; Waikato University, Hamilton: 99-108.

Dixon, A., Robertson, R. and Bal, R. (2008). The experience of implementing choice at point of referral: a comparison of the Netherlands and England.

Dixon, A. & Le Grand, J. (2006), Is greater patient choice consistent with equity? The case of the English NHS, *Journal of Health Services Research and Policy*, vol 11, No 3, 162-166

Dixon, A. & Robertson, R., & Appleby, J. & Burge, P. & Devlin, N. & Magee, H (2010), *Patient Choice – How Patients Choose and How Providers respond*, [on line] The Kings Fund , Available from [http://www.kingsfund.org.uk/publications/patient\\_choice.html](http://www.kingsfund.org.uk/publications/patient_choice.html) [Last accessed 2nd June 2010]

Dixon-Woods, M. & Baker R. & Charles, K. & Dawson, J.& Jerzembek, G. & Martin, G. & McCarthy, I. & McKee, L. & Minion, J.& Ozieranski, P& Willars, J. & Wilkie, P. & West, M. (2013), Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study, *BMJ Quality and safety* [On line] Available from <http://qualitysafety.bmj.com/content/early/2013/08/28/bmjqs-2013-001947.full> [Accessed 29th September 2013]

Doherty, C. & Doherty, W. (2005), Patients' preferences for involvement in clinical decision making within secondary care and the factors that influence their preferences, *Journal of Nursing Management*,\_Vol 13 (2) 119-127

Doherty, R. & Loughrey, C. & Higgins, P. (2013), *Organisational Culture – A review of the literature* [on line] Available from [https://www.google.co.uk/search?sourceid=navclient&hl=en-GB&ie=UTF-8&rlz=1T4ADFA\\_enGB487GB488&q=doherty+and+loughrey+2013](https://www.google.co.uk/search?sourceid=navclient&hl=en-GB&ie=UTF-8&rlz=1T4ADFA_enGB487GB488&q=doherty+and+loughrey+2013) [Accessed 31<sup>st</sup> March 2015]

Douglas, K. & Potter, T. & Treharne, G. & Obrenovic, K. & Hale, E. & Pace, A. & Mitton, D. & Erb, N. & Whallett, A. & Delamere, J. & Kitas, G. (2004) Rheumatology patient preferences for timing and location of outpatient clinics, *British Society for Rheumatology*, Vol 44, 80-82

Dowding, K. & John, P. (2011) Voice and Choice in Health Care in England: Understanding Citizen Responses to Dissatisfaction, *Public Administration*, 89:4 1403-1418

Dusheiko, M. (2013), Patient Choice and Mobility in the UK Health System: Internal and External Markets in Levaggio, R. & Montefiore M. (2013) Health Care Provision and Patient Mobility – Health Integration in the European Union , Springer Science & Business Media, 2013

Dyer, W. (1985), The cycle of cultural evolution in organisations. In : R Kilmann, M Saxton, R Serpa et al (eds) *Gaining Corporate Control*, Jossey-Bass, San Francisco, CA, pp.200-29

Earwicker, S.C. & Whynes, D.K. (1998), General practitioner's referral thresholds and choices of referral destination: an experimental study, *Health Economics*,\_Vol 7 (8), 1057-9230

Easterby-Smith, M. & Thorpe, R & Lowe, A. (2008), *Management Research – An Introduction*. 3<sup>rd</sup> Ed, London: Sage Publications Ltd

Edwards, A. & Elwyn, G, Wood, F. & Atwell, C. & Prior, L. & Houston, H. (2005) Shared decision making and risk communication in practice: a qualitative study of GPs' experiences, *British Journal of General Practice*,\_55 (10):6-13

Edwards, A. & Elwyn, G. (2006) Inside the black box of shared decision making: distinguishing between the process of involvement and who makes the decision *Health Expectations*, 9, 307-320

Eisenhardt, KM. (1989), *Building Theories from Case Study Research*, The Academy of Management Review, 14(4):532-550

Ellins, J. & Coulter, A. (2005) *How engaged are people in their own health care*, Picker Institute

Elmslie, M. & Campbell, M. & walker, K. & Robertson, S. (1999), Developing consumer led maternity services: a survey of women's views in local health care setting, *Health Expectations*,\_2, 195-207

Feeney, C. & Roberts, N. & Partridge, M. (2005), Do medical patients want 'out of hours ' clinics, *BMC Public Health*,\_5/47



- Feldman, M. S., & Pentland, B. T. (2003). Reconceptualizing organizational routines as a source of flexibility and change. *Administrative Science Quarterly*, 48(March), 94-118.
- Ferlie, E. (1994). 'The creation and evolution of quasi markets in the public sector: early evidence from the National Health Service. ' *Policy and Politics*, 22(2): 105-12.
- Finch, T. & Mort, M. & Mair, F. & May, C. (2008), Future patients? Telehealthcare, roles and responsibilities, *Health and Social Care In the Community* 16 (1), 86-95
- Fleetwood, S. (2005), The ontology or organisation and management studies: A critical realist approach. *Organization*, 12 (2). 197-222
- Flyvbjerg F in Seale, C. & Gobo, G & Gubruim, J & Silverman, D. (2004), *Qualitative Research In Practice*, London and Thousand Oaks, CA Sage pp420-434
- Ford, J.D. and Ford, L.W. (1995), ``The role of conversations in producing intentional change in organizations'', *The Academy of Management Review*, Vol. 20, pp. 541-70.
- Ford, S. & Schofield, T. & Hope, T. (2003) What are the ingredients for a successful evidence based patient choice consultation? A qualitative study, *Social Science of Medicine*, 56 (3): 589-602
- Ford, S. & Schofield, T. & Hope, T. (2006) Observing decision making in general practice consultation: who makes which decision, *Health Expectations*, 9, 130-137
- Fotaki, M (1999). The impact of market orientated reforms on choice and information: a case study of cataract surgery in outer London and Stockholm, *Social Sciences Medicine*, 48 (10), 1415-32
- Fotaki, M (2011). Towards developing new partnerships in public services: users as consumers, citizens and/or co-producers driving improvements in health and social care in the UK and Sweden, *Public Administration*, 89: 933-95
- Fotaki, M (2013), Is patient choice the future of health care systems? *International Journal of Health Policy and Management*, 1:121-123
- Fotaki, M. (2014), *What market based choice can't do for the NHS* [on line]. Available from <http://blogs.lse.ac.uk/politicsandpolicy/what-market-based-patient-choice-cant-do-for-the-nhs/> [Accessed 10<sup>th</sup> August 2014]
- Fotaki, M. & Boyd, A. & Smith, L. & McDonald, R. & Roland, M. & Sheaff, R. & Edwards, A. & Elwyn, G. (2005) *Access to Healthcare Patient Choice and the Organisation and Delivery of Health Services: Scoping Review*. Manchester: National Co-ordinating Centre for the NHS Service Delivery and Organisation, R&D (NCCSDO)

Fotaki, M. & Roland, M. & Boyd, A. & McDonald, R. & Sheaff, R. & Smith, L. (2008). What benefits will choice bring to patients? Literature review and assessment of implications, *Journal of Health Services Research*, Vol 13, 3, 178-184

Fotaki, M. (2014), *What market-based patient choice can't do for the NHS: The theory and evidence of how choice works in health care*. [On line] Centre for Health and Public Interest. Available at <http://chpi.org.uk/wp-content/uploads/2014/03/What-market-based-patient-choice-cant-do-for-the-NHS-CHPI.pdf> [Last accessed 5th April 2014]

Frosini, F & Dixon, A. & Roberston, R. (2012) Competition in the NHS: a provider perspective, *Journal of Health Services Research and Policy*, 17:16

Gagliardi, P. (1986). The creation and change of organizational cultures: A conceptual framework. *Organization Studies*, 7,117-34.

Galpin, T. (1996), *The Human Side of Change: A Practical Guide to Organization Redesign*, Jossey- Bass

Garson, G. (2008), *Case Studies.*, [Available on line at <http://www2.chass.ncsu.edu/garson/pa765/cases.htm>] accessed on 16<sup>th</sup> March 2010

George and Bennett (2005), *Case Studies and Theory Development*, MIT Press, Harvard

Gillham, B. (2000), *Case Study Research Methods*, London: Continuum

Glennerster, H. (1998), Competition and quality in health care: the UK experience, *International Journal for Quality in Health Care*, Vol 10, No.5 403-410

Goddard, M. and C. Hobden (2003), *Patient Choice: a review*. Report to the Department of Health, York: Centre for Health Economics.

Gold, K.A., (1982), "Managing for Success: A comparison of private and public sectors", *Public Administration Review*, Nov-Dec, 568-575

Goldin, G (1985), *Historic Hospitals of Europe 1200 – 1981* [On line] Available at <http://www.nlm.nih.gov/hmd/pdf/historic.pdf> Last accessed 1<sup>st</sup> April 2012

Goodman, P. (1982), *Change In organisations*, San Francisco: Jossey-Bass

Goodwin, N. Nelson, J. Ackerman, F. & Weisskopf T (2007) *Consumption and Well Being* Available from [http://www.eoearth.org/article/consumption\\_and\\_well-being](http://www.eoearth.org/article/consumption_and_well-being) [Last accessed 23rd April 2010]

Goodwin, N. (2007) *Healthcare system strategy and planning*, [On line] Available at [www.goodwinhannah.co.uk/.../svr-download.asp?.../...](http://www.goodwinhannah.co.uk/.../svr-download.asp?.../...) Last accessed 23<sup>rd</sup> March 2012

Green, S. (2002) *Rational Choice Theory: An Overview*, Available at [http://www.google.co.uk/search?aq=f&sugexp=chrome,mod=11&sourceid=chrome&ie=UTF-8&q=rational+choice+theory#hl=en&q=rational+choice+theory+economics&revid=121455661&sa=X&ei=qbXMT8CoMYrw8QPI5rS3Bg&ved=0CBIQ1QloBg&bav=on.2,or.r\\_gc.r\\_pw.r\\_qf.,cf.osb&fp=205fca0967bb225c&biw=1024&bih=677](http://www.google.co.uk/search?aq=f&sugexp=chrome,mod=11&sourceid=chrome&ie=UTF-8&q=rational+choice+theory#hl=en&q=rational+choice+theory+economics&revid=121455661&sa=X&ei=qbXMT8CoMYrw8QPI5rS3Bg&ved=0CBIQ1QloBg&bav=on.2,or.r_gc.r_pw.r_qf.,cf.osb&fp=205fca0967bb225c&biw=1024&bih=677) Last accessed 2<sup>nd</sup> June 2012

Green, D. & Shapiro, I. (1994), *Pathologies of Rational Choice Theory: A Critique of Applications in Political Science* New Haven: Yale University Press, 1994

Greengross, P & Grant K & Collini, E, (1999) *The History and Development of The UK National Health Service 1948 – 1999* [On line], Available from <http://www.healthsystems.org/2010/02/> [Accessed 21 February 2011]

Greener, I. (2007), Are the assumptions underlying patients choice realistic? A review of the evidence. *British Medical Bulletin*, 83, 249-258

Greener, I. (2008) 'Choice and voice - a review', *Social Policy and Society*, 7: 255-65.

Greener, I. & Mannion, R. (2008), Will Practice based Commissioning in the English NHS Resolve the Problems Experienced By GP Fundholding, *Public Money and Management*, August, 231-238

Greener, I. & Mills, N. & Powell, M. & Doheny, S. (2006), *How did consumerism get into the NHS? An empirical examination of choice and responsiveness in NHS policy documents*, ESRC Cultures of Consumption, working paper 29 Available from [http://www.consume.bbk.ac.uk/working\\_papers/GreenerOctober20061.doc](http://www.consume.bbk.ac.uk/working_papers/GreenerOctober20061.doc) [accessed 1<sup>st</sup> May 2011]

Greenhalgh, T. & Russell, J. & Swinglehurst, D. (2005) *Narrative Methods in Quality Improvement Research*, *Quality Safety in health Care*, 14: 443-449

Gregory, K., (1983), "Native View Paradigms: Multiple Culture and Culture Conflicts in Organizations", *Administrative Science Quarterly*, 28, 359-76

Griffiths, R (1983), *NHS Management Inquiry*, [on line] Socialist Health Association, Available from <http://www.sochealth.co.uk/history/griffiths.htm> [Accessed 1<sup>st</sup> December 2010]

Gummesson, E. (1991), *Qualitative Methods in Management Research.*, California, USA: Sage Publications Ltd.

Ham, C. (2007). *Competition and Collaboration in the English Health Reforms*. Seminar Note. London Nuffield Trust.

- Hambrick, D.C. (1983). High profit strategies in mature capital goods industries: A contingency approach. *Academy of Management Journal*, December, 26, 687-707.
- Harris, P. (1996) Sufficient grounds for optimism? The relationship between perceived controllability and optimistic bias, *Journal of Social and Clinical psychology*, 15(1): 9–52.
- Harrison, S. & Hunter, D. & Marnoch, G. (1992), *Just Managing: power and culture in the National Health Service*, London: Macmillan
- Hatch, M., (1993), “The dynamics of organizational culture,” *Academic Management Review*, 18, 657-93
- Hatch, MJ. & Cunliffe, A. (2006), *Organisation Theory, Modern, Symbolic and Post Modern Perspectives*, Oxford University Press
- Hay, C. (2009) Theory, Stylized heuristic or self-fulfilling prophecy? The status of rational choice theory in public administration, *Public Administration*,\_Vol. 82 No.1, (39-62)
- Heath, A. (1976) *The Rational Choice and Social Exchange*.\_Cambridge, Cambridge University Press
- Healthcarecommission.org.uk, (2006), *State of Healthcare*, [On line], Available from [http://www.healthcarecommission.org.uk/\\_db/\\_documents/state\\_of\\_healthcare\\_2006](http://www.healthcarecommission.org.uk/_db/_documents/state_of_healthcare_2006) Last accessed 12<sup>th</sup> June 2013
- Health link (2006) *Taking Soundings on Maternity Choice – A consultation with women in South East London*.\_South London Health Authority
- Health link (2004) *Taking Soundings Patient and Public Involvement on the London Patient Choice Project. Testing the views of Patients including hard to reach groups*, Health Link
- Henwood, F. & Wyatt, S, & Hart, A. & Smith, J. ( 2003) Ignorance is bliss sometimes: constraints on the emergence of the informed patients in the changing landscapes of health information, *Sociology of Illness and health*,\_no. 6, 589-607
- Hewitt, P (2007), *NHS Choices Website Launched - E-Health Insider*,[on line] available from <http://www.digitalhealth.net/news/ehi/2795> [Last accessed 23<sup>rd</sup> may 2015]
- Higgins, M. & Gray, K. & Bailey, M. (2010) *Exploring the development of relationship marketing in the National Health Service: An empirical analysis of the supplier purchaser relationships in a quasi-market*, Maney Publishing
- Hirschmann, A (1970), *Exit, Voice and Loyalty*.\_Cambridge, Harvard University Press

- Hitt, M.A., & Ireland, R.D. (2002). The essence of strategic leadership: Managing human and social capital. *Journal of Leadership & Organizational Studies*, 9(1), 3-14.
- Holloway, I. (2005), *Qualitative Research in Health Care*. Maidenhead: Open University Press
- Horrocks, S. & Coast, J. (2007), Patient choice: an exploration of primary care dermatology patients' values and expectations of care, *Quality in Primary Care*, 15: 185-93
- Hunger, J.D. & Wheelen, T.L. (2001), *Strategic Management and Business Policy*, 7<sup>th</sup> ed, Prentice Hall
- Ipsos Mori, (2010), What people need and want from public services [on line], Available from [http://www.ipsos-mori.com/DownloadPublication/1345\\_sri\\_what\\_do\\_people\\_want\\_need\\_and\\_expect\\_from\\_public\\_services\\_110310.pdf](http://www.ipsos-mori.com/DownloadPublication/1345_sri_what_do_people_want_need_and_expect_from_public_services_110310.pdf) [Accessed 10th August 2014]
- Jacobs, R. & Mannion, R. & Davies, H. & Harrison, S. & Konteh F. Walshe, K. (2013) The relationship between organizational culture and performance in acute Hospitals, *Social Science & Medicine* 76 (2013) 115-125
- Jehn, K., & Bendersky, C. (2003). Intragroup conflict in organizations: A contingency perspective on the conflict–outcome relationship. *Research in Organizational Behaviour*, 24, 187–242.
- Jonas, S. (1998) *An introduction to the US Health Care System*, 4<sup>th</sup> edition, Springer Publishing Company
- Jolley, S. (2005) Single rooms and patient choice, *Nursing Standard*, 20.9:41-8
- Jones, D. & Lester, C. & West, R. Monitoring Changes in health services for older people in Robinson, R & Le Grand, J. (2004) *Evaluating the National Health Service Reform*, Policy Journals
- Jones, L & Mays, N (2009), *Systematic Review of the impact of patient choice on provider in the English NHS*, [on line] London, Available from: <http://hrep.lshtm.ac.uk/publications/Choice%20review%20March%202009.pdf> [Accessed 25<sup>th</sup> October 2011]
- Jung, C., (1923) *Psychological Types*, Routledge and Kegan Paul, London
- Jung, C., (1973), *Four archetypes: mother/rebirth/spirit/trickster*. Princeton University Press, Princeton, NJ
- Jung, T, T Scott, HTO Davies, P Bower, D Whalley, R McNally, and R Mannion (2007), Instruments for the Exploration of Organisational Culture, Working Paper,

Available at <http://www.scothub.org/culture/instruments.html> [Accessed 15th May 2015]

Jung, T & Scott, T. & Davies, H. & Bower, P. & Whalley, D. & McNally, R. & Mannion, R. (2009), Instruments for exploring Organisational Culture: A review of the Literature, *Public Administration Review*, November/ December, 1087-1096

Kahneman, D. & Tversky, A. (1979), Prospect theory: an analysis of decision making under risk, *Econometrica* 47,263-91

Kan, M. & Parry, K. (2004), Identifying Paradox: A grounded theory of leadership in overcoming resistance to change, *The Leadership Quarterly*, vol 15, 467-491

Kanter, R. M. (1983). The Change Masters: Innovations for Productivity in the American Corporation University of Illinois at Urbana-Champaign's Academy for Entrepreneurial Leadership Historical Research Reference in Entrepreneurship. Available at SSRN: <http://ssrn.com/abstract=1496170>

Katz, R. and Allen, T. J. (1982), Investigating the Not Invented Here (NIH) syndrome: A look at the performance, tenure, and communication patterns of 50 R & D Project Groups. *R&D Management*, 12: 7–20.

Katz, D & Kahn, RL (1978), *The Social Psychology of Organisations*, 2<sup>nd</sup> Edition, New York, Wiley

Keen, S. (2001) *Debunking Economics: the naked emperor of the social sciences*, Annandale: Pluto

Kennedy, H. (2004), Sudden unexpected death in infancy [on line] available at <https://www.rcpath.org/NR/rdonlyres/30213EB6-451B-4830-A7FD-4EEFF0420260/0/SUDIreportforweb.pdf> Accessed August 2013

Kezar, A. (2001), Theories and Models of Organizational Change, *Understanding and Facilitating Change in the 21<sup>st</sup> Century*, vol 28, no 4: 25-56, John Wiley and Sons

King's fund Institute (2014), Clinical commissioning: what can we learn from previous commissioning models? [on line], Available at <http://www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning> [Accessed 16th August 2014]

Kirzener, I.M. (1973) *Competition and entrepreneurship*\_Chicago, IL: University of Chicago Press

Klein, R. (1995), *The New Politics of the NHS*, London, Longman

Klein, R. (2006) *The new politics of the NHS*. Oxon: Radcliffe.

Kluckhohn, F.R. & Strodtbeck, F.L. (1961), *Foundations of Behavioural Research*,



3<sup>rd</sup> Edition, New York, NY: Holt, Rinehart Winston

Knight, J. (2007) Change Management in Cancer Care: a one stop gynaecology clinic, *British Nursing Standards*, Vol 16, No 18, 1122-1126

Konteh, F. & Mannion, R. & Davies, HTO, (2010), Understanding culture and culture management in the English NHS: a comparison of professional and patient perspectives, *Journal of Evaluation in Clinical Practice*, [on line] Available at <http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2011/culture-management-English-NHS.pdf> [Last accessed 11th May 2014]

Kotter, J.P (1995), Leading Change: why transformation efforts fail, *Harvard Business Review*, March/ April: 59-67

Kotter, J. & Heskett, J (1992), *Corporate Culture and Performance*, New York: MacMillan

Kotter, J. & Schlesinger, L. A. (2008), Choosing Strategies for Change, *Harvard Business Review*, Harvard Business School Publishing Corporation.

Kroeber, L. & Kluckhohn, C. & Untereiner, W. (1952) *Culture; A critical review of concepts and definitions*, New York: Vintage Books

Lacey, A. & Luff, D. (2001), Trent Focus for Research and development n Primary Health Care: An Introduction to Qualitative Analysis. Sheffield, Trent Focus Group

Lawton, R. & Armitage, G. (2012), The role of the patient in clinical safety, *The Health Foundation*, [on line] Available at <http://www.health.org.uk/public/cms/75/76/313/3424/The%20role%20of%20the%20patient%20in%20clinical%20safety%20thought%20paper.pdf?realName=3MmWi0.pdf> [last accessed 29<sup>th</sup> August 2014]

Laverty, A. & Smith, P. & Paper, U. & Wachter, R. & Millett, C. (2012) High-Profile Investigations into Hospital Safety Problems in England Did Not Prompt Patients to Switch Providers, *Health Expectations*, and 31:3 593-601

Leathard, A (2000), *Health Care Provision. Past, present and into the 21<sup>st</sup> Century, Second Edition*, Cornwall, TJ International Ltd

Lee, T.W. (1999), *Using Qualitative Methods In Organizational Research*, London: Sage Publications

Le Grand, J., Mays, N. and Mulligan, J. (1998) Learning from the internal market: a review of the evidence. London: The Kings Fund.

Le Grand, Julian (2003) The case for the internal market In: Can Market Forces Be Used for Good? King's Fund, London

Le Grand, (2006), Does the NHS Reform make sense [on line] Socialist Health Association. Available from <http://www.sochealth.co.uk/conf/jleg.htm> [accessed 1 December 2010]

Le Grand, J. (2007), *The other invisible hand*, Princeton University Press.

Le Grand, J. (2010) Knights and Knaves return: Public Service Motivation and the Delivery of Public Services, *International Public Management Journal*, 13:1, 56-71

Levenson, R. & Atkinson, S, & Shepherd, S. (2010), *The 21<sup>st</sup> Century Doctor – Understanding the Doctors of Tomorrow*, Kings Fund Institute

Levy, A. & Merry, U. (1986), *Organisational Transformation: Approaches, Strategies, Theories*, NY: Praeger

Lewin, D. & Piper, S. (2006) Patient empowerment within the coronary care unit: Insights for health professionals drawn from patient satisfaction survey, *Intensive and Critical Care Nursing*, Vol 23, (2), 81-90

Le Maistre, N. Reeves, R, Coulter, A (2003) *Patients' experience of CHD choice* , Oxford Picker Institute

Lincoln, YS. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lok, P., Westwood, R., Crawford, J. (2005) Perceptions of organisational subculture and their significance for organisational commitment. *Applied Psychology*. Vol. 54. No. 4. pp 490-514.

Longo, M. & Cohen, R. & Hood, K. & Edwards, A. & Robling, R. & Elwyn, G. & Russell, I. (2006), Involving patients in primary care consultations: assessing preferences using discrete choice experiments, *British Journal of General Practice*, 56 (522): 35-42

Losina, E., Plerhoples, T., Fossel, A. H., Mahomed, N. N., Barrett, J., Creel, A. H., Wright, E. A. and Katz, J. N. (2005), Offering patients the opportunity to choose their hospital for total knee replacement: Impact on satisfaction with the surgery. *Arthritis & Rheumatism*, 53: 646–652.

Lothian, K. & Philip, I. (2001) Maintaining the dignity and autonomy of older people in the health care setting, *British medical Journal*, 322 (7287) 668-670

Lundberg, C. (1985) On the feasibility of cultural intervention. In P. Frost, L. Moore, M.Louis, C Lundberg, and J Martin (eds), *Reframing Organizational Culture*, Sage, Newbury Park, CA, pp. 169-85



Lunt, N. & Mannion, R. & Smith, P. (1996), Economic discourse and the market: The case for community care, *Public Administration*, vol 74: 369-391

Mabey, C. & Mayon-White, B. (1985), *Managing Change*, Oxford University Press; London

Macdonald, S. (2003), NHS Urged to be less paternalistic, *British Medical Journal*, 326:618.4

Magee, H. & Davis, L. & Coulter, A. (2003) Public Views on health care performance indicators and patient choice, *Journal of the Royal Society of Medicine*, 96: 338-342

Mahon, A. & Wilkin, D. & Whitehouse, C., Choice of hospital for elective surgery referral: GP's and Patients' Views in Robinson, R & Le Grand, J. (2004) *Evaluating the National Health Service Reform*, Policy Journals

Mannion, R & Davies, H & Marshall, M (2005), *Cultures for performance in health care*, Berkshire, England: Open University press

Mannion, R & Davies, H & Marshall, M (2005), Impact of star performance ratings in English acute hospital trusts, *Journal of Health Services Research Policy*, vol 10 No , 18-25

Mannion, R. & Davies, H. & Konteh, F. & Jung, T. & Scott, T. & Bower, P. & Whalley, D. & McNally, R. & McMurray, R. (2008), *Measuring and assessing culture in the NHS: Research Report for the National Institute for Health Research Service Delivery and Organisation programme*. Queen's printer and controller of HMSO

Mannion, R. & Greener, I (2009), Patient Choice in the NHS: what is the effect of choice policies on patients and relationships in health economies, *Public Money and Management*, 95-100

Martin, J. and Siehl, C., (1983), "Organisational Culture and Counter Culture: An uneasy Symbiosis", *Organizational Dynamics*, Autumn, 52-64

Martin, J., (1992), *Culture In Organisations: three perspectives*. New York: Oxford University Press

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd Ed.). Thousand Oaks, CA: SAGE Publications

Mays, N. (2010), Impact of reintroducing competition in the English NHS: a synthesis of evidence from the Health Reform Evaluation Programme, *Health Services Research Network and Society for Social Medicine Conference*

Mays, N. (2011) The English NHS as a market: challenges for the Coalition government in *Social Policy Review 23 – Analysis and debate in social policy, 2011*, Edited by Holden, C & Klikey, M. & Ramia, G. The Policy Press.

Mays, N. & Pope, C. (1995), Qualitative Research: Rigour and qualitative research, *British Medical Journal*, 311: 109

Mays, N. & Pope, C (2000), Quality in qualitative research. In C. Pope and N. Mays, (Eds), *Qualitative research in healthcare*, (2<sup>nd</sup> Ed), London

Mays, N & Tan, S (2012) Evaluating Labour's market reforms, 2002-10. *Journal of health services research & policy*, 17 pp. 1-6

McIntyre, A. (1999) *Dependent Rational Animals*. Chicago, IL: Open Court

McKee, M & Healy, J (2000) The role of the hospital in a changing environment, *Bulletin of the World Health Organisation* [on line] Available at [http://www.scielosp.org/scielo.php?pid=S0042-9686200000600012&script=sci\\_arttext](http://www.scielosp.org/scielo.php?pid=S0042-9686200000600012&script=sci_arttext) [Last accessed 6<sup>th</sup> April 2013]

McNeil P, 1990, *Research Methods*, Second Edition, Routledge

Meyerson, D., and Martin, J., (1987), "Cultural Change: An integration of three different views", *Journal of Management Studies*, 24 (6): 623-647

Mickan, S. & Boyce, R (2007) *Organisational behaviour: understanding people in healthcare organisations* [On line] Available at [http://www.unc.edu/courses/2008fall/nurs/379/960/65\\_604078165817-effective\\_teams.pdf](http://www.unc.edu/courses/2008fall/nurs/379/960/65_604078165817-effective_teams.pdf) Last accessed 1<sup>st</sup> April 2012

Miles, M.B, and Huberman, A.M. (1994). *Qualitative Data Analysis*, 2nd Ed., p. 10-12. Newbury Park, CA: Sage.

Miles, R. & Snow, C. (1978) *Organisational Strategy, Structure and Process*, New York: McGraw Hill

Miller, L. & May, D (2006) Patient Choice in the NHS. How critical are facilities in influencing patient choice, *Facilities*, Vol 24 No9/10, 354-364

Miller, R.H. (1998), Healthcare Organizational Change: Implications for Access to care and Its Measurement, *Health Services Research*, 33(3):653-680

Miner, J.B. (1994), Role motivation theories – *People and Organisations*, Psychology Press

Mintzberg, H. (1983), *Structure in Fives – Designing Effective Organisations*, Prentice Morgan, G. (1986)., *Images of Organisations*, Beverly Hills, California: Sage Publications

Morgan, G. (2000), *Images of Organisations*. 2<sup>nd</sup> Ed., Beverly Hills, California: Sage Publications

Mori, (2004), *Public Perceptions of the NHS Winter 2003 for the Department of Health*, MORI

Mori, (2006), *Understanding Public and Patient Attitudes to the NHS for the Healthcare Commission*, [on line] Available from <http://www.ipsos-mori.com/Assets/Docs/Archive/Polls/healthcarecommission.pdf> [Last accessed 29<sup>th</sup> June 2012]

Morris S, Devlin N, Parkin D (2007). *Economic Analysis in Health Care*. Chichester: Wiley

Morse J. Ed (1992) *Qualitative Health Research*, Newbury Park, California, Sage

Nadler, D. (1983) in *Managing Change*, Mabey, C. & Mayon-White, B. (1985), Oxford University Press; London

Nadler, D. & Tushman, M. (1988), *Strategic organisation design: concepts, tools and processes*. Scott, Foresman and Company. Glenview, London England

Nagpaul, C. (2012) Choice 'destablising hospitals', *Pulse today* [On line] Available at <http://www.pulsetoday.co.uk/dr-chaand-nagpaul/152.subject?cmd=changesortorder&val=3> [last accessed August 2014]

National Co-ordinating Centre for the NHS Service Delivery and Organisation R&D, (2005) *Patient Choice and the Organisation and Delivery of Health Services: Scoping Review*, National Co-ordinating Centre for the NHS Service Delivery and Organisation R&D

O'Connor, M.K. & Netting F.E. (2002) Using qualitative research in practice evaluation in *Social Workers' Desk Reference* Oxford: Oxford University Press, 777-789

O'Flynn, N & Britten. N (2006) Does the achievement of medical identity limit the ability of primary care practitioners to be patient-centred? A qualitative study, *Patient Education and Counselling*, 60: 49-56 [on line] available at [http://www.stes-apes.med.ulg.ac.be/Documents\\_electroniques/PREV/PREV-EDP/ELE%20PREV-EDP%20A-7850.pdf](http://www.stes-apes.med.ulg.ac.be/Documents_electroniques/PREV/PREV-EDP/ELE%20PREV-EDP%20A-7850.pdf) [Last accessed 6<sup>th</sup> September 2013]

Oliver, A. and Brown, L.D. (2010) *On the Use of Personal Financial Incentives to Address Health Inequalities*. LSE working paper.

Ogden, J. & Barnett, J. & Daniels, E. (2008) The value of choice: a qualitative study, *British Journal of General Practice*,\_vol 15, 58/554, (609-613)

- Parker, M., (2000), *Organisational Culture and Identity*, Sage London
- Patiar, S. & Lo, S. & Spraggs, S. (2006) Patient satisfaction with NHS elective tonsillectomy outsourced to the private sector under the Patient Choice Programme, *Journal of Evaluation of Clinical Practice*,\_12/5, (569-72), 1356-1294
- Patton MQ (2002) *Qualitative Research and Evaluation Methods Evaluation Methods*. Third edition. Sage . Publications.
- Pawson, R. & Tilley, N. (1997) *Realistic Evaluation*, London, Sage
- Pawson, R. & Tilley, N. (2004) A Realist Evaluation,[On line], Available from [http://www.communitymatters.com.au/RE\\_chapter.pdf](http://www.communitymatters.com.au/RE_chapter.pdf) [Last accessed 2nd April 2013]
- Peattie, L. (2001) *Theorising planning: some comments on Flyvbjerg's rationality and Power*, *International Planning Studies*, 6 (3):257-262
- Peckham, S & Sanderson, M. & Entwistle, V. et al (2011) *A comparative study of the construction and implementation of patient choice policies in the UK*. Final Report. NIHR Service Delivery and Organisation programme
- Peters, T., and Waterman, R., (1982), *In search of excellence: lessons from America's best run companies*. New York, Harper and Row
- Peterson, R., & Behfar, K. J. (2003). The dynamic relationship between performance feedback, trust, and conflict in groups: A longitudinal study. *Organizational Behaviour and Human Decision Processes*, 92, 102–112.
- Pettigrew, A.M. (1985) *The Awakening Giant*. Oxford, UK: Blackwell Publishers.
- Pettigrew, A. & Ferlie, E. & McKee, K (1992) *Shaping strategic change*, Sage
- Picker Institute, (2006), Patient focussed interventions – a review of the evidence [on line] available from <http://www.health.org.uk/public/cms/75/76/313/526/Patientfocusedinterventions.pdf?realName=juNCmR.pdf> last accessed April 2011]
- Pope, C & Ziebland, S. Mays, N. (2000), *Analysing Qualitative Data*, BMJ, 2000:320:114
- Populus, (2014), NHS England and Monitor - Outpatient Appointment Referrals, [on line] Available from <http://www.england.nhs.uk/2014/08/07/choice-for-patients/> [Accessed 10<sup>th</sup> August 2014]
- Porras J. I. & Robertson P. J. (1992). Organizational development: theory, practice, research. In M. D. Dunnette & L. M. Hough (Eds.), *Handbook of organizational psychology* (Vol.3, pp. 719- 822). Palo Alto, CA: Psychology-Press.

- Porter, M.E. (1980), *Competitive Strategy*, New York Free Press
- Powell, M. (1997), *Evaluating the National Health Service*, Buckingham, Oxford University Press
- Propper, C. & Croxson, B. & Shearer, A. (2002) Waiting times for admissions: the impact of GP fundholding, *Journal of Health Economics*, Vol 21, 2, 227-252
- Propper, C. & Damiani, M. & Dixon, J. (2005), Mapping choice in the NHS: a cross sectional study of routinely collected data *British medical Journal* 330 (7486): 284
- Pugh, D. (1971), *Organization Theory – Selected Readings*, Penguin Books
- Pugh, D. S., & Hickson, D. J. et.al (1963). A Conceptual Scheme for Organizational Analysis. *Administrative Science Quarterly*, 8, 289 – 315
- Raelin, J. A. (1985), The basis for the professional's resistance to managerial control. *Hum. Resource. Management*, 24: 147–175
- Rawls, J. (1971) *A theory of Justice*, Cambridge MA: Belknap press, Harvard University Press
- Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R, editors. *Analysing qualitative data*. London: Routledge; 1993. pp. 173–194
- Ritchie, J. and Spencer, E. (1994) Qualitative data analysis for applied policy research. In, Bryman, A. and Burgess, R.G. (eds.) *Analyzing Qualitative Data*. London: Routledge.
- Rivett, G. (1986), *National Health Service History*, [on line]. Available from <http://www.nhshistory.net/bevan.htm> [accessed 1 December 2009]
- Robbins S.P., & Judge T.A., (2007), *Organizational Behaviour*, 12<sup>th</sup> Edition, New York: Pearson International – Prentice Hall, Inc.
- Roberts, A & Marshall, L & Charlesworth, A (2012), The funding pressure facing the NHS 2011/12 to 2021/22 - *A decade of Austerity* [On line], Available at [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203\\_a\\_decade\\_of\\_austerity\\_summary\\_1.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_a_decade_of_austerity_summary_1.pdf) [Last accessed 3rd March 2012]
- Robertson, R. & Dixon, A (2009), *Choice at the point of referral*, Kings Fund
- Robertson, R. & Thorlby, R (2008), *Patient Choice*, [on line] London: Kings Fund, Available from [http://www.kingsfund.org.uk/publications/briefings/patient\\_choice.html](http://www.kingsfund.org.uk/publications/briefings/patient_choice.html) [last accessed 17th May 2010]

Robinson, R. & Le Grand, J. (1994), *Evaluating NHS Reforms*, Berkshire, Policy Journals

Roland, M. (2008). 'Assessing the options available to Lord Darzi', *British Medical Journal*, 336: 625-6.

Rollinson, D (2008), *Organisational Behaviour and Analysis – An Integrated Approach - 4<sup>th</sup> Edition*, Pearson Education Limited

Rogers, P, J., Petrosino, A., Huebner, T. A., & Hacsı, T. A. (2000). Program theory evaluation: Practice, promise, and problems. *New Directions for Evaluation*, 87, 5-13.

Rosen, R & Curry, N. & Florin, D. (2005), *Public Views on Choices in Health and Health Care*, [on line], London: Kings Fund, Available from [http://www.kingsfund.org.uk/publications/public\\_views\\_on.html](http://www.kingsfund.org.uk/publications/public_views_on.html) [last accessed 17th May 2010]

Rosen, r. & Florin, D. & Hutt, R. (2007) *An anatomy of GP Referral Decisions. A qualitative study of GP's views on their role in supporting patient choice.* Kings Fund Publications

Ross, K. (2008), *Immanuel Kant 1724 – 1804* Available from <http://www.friesian.com/kant.htm> [Last accessed 28th April 2010]

Saunders, M. Phillips, L. Thornhill, A. (2007), *Research Methods for Business Students*, 4<sup>th</sup> Ed, Harlow Financial Times Prentice Hall

Schein, E.H., (1985), How culture forms, develops and changes, in R.H. Kilmann, M.J.Saxton, R. Serpa, and associates (eds), *Gaining Control of the Corporate Culture*, San Francisco, Calif: Jossey Bass, 17-43

Schein, E. (1985), *Organisational culture and leadership 1<sup>st</sup> Edition*, San Francisco, Jossey Bass

Schein, EH., (1990), Organisational Culture, *American Psychologist*, 45 (2):109-119

Schwandt, T. (2007), *The Sage Dictionary of Qualitative Inquiry*, 3<sup>rd</sup> Ed, California, USA: Sage Publications

Schwartz, H., and Davis, S.M., (1981), Matching corporate culture and business strategy, *Organisational Dynamics*, 10 (1), 30-48

Scott, J. (2000), *Rational Choice Theory*, Available from; <http://privatewww.essex.ac.uk/~scottj/socscot7.htm> [Last Accessed 23rd April 2010]

Scott, T. & Mannion, R. & Davies, T.O. & Marshall, M. (2003) Implementing culture change in health care: theory and practice, *International Journal for Quality in Health Care*, 15 (2), 111-118

Scott, T., and Mannion, R., and Marshall, M., (2003), *Healthcare Performance and Organisational Culture*, Oxon, UK: Radcliffe Medical Press Ltd

Seale, C & Silverman, D. (1997), Ensuring rigour in qualitative research, *European Journal of Public Health*, 7:379-384

Selznick, P. (1949), *TVA and Grass Roots*, Berkeley, CA: California Press

Selznick, P. (1957). *Leadership in administration: A sociological interpretation*. Berkeley: University of California Press.

Shortell, S.M. & Morrison, E.M. & Robbins, S. (1985), Strategy Making in Health Care Organisations: A framework and agenda for research, *Medical Care Research and Review*, 42(2):219-266

Siciliani, L. & Martin, S. (2007), An empirical analysis of the impact of choice on waiting times, *Health Economics*, 16, 763-779

Sidani, S., & Sechrest, L (1999). Putting program theory into operation. *American Journal of Evaluation*, 20(2), 227-238.

Silverman, D. (1970), *The Theory of Organisations*, London Heinemann

Silverman, D. (2005), *Doing Qualitative Research – A Practical Handbook*, 2<sup>nd</sup> Ed, London: Sage Publications Ltd.

Soy, S. (2006), *The Case Study as a Research Method*, [Available online at <http://www.ischool.utexas.edu/~ssoy/useusers/1391d1b.htm> ] accessed on 2nd December 2010

Smircich, L., (1983), "Concepts Culture and Organizational Analysis", *Administrative Science Quarterly*, 28: 339-358

Spurgeon, P. & Hickers, C. % Richards, R (2006) Piloting the uptake of patient choice in a single Trust, *British Journal of Healthcare management*, 12, 214-218

Srivastava, A. & Thomson, S (2009), *Framework Analysis: A Qualitative Methodology for Applied Policy Research*, JOAAG, vol4. No2 [Available on line at [http://www.joaag.com/uploads/06\\_Research\\_Note\\_Srivastava\\_and\\_Thomson\\_4\\_2\\_.pdf](http://www.joaag.com/uploads/06_Research_Note_Srivastava_and_Thomson_4_2_.pdf)] accessed on 9<sup>th</sup> January 2011

Stake, R. (1995) *The Art of Case Study Research*, Thousand Oaks, CA: Sage

Starkey, K. (2001), Power and Change: Andrew Pettigrew on strategy and change, *Academy of Management Executives*, vol 15 no 3: 45- 47



Stephenson, T (1985), *Management: A political activity*, Basingstoke: Macmillan

Stevens, S. (2004), Reforming strategies for the English NHS, *Health Affairs*, vol 23, no3, 41-44

Stock, G., McFadden, K., and Gowen III, C. (2007), "Organizational culture, critical success factors, and the reduction of hospital errors", *International Journal in Production Economics*, 106(2): 368-392.

Swayne, L.E. & Duncan, J. & Ginter, P.M. (2006), *Strategic Management of Health Care Organisations*, 5<sup>th</sup> ed, Wiley-Blackwell Publishing

Taras, V. & Rowney, J. & Steel, P. (2009) Half a century measuring culture: Review of approaches, challenges and limitations based on the analysis of 121 instruments for quantifying culture, *Journal of International Management*, (15)357-373

Taylor, R. & Pringle, M. & Coupland, C (2004), *Implications of offering "Patient Choice" for routine adult surgical referrals*, Department of Health

Taylor-Gooby, P. (2008) 'Choice and Values: Individualised Rational Action and Social Goals', *Journal of Social Policy*, (2): 167-85.

Thaler, Richard H.; Sunstein, Cass R. (2008). *Nudge: Improving Decisions about Health, Wealth, and Happiness*. Yale University Press

Thatcher, M. *The Downing Street Years*, London, Harper Collins 1993

The Health Foundation, (2015), *Tests for a Credible Health Policy*, [on line] Available from

<http://testing.healthfoundation.apps.awsripple.com/sites/default/files/Three%20tests%20for%20a%20credible%20health%20policy.pdf> [Last accessed 12<sup>th</sup> June 2015]

Thompson, J. & Arthur, A. & Strickland, A.J. & Gamble, J.E. (2008) *Crafting and executing strategy 17<sup>th</sup> Edition*, McGraw Hill: Irwin, Boston MA.

Thompson, J.D., Tuden, A., 1959. Strategies, structures and processes of organizational decision. In: Thompson, J.D., Hammond, P.B., Hawkes, R.W., Junker, B.H., Tuden, A. (Eds.), *Comparative Studies in Administration*. University of Pittsburgh Press, Pittsburgh, pp. 195–216.

Thomson, S. & Dixon, A (2006), Choices in Health care: the European experience, *Journal of Health Services Research & Policy*, vol11, no3 167-71

Thorlby, R. (2006), *Where the patient was king*, London: Kings Fund

Tushman, M.L. (1977) Special Boundary Roles in the Innovation Process, *Administrative Science Quarterly*, Vol. 22, No. 4, pp. 587-605



Tversky, A. & Kahneman, D. (1983) Extensional versus intuitive reasoning: Conjunction fallacy in probability judgement *Psychological Review*, 90 293-315

Tweddell, L. (2008), the birth of the NHS - 5<sup>th</sup> July 1948, *Nursing times.net*, [Available on line at <http://www.nursingtimes.net/the-birth-of-the-nhs-july-5th-1948/441954.article>.] [Last accessed 5<sup>th</sup> August 2013]

Van de Ven, A.H & Poole, M.S., (1995). Explaining development and change in organizations. *Academy of Management Review*, 20 (3)

Van de Ven, AH & Sun, K (2011), Breakdowns in Implementing Models of Organization Change, *Academy of Management Perspectives*,\_Vol 25, no3, 58-75

Voss, C. Tsikrikitis, N. Frohlich, M. (2002), *Case Research in Operations Management*, International Journal of Operations and Productions Management, 22 (2), 195-219

Wallace, A. & Taylor-Gooby, P (2009) New Labour and the reform of the English NHS: user views and attitudes, *Health Expectations*, 13, 208-217

Walonick, D. (1993), *Organisation Behaviour and Theory*, [On Line] Available at <http://www.statpac.org/walonick/organizational-theory.htm> Last accessed on 27th April 2013

Watson, G. (1969). Resistance to change. In W. G. Bennis, K. D. Benne & R. Chin (Eds.), *The planning of change* (2nd ed., pp. 488-498). New York: Holt, Rinehart & Winston.

Weick, KE & Quinn, RE (1999), Organizational Change and Development, *Annual Reviews – Psychology*,\_50:361-86

Weir, N. & Kotecha, M. & Goel, K. (2007), Expanding choice options for older patients in relation to practice based commissioning: a qualitative study of older patients in a small GP surgery, *Quality in Primary Care*,\_15: 331-6

Wiles, R. & Higgins, J. (1996), Doctor-patient relationships in the private sector: patients perception, *Sociology of Illness and health* ,\_Vol 18, 341-356

Wilkinson, JE & Rushmer, RK & Davies, HTO (2004), Clinical Governance and the learning organisation, *Journal of Nursing Management*, Vol 12, 105-113

Williams, R. (1983), *Culture and Society 1780-1950*, Columbia University Press

Yiedler, J. (2005), Leadership and Power in Medical Imaging, *Radiography*, 12, 305-3013

Yin, R.K. (1994), *Case Study Research – Design and Methods*, 2nd ed, Thousand Oaks: Sage Publications Ltd.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Yin, R. K. (2003b) *Case study research: Design and methods, 3rd edition*, London, SAGE Publications

Yin, R.K. (2009), *Case Study Research- Design and Methods*, 4<sup>th</sup> Ed Los Angeles USA: Sage Publications Ltd.

Zaidi, F. & Corbett, M. & Burton, B. & Bloom, P (2007), Raising the benchmark for the 21<sup>st</sup> century – the 1000 cataract operations audit and survey: outcomes, Consultant supervised training and sourcing NHS Choice, *British Journal of Ophthalmology* ; 91:731-736

Zaller, John, and Stanley Feldman. 1992. "A simple theory of the survey response: Answering questions versus revealing preferences." *American Journal of Political Science* 36(3):579-616.