Provider Diversity in the NHS:

Impact on Quality and Innovation

Final Report

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EXECUTIVE SUMMARY

Health system reforms were introduced in the UK in 1990, partially reversed in 1997, and relaunched with the NHS Plan of 2000. The reforms introduced by New Labour (DH 2005a) aimed to encourage a diversity of providers with freedom to innovate and improve service quality. The reforms also involved centralised price setting, decentralised commissioning, and entry reforms to encourage a diversity of providers with more freedom to innovate and improve service quality (DH 2005a). Commissioners of NHS services were expected to engage with new providers from the for-profit private sector and the 'Third Sector' including voluntary groups, registered charities, foundations, trusts, social enterprises, and cooperatives alongside incumbent NHS providers[1]. The promotion of the entry of new providers was designed to stimulate innovation, quality and choice in the provision of health and social care services. Yet relatively little was known about the comparative performance of different types of providers, the barriers to entry and growth which they faced, or how their involvement could best be used to improve quality and innovation in service delivery.

Outline of the project

The overall objective of the research project has been to assess the impact of provider diversity on quality and innovation in the NHS. The specific research aims were to identify the differences in performance between non-profit Third Sector organisations, for-profit private enterprises, and incumbent public sector institutions within the NHS as providers of health care services, as well as the factors that affect the entry and growth of new private and Third Sector providers.

The study used both qualitative and quantitative methods based on case studies of four Local Health Economies (LHEs). Qualitative methods included documentary analysis and interviews with key informants and managers of both commissioning and provider organisations. To provide a focus to the study, two tracer conditions were followed: orthopaedic surgery and home health care for frail older people. In the case of hospital inpatient care, data on patient characteristics were also collected from the HES database. The analysis of this data provided preliminary estimates of the effects of provider type on quality, controlling for client characteristics and case mix. In addition, a survey of patient experience in diverse provider organisations was analysed to compare the different dimensions of quality of provision of acute services between incumbent NHS organisations and new independent sector treatment centres.

[1] The 'Third Sector' includes both not-for profit enterprises and for-profit enterprises which work for a social purpose, such as some social enterprises and the trading arms of charities which focus on fund-raising, as well as workers cooperatives.

Mapping diverse providers in local health economies

Thus far the extent of involvement of diverse providers in supplying services to the NHS is extremely limited, especially in the social enterprise sector. Strategies adopted by commissioners are an important determinant of the extent and nature of diversity in local health economies.

Performance differences in quality

The research has shown that, in respect of inpatient hospital services, diverse providers supply health services of at least as good quality as traditional NHS providers, and that there is ample opportunity to expand their scale and scope as providers of services commissioned by the NHS. The research used patient experience survey data to investigate whether hospital ownership affects the quality of services reported by NHS patients in areas other than clinical quality. The raw survey data appear to show that private hospitals provide higher quality services than the public hospitals. However, further empirical analysis leads to a more nuanced understanding of the performance differences. Firstly, the analysis shows that each sector offers greater quality in certain specialties. Secondly, the analysis shows that differences in the quality of patients' reported experience are mainly attributable to patient characteristics, the selection of patients into each type of hospital, and the characteristics of individual hospitals, rather than to hospital ownership as such. Controlling for such differences, NHS patients are on average likely to experience a similar quality of care in a public or privately-run hospital. Nevertheless, for specific groups of patients and for specific types of treatments, especially the more straightforward ones, the private sector provides an improved patient experience compared to the public sector. Elsewhere, the NHS continues to provide a high quality service and outperforms the private sector in a range of services and for a range of clients.

The research has also shown that there are differences in the way that quality is delivered among the diverse providers. There is greater concern among private sector providers for improved organisation of patient pathways and for improved patient experience, whereas Third Sector providers have brought about quality improvements through a more holistic approach and a greater degree of community involvement. Private organisations have improved the quality of service delivery by introducing more efficient patient pathways, and through a greater emphasis on patient experience. Third Sector organisations have emphasised the latter aspect, adopting a holistic approach in which patients and the wider community are seen as partners in a joint effort to improve well-being.

Concerning innovation, the findings of the qualitative research has revealed that significant process innovations have been introduced by new private and Third Sector providers, while product

innovations have continued to be a strong point of traditional NHS providers. NHS organisations have greater resources to drive innovation in clinical practice, and private and Third Sector organisations have innovated more in organisational and working practices. An important area of innovation among the Third Sector providers has been to extend health care services throughout a broader range of community activities than has been possible through traditional NHS organisations.

The entry of new providers, including the commissioning process

The extent to which new providers can stimulate performance improvements throughout the NHS is limited by the barriers they face to entry and growth. The qualitative component of the research has involved interviews with both commissioning and provider organisations from public, private and Third Sector organisations. One of the clear messages to come out of the research is the key importance of the strategy of the commissioning organisations towards market making. Commissioners hold the key to the extent of diversity of provision, and their varying strategies have strongly influenced the degree of diversity in each case study area.

The research has revealed the strong barriers to the entry of new organisations, especially to the entry of new providers from the Third Sector, due to economies of scale in the bidding process which disadvantage small niche providers. Resistance from incumbent providers has also been observed. Similar factors have also inhibited the growth of new providers. The growth of private sector providers has been inhibited in more deprived areas by the more extensive demands of patients, suggesting that business models of private providers were not appropriate for the type of population served. Third Sector organisations in such areas have been inhibited from growing their services by the short duration of their contracts.

Impact of the entry of new providers on performance of incumbents

Finally the research has investigated the impact of new entrants on the strategies and practices of incumbents. The research has demonstrated that the entry of new providers has driven a response among incumbents which have sought to match them with equivalent improvements. NHS Trusts have responded to the entry of new ISTCs by introducing new surgical pathways, and have placed a greater strategic emphasis on improving the patient experience. However, information sharing among incumbents has diminished as competition has intensified. The entry of new Third Sector providers in the community care field has led to a sense of fragmentation in the provision of community health, and to a more competitive orientation of traditional NHS organisations which are themselves being spun off into independent arms length organisations.

CHAPTER 1: STUDY AIMS AND BACKGROUND

1.1. NHS REFORMS AND ROLE OF DIVERSITY OF PROVISION

The NHS Plan 2000 set out the Government's vision for modernising the health service through sustained investment and radical reform. The aim was to create a 'patient-led NHS' (Department of Health 2005a) – that is, an organisation that embodies 'a decisive shift from top-down to bottom-up as we develop a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management' (Department of Health 2006a: 5). The reforms involve centralised price setting, decentralised commissioning, and entry reforms to encourage a diversity of providers with more freedom to innovate and improve service quality. Commissioners are to engage with new providers from the for-profit private sector including independent sector treatment centres (ISTCs), from the not-for-profit Third Sector including local voluntary groups, registered charities, non-profit social enterprises, and cooperatives, and from the public sector including Foundation Trusts and new Community Foundation Trusts.

A wide ranging set of reforms has therefore been introduced into the English National Health Service (NHS), designed to replace centrally directed targets by decentralised quasi-market incentives for autonomous providers of care to stimulate improvements in efficiency, quality, innovation, and responsiveness of services. Four distinct aspects of the reforms have been designed to embed incentives for self-sustained performance improvement (DH 2007b). Firstly, demand side reform, aims to give more choice for patients. Secondly, transactional reform, is designed to ensure that the level of reimbursement of providers is sensitive to patient choices, rewarding those who provide better quality care. Thirdly, system management reforms set out a framework of regulation to oversee market forces in order to guarantee quality, fairness and equity. Fourthly, supply-side reforms encourage a more diverse range of providers of health services to NHS patients. (DH 2007b, Allen, 2009).

This project is concerned with the latter aspect of the reforms designed to increase the diversity of types of providers of care to NHS patients. Increasing diversity means that services will be provided by a variety of different types of organisations, including transformed NHS incumbents and new entrants from the independent sector. The latter include both for-profit and Third Sector organisations (TSOs), including 'social enterprises'. The former includes publicly owned providers known as NHS Foundation Trusts whose governance arrangements enable them to operate autonomously from government control.

The Government argued that diverse providers from different ownership and organisational sectors (public and private) possessed complementary capabilities. In a pamphlet produced for the Social Enterprise Coalition, the then Secretary of State for Health, Patricia Hewitt, outlined the different benefits that diverse providers of health care could bring (Hewitt 2006). She argued that, while incumbent NHS organisations foster a 'public service commitment' and treat all patients equally, the private sector possesses 'commercial discipline' and is oriented towards patients as 'customers' and the Third Sector, by involving healthcare users in the design and delivery of services, is flexible and capable of 'rapid innovation'. Opportunities for different types of providers would emerge in different areas of health service, while potential providers would be commissioned on the basis of the quality of care they were able to offer in different sectors of the service, irrespective of their form of ownership.

Thus, an important element of the recent reforms of the health care system in England has been the entry of private-sector providers into the new National Health Service (NHS) quasi-market. So far, 36 private sector Independent Sector Treatment Centres (ISTCs) have been contracted to provide elective surgery and diagnostic procedures to NHS patients. These have been contracted in two stages or 'waves' since 2002. In a complementary aspect of the reform, patients, advised by their GPs, are also gradually being offered an increased choice among the diversity of providers (Sutton, 2009). The entry of these new private-sector providers was expected to reduce cost, improve quality, and promote innovation and responsiveness to patients throughout the health care system (Allen 2009).

Private, for-profit organizations are generally thought to have greater incentives to minimise costs than public sector ones. However, the effect of ownership on service quality is less certain. International comparative research on the clinical quality of for-profit, non-profit and state-owned hospitals is inconclusive (Sloan et al. 2001, Eggleston et al. 2006). Profit incentives may have complex effects, so that certain aspects of quality may be under-supplied by private firms commissioned to provide public services, while in other areas quality may improve with for-profit supply depending on the contracting situation and the incentives provided to staff and staff motivation (Hart et al. 1997, Benabou and Tirole 2006, Besley and Ghatak, 2003).

As a result of the supply-side reforms, a wide range of public, private and Third Sector organisations now provide health care to NHS patients in England. In order to understand how the current set of system reforms is working in practice, it is important to understand the organisational characteristics of the entities involved. These organisations have several distinct legal forms, and differ in their aims and objectives. They differ in ownership forms, governance arrangements, and decision making

structures and these differences may influence their abilities to provide efficient, responsive and high quality services. Currently, little research has been carried out into the effects of these differences on performance in the English case. Evidence from other countries provides little evidence that independent providers perform better than those owned and run by the state. Economic theorists have argued Third Sector providers may provide better quality of care than other types of providers due to their altruistic motivations (Grout and Stephens 2003, Ben-Ner 2006). In order to better identify these sorts of motivations in the case of the supply-side reforms in the English NHS reforms, is it important first of all to understand how these providers are actually governed in terms of both formal governance structures and actual practices. This is needed in order to predict the relationship of organisational form to performance. For example, what effect might the participation of new stakeholders in Foundation Trusts (FTs) have on the aims and motivations of these organisations, and hence on their likely response in terms of quality and innovation to the new quasi-market incentives provided as a consequence of increased patient choice and centralised price setting through the system of 'payment by results'?

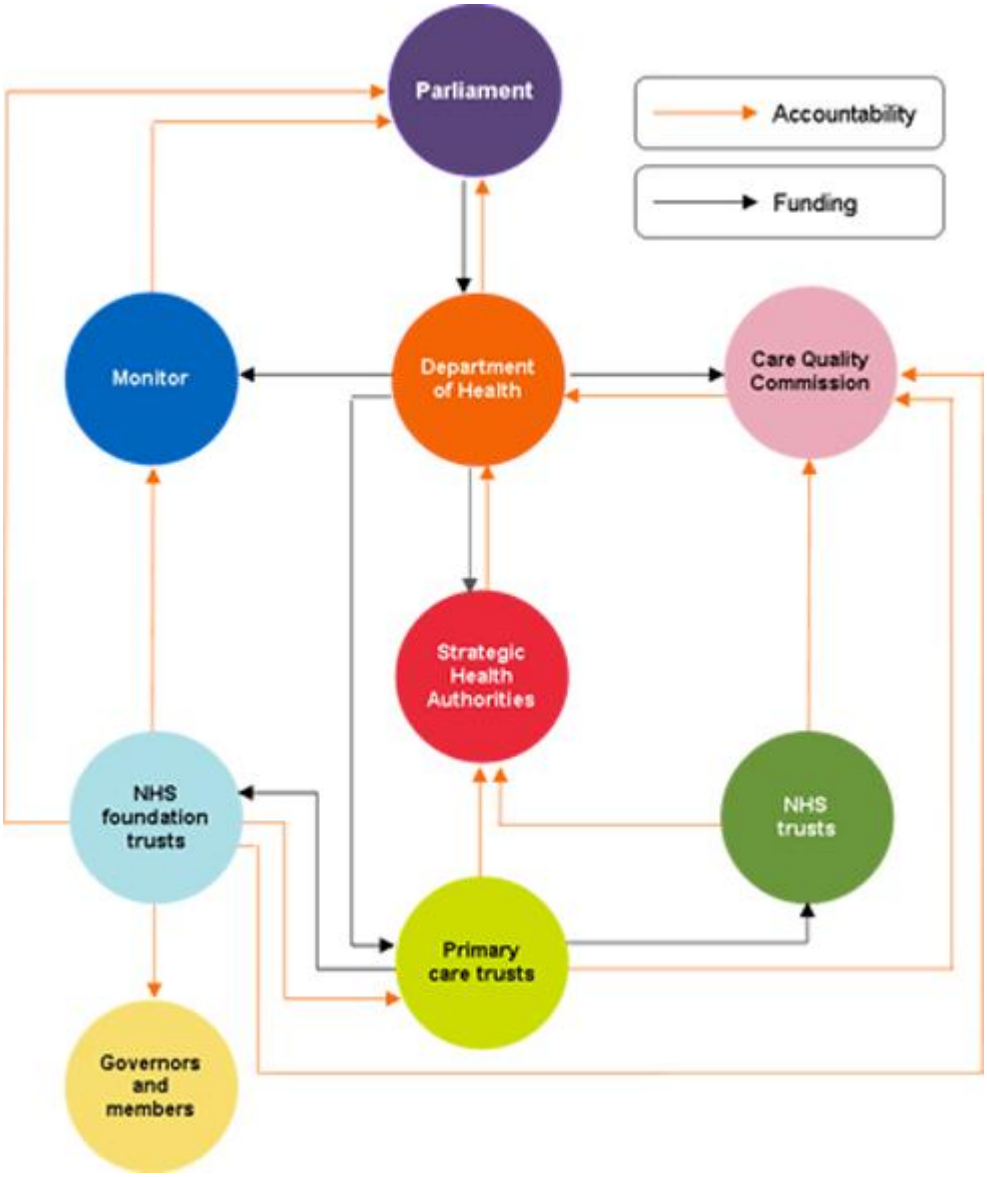
1.1.1 NHS Foundation Trusts

NHS Foundation Trusts (FTs) were introduced through the Health and Social Care Act 2003 (now consolidated in the NHS Act 2006) as not-for-profit public benefit corporations[2]. The advantages of this status were that the organisations would obtain greater autonomy from central control, may retain financial surpluses, and are not required to break even every financial year. FTs are also able to borrow funds for investment in service improvements from commercial sources within a 'Prudential Borrowing Limit' set by Monitor. Since 2004/5, NHS Trusts that delivered above-average financial and quality performance, as evidenced by achieving a 'three star' assessment by the regulatory organisation 'Monitor', have been able to transform themselves into NHS Foundation Trusts (FT). There are currently 130 NHS FTs, of which 40 are mental health trusts. The Department of Health intends that all NHS Hospital Trusts should transform themselves into FTs, provided that they have a proven degree of financial stability. Thus, one of the most important new providers to the NHS is a transformed NHS organisation, rather than an external organisation.

The external governance arrangements of FTs differ from that of existing NHS Trusts since they enjoy increased organisational autonomy from NHS central control. Unlike ordinary NHS trusts, FTs are not directly accountable to the Secretary of State for Health and nor are they performance managed by Strategic Health Authorities. FTs are less bound by central 'command and control' constraints than

[2] See http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/what-are-nhs-foundation-trusts

their predecessor organisations, the NHS Trusts. NHS Trusts are funded by Primary Care Trusts and are responsible to them, to their stakeholders (governors and members), to Monitor, to the Care Quality Commission and, ultimately, to Parliament.



They also differ from their predecessors in their internal governance arrangements. Since FTs empower local communities to become involved in the stewardship of their local hospitals, they consequently embody a form of social ownership (Vincent-Jones, 2006). Such organisations take on some of the characteristics of mutual organisations in so far as they combine business efficiency with member benefits, and offer a clear customer focus (Mutuo, 2005, quoted in Vincent-Jones, 2005).

They have furthermore been characterised by the Department of Health as modern exemplars of the co-operative and mutualist tradition:

> 'NHS Foundation Trusts are a new type of NHS hospital tailored to the needs of local populations and run by local managers, staff and members of the public. The Health and Social Care Act 2003 establishes NHS Foundation Trusts as independent public benefit corporations modelled on co-operative and mutual traditions.' (DH, 2005b)

FTs are established as a new form of organisation known as public benefit corporations. A public benefit corporation with its own constitution, Membership, a Board of Governors, and a Board of Directors. There are no specific provisions in the Law concerning the ownership of an FT, which seems to imply that their ownership is the same as ordinary NHS Trusts.

The ownership of the assets of the FT is somewhat opaque. Although Section 7(7) of HCSA states that an FT's property 'is not to be regarded as property of, or property held on behalf of, the Crown', section 13 of HCSA states that the initial public dividend capital (PDC) of an FT is an asset of the Consolidated Fund which represents the Department of Health's equity interest in defined public assets across the NHS. It is an equity stake, not a government asset[3]. Subsequently, guidance was issued by the DH in April 2005 stating that no further PDC will be issued and that interest bearing debt will be issued instead. Moreover, FTs are free to dispose of their surplus assets and use the resulting revenues for reinvestment in service improvements. However, not all assets may be freely sold. When an FT is authorised by Monitor, some of its property is designated as 'protected property', which the FT needs in order to meet its authorised obligation to provide health services in England. This protected property cannot be disposed of without the approval of the regulator. The ability to dispose of assets implies that, in the process of establishing an FT, the assets are transferred from state ownership to FT ownership. The assets effectively become the property of the FT, some of which are in need of 'protection' from unwarranted sales by an FT's Board of Governors or Board of Directors. However, it seems likely that the government's ownership stake, through the mechanism of PDC, will diminish over time and eventually become a minority stake, and that majority ownership of the assets will transfer over time to the FT sector, whenever earned surpluses are reinvested as new business assets.

An analogy can be made with socialist labour-managed firms in the former Yugoslavia which were established on the basis of 'social ownership'. There, social ownership was formalised through the

[3] See speech by Lord Warner, Parliamentary Under-Secretary, Department of Health, on the Health and Social Care Bill, 13th October 2003 in the House of Lords: http://www.theyworkforyou.com/lords/?gid=2003-10-13a.730.0

institution of 'social capital', rather similar to public dividend capital of FTs. Each production unit had 'usufruct' rights on which current workers had substantial control over the firm's policies, such as use of the firm's assets and a legal claim on the firm's residual earnings during the period of their employment (ius fruendi). The workers did not, however, have permanent or transferable claims on the assets of the firm because any rights they had over such assets came to an end when they ceased to be employees. Consequently, it has been argued that this form of ownership is socially inefficient because due to their short time-horizon the workers had little incentive to support investment in such a firm (Furubotn and Richter, 2005). However, Uvalic (1992) and Dow (2003) dispute this since employees, who may work for a firm for 40 years, may actually have a longer term time-horizon than a real-world capital market driven by the short term need to make profits today. Moreover, the labour-managed benefits from the involvement of workers in management which may give an incentive to increased productivity giving workers a say in improving their working conditions and practices and by reducing worker-management conflict.

However, there are several potential limitations to this analogy. *First*, it is hard to argue that employees of FTs have substantial usufruct rights because they are not formally entitled to any residual income and there are national constraints on the pay scales which can be used. On the other hand, it may be relatively easy for controlling workers to manipulate national pay scales through excess promotion beyond the level envisaged by the designers of the scale, and in this way appropriating residual income.

Secondly, due to the non-distribution constraint embodied in the FT legislation, it could be argued that a more appropriate analogy for the FTs is a non-profit mutual organisation. However, the HSCA stipulates that in the event of dissolution of an FT, the Secretary of State can order its assets to be transferred another FT, an NHS Trust or the Secretary of State. As with the Yugoslav firm, assets cannot be distributed to the members. This view is supported by a consultation document ('Consultation on a regime for unsustainable NHS providers', DH 2008b) issued by the Department of Health which suggests that the insolvency regime for FTs should not be that used by the courts for insolvent privately owned companies. Instead, the regulator would 'de-authorise' the FT, and it would revert to NHS Trust status (without members), at which point the proposed 'unsustainable provider regime' for NHS Trusts would apply (and thus a special administrator of the NHS Trust would be appointed). All this suggests that FT ownership is structured somewhat along the lines of 'social ownership' with remaining aspects of traditional state-managed public ownership and not really resembling independent non-profit ownership.

As in the labour managed firm, the NHS FT embodies an element of employee democracy in its governance arrangements. The 'members' of the FT are not shareholders, but are comprised of employees, patients, and people living in the local community, who have the right to vote for a board of governors, on which the local municipal authority and the local primary care trusts are also represented. The governors appoint the chair of the board of directors and non executive directors. The majority of the board of governors must be elected by the public members, and there must be at least three governors representing employees of the FT and one representing any local university medical school. The board of governors is meant to work with the board of directors in setting the strategic goals of the FT. They are required to pass information about FT performance to their constituency, and to inform the regulator if they have serious concerns about the board of directors which cannot be resolved at local level. Employees therefore have an important say in the management of the FT through their membership function and their right to vote for the board of governors.

Compared to NHS Trusts, FTs have greater freedom to determine the level and type of investment in new capacity. Also, they do not need to break even, year on year, and can retain any surpluses which they accrue. FTs can borrow money from whom they wish, within a borrowing limit set by the regulator. Not all assets may be used as security, as protected property may not be charged without the regulator's permission. FTs are allowed to make independent investments by forming companies or acquiring membership in corporate bodies (HSCA, s17). FTs have a small degree of increased freedom in setting rates of pay (NHS Employers, 2005), but they are still subject to the national NHS pay regime.

Due to informational asymmetries between users and providers of healthcare, there is always a need to regulate providers to ensure safe and high quality care is delivered. To this end, the provision of services by FTs is inspected by the Care Quality Commission. To come into being, FTs have to be licensed (in an 'authorisation') by the independent regulator (Monitor). The autonomy of the FT is residual: it is the sphere of freedom left over once the license conditions have been complied with (Davies, 2004). The authorisation sets out the services which the FT must provide to NHS patients ('regulated services'), how much income can be received from private patients (not more than in the year before becoming an FT) and the borrowing limit for the FT. Their financial affairs are overseen by Monitor, which can demand financial information and give directions about how money is spent. Monitor has said that it will operate a risk based approach to regulation, allowing a lighter touch for FTs which are performing well (Monitor, 2005). Moreover, there is a legal obligation for FTs to work in partnership with other health and social care partners (HSCA, s29).

The financial accounts of the NHS FT sector are published annually by the regulator Monitor. In the financial accounts for 2008-2009, it was shown that the total fixed assets of the FT sector were £15.9 billion, of which £10 billion was Public Dividend Capital. Overall therefore, the State still retains a majority equity stake in the FT sector. According to these accounts, the total assets of the FT sector, including public dividend capital, are 'taxpayers equity' a phrase which comes very close to saying that the assets are 'social capital' owned by society at large, rather than by the FTs themselves. This suggests that the Yugoslav model of a self-managed firm under social ownership is a more appropriate analogy for the FT form of organisation than the mutual organisation, whose assets are under the clear legal ownership of the members of the mutual organisation itself. FTs in England retained a surplus income of £269 million, on top of a payment to the government of £486 million as dividends on the Public Dividend Capital.

Moreover, given the lack of any evidence of serious levels of contribution to decision making by members (Allen et al, 2010), it does not seem appropriate to regard FTs as having incentive structures similar to mutually owned organisations. Rather, FTs are more appropriately viewed as socially owned public sector organisations whose management has been given a larger degree of autonomy than the former state-owned NHS hospitals.

Simultaneous reforms in the NHS are also providing market-style economic incentives to FTs. Payment by Results is a national tariff of fixed prices for procedures, applicable to all types of providers, currently being introduced (DH 2007c). The idea is to sharpen incentives, as each episode of care reimbursed (or lost to another provider) is charged at national tariff rates, which are average costs. This is expected to increase the incentives for providers to reduce costs. In some cases this could be at the expense of quality. Some have argued that this effect is more likely to be found among private for-profit providers than among not-for-profit social enterprises such as FTs and charitable organisations which have an explicit social purpose to benefit their patients.

As for innovation and entrepreneurship, while FTs certainly have more autonomy from central ministerial control they are still heavily regulated. They must provide the healthcare to NHS patients which they have been authorised to do; they must not increase their income from private patients (the most obvious source of additional income) over a set amount; and they cannot dispose of their assets. But it is possible, within these constraints, for new ventures to be set up with independent partners. It is not clear the extent to which FTs will in fact undertake new activities under this regime. If the membership structure is to be of any use, one might expect to see FTs making changes to the way they deliver services in response to members' suggestions.

1.1.2. The private sector and the NHS

The NHS Plan of 2000 announced the government's intention to increase the presence of the independent sector in secondary care. In mid-2003, 68% of hospital, beds and revenue in the independent sector as a whole were owned by for-profit providers. In 2006, the sector was dominated by five hospital providers, three of these UK-based, the others being UK subsidiaries of Swedish- and US-based companies. The US and other trans-national hospital groups operating in the UK generate a particularly high level of revenue per bed (Talbot-Smith and Pollock, 2006). The policy of encouraging a diversity of providers into the NHS has created opportunities for private enterprises to secure NHS contracts. Specifically, the NHS plan emphasised the importance of commissioners contracting extra capacity from outside the NHS to treat more patients.

For many years independent for-profit hospitals have carried out small amounts of surgery for NHS patients, mainly on an ad hoc basis. The inception of the reforms discussed here has been marked by a large increase in the use of for-profit providers, mainly in the form of independent sector treatment centres (ISTCs), which have been set up to carry out routine NHS surgical work (HCHC, 2006a). ISTCs came into being against the background of long NHS waiting lists and pressure to separate acute and elective work in order to improve elective surgical throughput. The first wave of over 40 ISTCs was commissioned centrally by the Department of Health in 2002. The government's aim was that ISTCs will undertake half a million procedures per year by 2008, amounting to about 15 per cent of NHS elective activity. This was not achieved, although substantial amounts of care were delivered. Voluntary (Third Sector) and private organizations have also always delivered some secondary care services for the NHS.

ISTCs are run by a range of for-profit providers. Some are relatively large chains of private health care providers, including publicly quoted companies. All the organisations running ISTCs take the form of companies limited by shares. Companies have a separate legal personality which differentiates them from some of the ways in which not-for-profit concerns can operate. Commercial companies have a governance structure with a board of directors (including both non executives and executive directors) and shareholders. Directors make the day to day decisions, while shareholders have the power to make the most important decisions (e.g. winding up) and can appoint and remove directors. Usually, members have the number of votes in proportion to their number of shares in the company. Since ownership is associated with the capital contribution to the company, a company's primary financial obligation is to its shareholders, who usually expect a return on their investments in the form of a dividend, the size of which is in theory linked to the

profitability of investment in the company. In the case of bankruptcy, after the payment of debts, any remaining net assets of the company are distributed to the shareholders.

The main source of financial regulation for companies is the Companies Acts, which deal with a wide range of issues from the behaviour of directors to the use of share capital and winding up. ISTCs' provision of care is regulated by the Care Quality Commission. But the pay regulation imposed by the national NHS *Agenda for Change* policy does not apply, meaning that ISTCs can set their own rates of pay. All other relevant statutory regulations, such as health and safety, apply.

The contracts which companies make with the NHS are legally binding (as for FTs), and not subject to the current statutory exceptions for NHS Trusts. Current ISTCs are subject to contracts negotiated with the Department of Health at national level, rather than with local PCTs. These have not been made public. It is known that payment in these contracts is not on the basis of spot prices, but that cheaper rates were negotiated for certain volumes of care.

The Government announced its intention to treat 250,000 patients per year using ISTCs in September 2003, with an investment of £2 billion over five years (Department of Health 2003a). The work of the ISTCs would include the performance of 135,000 new operations, and 115,000 that had already been planned to take place in the NHS and would be transferred to the independent sector. ISTCs specialise in the delivery of elective (pre-booked) surgery and diagnostic services, primarily for operations with the longest waiting times such as knee, hip and cataract surgery. One of the main benefits of the specialist centres is that they are not required to perform emergency work, which may interfere with the programme of planned operations, and thus such facilities are better placed to see patients on schedule and reduce waiting times (Department of Health 2003b).

ISTCs were introduced to reduce waiting times for operations, which would become subject to a government target of a maximum of six months by the end of 2005, and 18 weeks in January 2008 (Department of Health 2002a). In October 2002, DH asked the Strategic Health Authorities (SHAs) to identify any anticipated gaps in capacity that might impinge on their ability to meet the 2005 waiting time targets. The exercise revealed the need for additional capacity across the country in specialist fields such as cataract removal and orthopaedics (Department of Health 2006c). Following a call from DH for expressions of interest from the independent sector to run the centres in December 2002, contracts were signed with a series of private companies in September 2003 and the first centre opened in Daventry in October 2003.

Contracts for running an initial group of 26 treatment centres distributed across England were awarded to a handful of private enterprises, with owners from the UK (Mercury Health Ltd; Birkdale

Clinic), North America (Anglo Canadian; Nations Healthcare; New York Presbyterian), and South Africa (Netcare UK; Care UK Afrox). This first wave of ISTCs became fully operational in 2005. As of April 2008, there were 25 wave one schemes in operation which were distributed throughout England. A second round of procurement, 'phase two', began in March 2005. The new programme covers both elective surgery and diagnostic tests, with the aim of providing 250,000 of the former and 1.5 million of the latter procedures per year. As of April 2008, there were 7 phase two schemes being run by private enterprises, each typically including a chain of treatment centres serving a geographical region.

Table 1. Major acute medical/surgical hospital operators by number of acute medical/surgical hospitals (overnight, day surgery only, and ISTCs) and number of overnight (inpatient) beds, mid-2007

Operator	#Hospitals overnight beds	#Hospitals day surgery only	ISTCs	Overnight Beds	beds %
1 Netcare	45[1]	1	5[5]	2392	25.0
2 Nuffield Hospitals	41	1	0	1700	17.8
3 BUPA Hospitals	25	0	2[6]	1420	14.8
Top 3 providers	111	2	7	5512	57.6
4 Capio Healthcare	20[2]	1	9[7]	923	9.6
5 HCA International	6[3]	0	0	763	8.0
6 Classic Hospitals	10	0	0	357	3.7
7 St John & Elizabeth	1	0	0	155	1.6
8 The London Cinic	1	0	0	144	1.5
9 Aspen Healthcare	3	0	0	141	1.5
10 Covenant Healthcare	7[4]	2	0	140	1.5
11 Medical Services International	1	0	0	128	1.3
12 Benenden Hospital Trust	1	0	0	120	1.3
Other Hospitals	36	72	20[8]	1189	12.4
TOTAL	197	77	36	9572	100.0

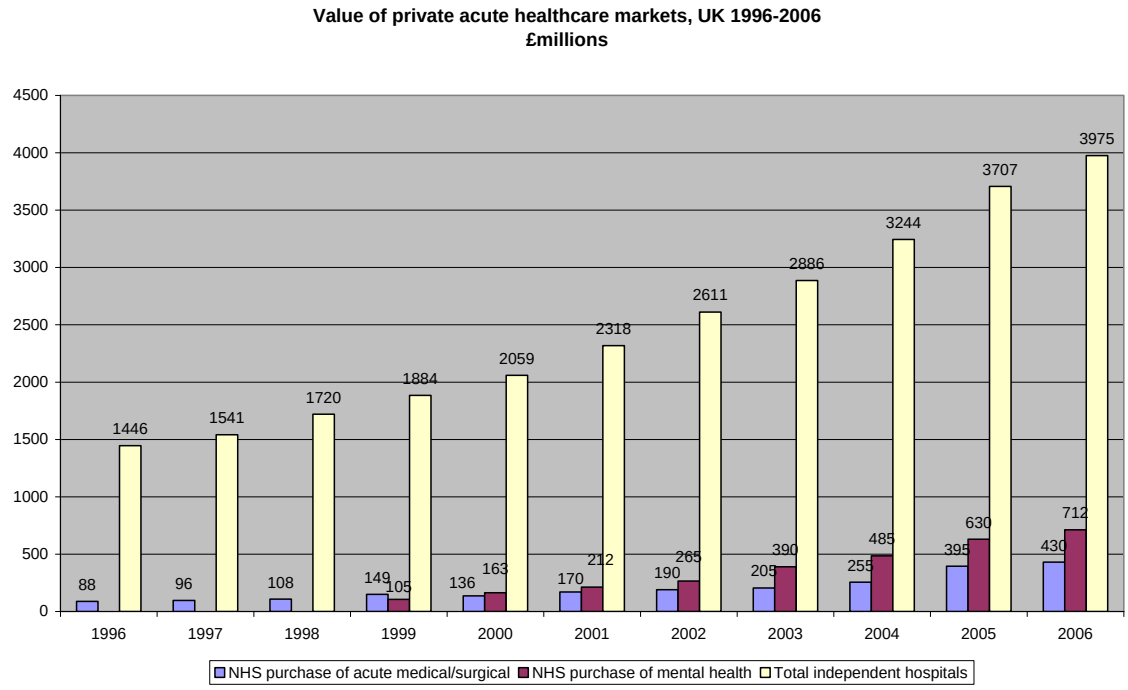
Notes:
Source: Laing's Healthcare Market Review 2007-2008
[1] including one Private Patient Unit (PPU) owned by BMI Healthcare, excluding three hospitals managed by BMI
[2] excluding two NHS PPUs managed by Capio Healthcare
[3] excluding one NHS PPU managed by HCA

[4] excluding two non-surgical clinics classified as hospitals
[5] includes 2 CATS, one under consultation in 2007
[6] 1 ISTC contract terminated in 2007 and 2 ISTCs new contracts signed 2007
[7] 8 contracts signed in wave 1, 1 contract signed in wave 2
[8] Includes 5 ISTCs of PHG, 2 ISTCs InterHealth Care, 6 ISTCs Mercury Health, 2 ISTCs UK Specialist, 3 ISTCs Nations Healthcare, 1 ISTCs Clinicenta, 1 CATS Care UK
BUPA is now Spire Healthcare
Capio is now Ramsay Healthcare
The number of ISTCs includes CATS.

Table 4. Resources by SHA

	Population '000	NHS budget £billion	# Acute NHS Hospitals	PCTs	# ISTC wave 1	# ISTC wave 2	Procedures contracted in ISTC[2]
North East	2,564.5	8.2	8	12	1	1	40,000
North West	6,864.3	10.6	29	24	2	5	316,300[2]
Yorkshire and the Humber	5,177.2	8	15	14	2	0	37,000
East Midlands	4,399.6	5.7	8	9	4	0	146,700
West Midlands	5,381.8	6.7	20	17	2	0	74,000
East of England	5,661.0	8.1	18	14	1	1	175,000
London	7,556.9	11.5	32	31	1	0	55,600
South East Coast	4,283.2	6	13	8	3	0	101,900
South Central	4,025.4	5.1	10	9	7	0	72,900[2]
South West	5,178.0	9.7	18	14	4	1	111,250[2]
England	51,092.0	79.6	171	152	27[1]	8	

Sources: Office for National Statistics, SHA's Annual Reports and web pages, Laing's Healthcare Market Review 2007-2008. Notes: ISCTs wave 2 includes CATS, does not include diagnostics schemes. [1] excluding a mobile unit contracted with Netcare UK. [2] Underestimated for lack of data for some contracts (see table 5). The contract period is 5 years.



As well as developing treatment centres within secondary care, the Government has also encouraged new entrants into the NHS to provide GP services. In March 2005, the then Health Secretary John Reid announced a programme of investment in new GP practices to increase capacity in areas of the country where there is a shortage of GPs (Department of Health 2005c). As part of this programme to address inequalities in healthcare provision, DH invited private companies to run GP practices, procuring such enterprises where necessary to fulfil patient needs in such 'under doctored' areas.

1.1.3 Third Sector enterprises and the NHS

The White Paper 'Our health, our care, our say' indicated that the Government interpreted the Third Sector as a source of knowledge, possessing links with underserved groups (and therefore well-placed to address inequalities) as well as expertise in specific health areas or types of care (Department of Health 2006b). DH defines a social enterprise as follows:

> Social enterprises are business-like entrepreneurial organisations with primarily social objectives. Their surpluses are mostly reinvested back into their business or the community to help achieve these objectives and change people's lives for the better. Social enterprises are not driven by the need to maximise profit for shareholders and owners.
>
> (Department of Health 2007a)

A social enterprise can take any legal form, including being a limited company, community interest company, co-operative, partnership, or charity. The only feature that unites these different organisations is the definition of social objectives, which should be underpinned by investment, although this does not necessarily imply that profits will not be distributed to owners or shareholders.

One of the important strands of supply side reform is the policy that, in addition to the corporate for-profit sector, commissioners should engage with new providers from the social economy including local voluntary groups, registered charities, foundations, trusts, social enterprises, and cooperatives (DH, 2006b). The aim is to develop the entrepreneurial impulse within health and social care, encourage entry of new providers, improve quality, and promote innovation. There are two reasons why not-for-profit TSOs may deliver higher quality services than for-profit organisations. The first is that the asymmetries of information that make consumer choice inoperative are decreased, especially if the organisation is client-led. The second is because non-profit organisations have no strong incentive to minimise costs. There is a survival constraint that should limit their costs, but no clear incentive to minimise costs as in for-profits (Hart et al, 1997; Grout and Stevens, 2003).

In order to support the entry of new social enterprises, and the Department of Health Social Enterprise Unit has identified a number of 'pathfinder' social enterprises as demonstrator projects.

Third Sector organisations (TSOs) are to play an important role since they are often client- and community-led (DH 2006b). There are about 35,000 TSOs in England providing health and social care services valued at £12bn, while a further 1,600 plan to enter in the near future (DH 2007a). Most provide services in the fields of mental health, disability, learning difficulties, or long term care. It is not clear how many of these would fit the definition of a social enterprise. The question of such a definition is discussed in the next section, as there is considerable confusion in policy circles about what a social enterprise is.

Social enterprises: definitions

Although TSOs have existed for many years (in fact centuries) in England, the use of the term 'social enterprise' to describe some of these is more recent. The EMES network uses the following definition of social enterprises: 'organisations with an explicit aim to benefit the community, initiated by a group of citizens and in which the material interest of capital investors in subject to limits' (Defourny and Nyssens, 2006). In this view social enterprises are not seen as simply a residual category of organisations which are neither part of the state, nor for-profit. In fact, they can be understood as entailing a mix of three elements: trading in markets (albeit without a profit

maximisation objective); benefiting from public support through public policies (and possibly also public funding); and embedded in civil society through collective action for common goals characterised by the public benefit dimension (Defourny and Nyssens, 2006).

Defourny (2001) makes the following suggestion for an ideal type for social enterprises:

a) Continuous activity, producing and selling goods and/or services
b) A high degree of autonomy from e.g. the public sector
c) Significant economic risk
d) A high degree of paid work, as opposed to volunteering
e) The explicit aim to benefit the community or a specific group of people
f) An initiative launched by a group of citizens sharing a well defined aim
g) Decision making power not based on capital ownership
h) Participation in decision making by various parties affected by the activities of the social enterprise
i) Limited profit distribution, avoiding profit maximising behaviour.

While this is not uncontroversial, it gives a starting point for considering the application of the concept to NHS related organisations.

Applicability of social enterprise definition to NHS related organisations

When considering the social enterprises involved in provision of healthcare to NHS patients, some of the aspects of the ideal type may be problematic in respect of certain organisations.

Some of the social enterprises consist of groups of health care professionals (usually nurses and other professions allied to medicine, such as dieticians) who were formerly employed by the NHS, and have been hived off into separate organisations (e.g. Central Surrey Health). It is not clear that element f) of the ideal type – an initiative launched by a group of citizens – can really be said to apply in these cases. The staff may not have had any choice about the change in the status of their organisation.

Using this ideal type, it is clear that FTs should not be considered as a form of social enterprise, rather than as socially-owned enterprises. The foregoing analysis of the legal and regulatory structure of FTs indicates that the following elements of the ideal type of social enterprise do not apply:

b) There is still a large degree of regulation and actual direction from government.

c) The question of economic risk for FTs has not been settled – despite policy announcement that they must be financially independent, to date no FT has been allowed to go under.

f) FTs are simply a different governance arrangement for pre-existing public sector organisations. They do not result from an initiative by a group of citizens.

h) It is not yet clear how much participation in decision making by stakeholders actually occurs in FTs, despite the introduction of a membership and a supervisory board, the few empirical studies of FT governance show mixed results, as stakeholders find a role for themselves (Allen et al, 2010).

As will be discussed below, TSOs take a wide range of legal forms, some of which do not fall within the ideal type of social enterprise either. Thus, one should be wary of using the term social enterprise to cover all the organisations involved in healthcare outside state-owned and private for-profit organisations.

Legal forms for Third Sector Organisations

TSOs can take a variety of legal forms in England. The issues of ownership, decision making and regulation will be addressed for different legal forms. It should be noted that for all of the legal forms of TSOs providing care to NHS patients, legally binding contracts with the NHS will be made. These are negotiated at a local level by individual PCTs and may vary.

Charities

It is important to understand that a charity is not a particular organisational form – rather it is a status which many kinds of organisational form may obtain.[4] The Charity Commission is the independent regulator of charities in England and Wales. Most charities must register with it to be accorded charitable status. It is necessary for the organisation to have charitable objects (there is a list of these in the Charities Act 2006 – they include the advancement of health), and these objects must also be for the public benefit. The main reasons for becoming a charity are that there are considerable financial benefits: there are many income tax advantages (such as no tax on profits, and tax relief for donations from individuals and corporations); and property taxes are lower. It is thought that public confidence in the organisation having laudable purposes is increased. Assets

[4] A new organisational form, called a Charitable Incorporated Organisation, is being introduced under the Charities Act 2006. This is not yet operational, but when it comes into effect, it will allow a charitable company to have a single registration with the Charity Commission, a less onerous form of reporting, a simpler constitution and duties for directors and members which are appropriate for charities, rather than companies (Charity Commission, 2008). If a charity is not in the form of a Charitable Incorporated Organisation, it must be registered with the Charity Commission and can also be a corporation registered under the Companies Acts.

must be applied to the charitable objects and cannot be distributed to members. The Social Enterprise Coalition (an English trade association and pressure group) takes the view that some social economy organisations do not wish to obtain charitable status because they see negative connotations in charities, which, due to the centuries long history of charitable donations, can be understood by some people as patronising and lacking in mutuality.

Unincorporated associations

Not-for-profit providers of health care may operate as a form of 'club' or unincorporated association rather than as a corporate body.[5] This form is best suited to membership organisations where members are involved in running the organisation themselves. They have the advantages of flexibility and enjoy low running costs as they are not regulated as incorporated bodies. They may also choose their own governance structures for decision making. This form of organisation does not have a legal identity distinct from the individual members. This causes several problems: legal liability is usually unlimited, so that individuals involved may be pursued for any debts or other liabilities run up by the organisation. Moreover, the organisation cannot enter into contracts or hold property in its own name (named individuals will be obliged to do this), and may find it difficult to borrow money as a consequence.

Unincorporated association can certainly be used as a legal form by genuine social enterprises, and could meet the characteristics of the ideal type of a social enterprise discussed earlier. However, unincorporated associations are probably not the best organisational forms to use for the delivery of health and social care where there are more than very small numbers of staff, as the responsibilities of running a larger organisation (such as renting premises, dealing with quality inspections and authorisations) can be better dealt with if there is a corporate structure.

Limited liability companies

Limited liability companies have a separate legal personality, which means they can enter into contracts and hold assets, and are governed by the Companies Acts. Although usually having profit-making objectives, they can also have public purpose objectives and act as if they are non-profits. The description of decision making, regulation and contracting in the section on for-profit companies above is applicable here.

[5] A partnership is also a form of unincorporated association. Limited liability partnerships are now also possible organisational forms. The latter have the advantage of the limited partnership itself being legally liable, and not the individual partners.

Companies limited by guarantee do not have a share capital. Instead, the members give a guarantee of a nominal sum which will be the maximum they would be liable to contribute if the company is wound up.

Companies limited by shares issue shares to their members. If the company is wound up, the maximum liability is the amount payable for the shares. As explained above, the issue of shares can be used to raise capital for the organisation. Profits can be distributed to shareholders in the form of dividends. A regular company limited by shares (as opposed to a CIC, see below) is unlikely to be a suitable vehicle for a social enterprise because decision making power is usually based on capital ownership (i.e. number of shares), thus violating aspect g) of the ideal type for a social enterprise.

Companies limited by guarantee can be registered as charities if they have suitable objects. It is unlikely that a limited company would be registered as a charity because of the ability to distribute profits to members.

Community Interest Companies (CICs)

CICs are a new form of limited liability company which was introduced by the Companies (Audit, Investigations and Community Enterprise) Act 2004 especially for social enterprises. (CICs can take the form of companies limited by guarantee, or by shares, so the relevant provisions governing decision making and ownership apply.)

The regulatory structure applying to CICs differs from that applicable to limited companies. The company must have primarily social objectives. There is a community interest test to become a CIC in which the company must demonstrate that a reasonable person would perceive its activities as being in the interests of the community (which means not having political motives or applying to an unduly restrictive group). In addition to the regulations which apply to all limited companies, there is also a new regulator specifically for CICs.

Assets can only be used for the stated community purpose. Surpluses must be principally reinvested in the business or the community. There is a dividend cap which means that payments out of profits to shareholders must be limited to 35% of distributable profits. A CIC cannot be registered as a charity.

Industrial and Provident Societies (IPSs)

These limited liability organisations have their origins in the self help and co-operative movements. Many are likely to fall within the ideal type of a social enterprise.

There is specific legislation governing IPSs (e.g. the Industrial and Provident Societies Acts 1965-2002 and the Cooperatives and Community Benefit Societies Act 2003). Nominal subscriptions to shareholding are made by members and the principle of one member one vote applies. Unlike the company structure, there is little statutory interference in the roles of participants. There is a committee of management or board accountable to the wider membership, but the distribution of powers and functions is flexible, according to the wishes of the IPS. On a winding up, members usually only have a right to return of their initial capital and not a share of the underlying asset value.

There are two models of organisation. The first is the *bona fide cooperative mutual* model where the organisation is formed for the benefit of its members, rather than society at large and which respects the core values of a cooperative. The principles of a cooperative are defined by the International Cooperative Association (ICA, 2009) (1) Voluntary and open membership; (2) Democratic member control (where members set policies and make decisions with equal voting rights); (3) Member economic participation (profits can be distributed to members, but not in proportion to size of shareholding); (4) Autonomy and independence (cooperatives are autonomous of government and external funders); (5) Education, training and information; (6) Cooperation among cooperatives and (7) Concern for community (working for the sustainable development of their communities).

The second is a *society for the benefit of the community*, i.e. one which pursues a wider public benefit rather than just its members' interests. This type of IPS (for example, a building society) cannot distribute profits to its members. In order to avoid demutualization and carpet bagging of profits which has occurred in some mutual organisations, this type of IPS can now apply an asset lock. This means that assets can only be distributed to another asset locked organisation (such as a charity or CIC) on winding up.

DH established a 'Social Enterprise Unit' in June 2006. The activities of the unit included establishing an investment fund, worth £100 million over four years from 2008/09 to 2010/11, designed to stimulate the growth of social enterprises through access to start-up capital, business and legal advice, and training. The unit also launched a £1.4 million 'pathfinder programme' in October 2006 that would follow a 'trailblazing' group of social enterprises that applied successfully for DH resources and mentorship. The initiative resulted in the funding of 26 social enterprise organisations. The awards allocated to the enterprises ranged from £5,000 (Bromley by Bow Centre, Tower Hamlets) to £655,000 (Lifestyle Solutions, Thurrock) in revenue and capital grants.

In addition to encouraging the entry of new providers from the Third Sector into the NHS, DH has also shown an interest in transforming existing NHS providers into social enterprise forms. In November 2009, the Care Services Minister announced that 20 organisations involving community-based staff within PCTs would be given support (including £30,000 of funding) to establish a social enterprise under the 'right to request' scheme. These new forms should ultimately benefit patients by providing existing NHS staff with 'the independence, flexibility and responsiveness to innovate and improve services and outcomes for patients' (DH, 2008a).

Community health services were one area where we thought that we might see activity by social enterprises. In comparison with hospital care, the amount of capital required to set up a business is much less. This is why we chose these services as one of the tracers for the study. In fact, there were few not for profit community health services operating in the four case study areas, and none delivering the main stream services (mainly district nursing) to frail older people in their homes. We made some further inquiries about the scale of transformation of NHS community health services into social enterprises across the country.

Under the Department of Health's right to request scheme (DH, 2008a), all primary and community health staff employed by PCTs can put forward a business case to set up a social enterprise. If approved, their PCT will support the development of the social enterprise and award it a contract to provide services. In November 2009 the Department of Health announced that organisations had exercised their right to request in respect of twenty projects, and were each awarded £30,000 additional funding to help with development of their local social enterprise. The types of services to be transferred into a social enterprise varied from whole PCT provider arms (i.e. all NHS community health services in an area) to small scale services specifically for homeless people (DH Press Release, 2009).

There is no information about the progress of these organisations systematically available from the Department of Health, although there have been reports in the press about staff resistance to some of these proposed transfers (e.g. Hull and Kingston upon Thames). As one of the key points of becoming a social enterprise is to involve staff more fully in the running (and ownership) of their employer, it is surprising that the 'right to request' has been exercised in areas where staff themselves are not in favour of being transferred out of the NHS.

The Department of Health announced earlier in 2010 that the organisational forms for all community health services had to be agreed by 31st March 2010. However, not all the arrangements have in fact been finalised at the time of writing.. We have investigated the position in respect of the

twenty community services listed as wishing to become social enterprises in November 2010. Out of the twenty places announced in November 2009, there are currently four PCT areas where all community services are being transferred from the NHS to social enterprises. There are a further four PCT areas where small scale projects for specific services will become social enterprises.

The trade union, UNITE, has been involved in supporting NHS staff who are opposing transfer to social enterprises. UNITE surveyed all English SHAs to find out where the right to request had been exercised (UNITE, 2010) and has kindly shared the results with us. These show that, as at March 2010, twenty five organisations across England had exercised the right to request, that being more than the twenty announced by the DH in November 2009. These were not evenly distributed across the country. In some SHA areas there were none (South West Coast SHA, West Midlands SHA, North East SHA). There were seven in East of England SHA and eight in London SHA.

The UNITE survey also reports that two of the original twenty organisations announced by the Department of Health in November 2009 were not going ahead with transfer to social enterprise (West Essex and Bedfordshire). The reason for this is that when staff were consulted, ballots indicated that they did not wish to leave the NHS. In other words, it was not the staff who had originally exercised the right to request, but the management, who were then unable to persuade staff.

The research aimed to understand the influence of the characteristics of these new providers from the private and Third Sector, including motivation and innovative activity, on the performance of the NHS services that they were contracted to deliver, and compared to NHS provision.

1.2 DIVERSE PROVIDERS, QUALITY AND INNOVATION - REVIEW OF LITERATURE AND RESEARCH HYPOTHESES

A wide range of organisations now provide health care. These organisations make use of several distinct legal forms, depending on their objectives (and these vary even among TSOs). The different ownership, regulatory and decision making structures of each type of organisation may contribute to their respective capacities to provide efficient, responsive and high quality services. Currently, there is little evidence to compare their performance.

Despite the aspirations of English policy makers, evidence from other countries discussed in this report does not indicate that non state providers are necessarily going to perform better than those owned and run by the state. While economic theory can be used to demonstrate that that both competition and altruism have a positive effect on quality and quantity of care (Grout and Stephens,

2003; Ben-Ner, 2006)), empirical evidence from the workings of the NHS system (with its complex interrelated reforms) is lacking. In order to draw conclusions from any future empirical quantitative evidence collected about the relative performance of different organisational forms of provider, is it important to understand how these providers are actually governed. Both analysis of formal (legal) governance structures and empirical examination of actual practices are required. In other words, the 'black box' of each type of organisation needs to be opened to examine their internal workings. This is necessary in order to draw the correct conclusions about the relationship of organisational form to performance. For example, in respect of FTs, there is some evidence of low levels of participation of new stakeholders (Allen et al, 2010).

Supply side reforms are being introduced into the NHS in England in order to increase competition (and thereby efficiency). Preker et al (2000) and Vining and Globerman, (1999) argue that independent providers can be more technically efficient than the public sector. This view is based on the idea that the incentives for providing services at lower costs are stronger outside the public sector, especially where there is a profit motive and surpluses can be distributed to owners of the business. The increased use of diverse providers is aimed to address a further objective of the reforms; that is improving providers' responsiveness to patients' needs. TSOs are thought to be particularly good at this (DH 2006a). This is expected especially among non-profit social enterprises, because they are businesses with primarily social objectives, whose surpluses are reinvested. Due to their 'intrinsic' social motivations they may be more effective in mobilising 'prosocial behaviour' than for-profit private enterprises (Bartlett, 1996). While for-profits may seek to cut quality in order to save costs and raise profits, the TSO with its non-distribution constraint has less incentive to seek commercial gain from quality reduction (Francois, 2002). However, research into domiciliary care providers in England shows that motivation is also sensitive to the situational context (Kendall et al, 2003). There is also evidence that, where TSOs are client-led, they find it easier to respond to client needs (Weisbrod 1988).

Hart et al. (1997) argue that in a for-profit organization contracted by a government to provide public services the incentive to minimise costs will dominate incentives to improve quality (for which higher prices have to be negotiated). As a result, the private provider will under-supply quality in areas where the level of quality is not specified in precise terms in the "contract" (the set of regulations applying to the private contractor) but is directly related to costs[6]. If reducing costs does not damage quality, the private firm will supply higher quality in that model. On the other hand, if

[6] "Incomplete contracts" in this sense are the rule, as uncertainty makes it impossible to specify all eventualities in a contract or regulation and instead makes it desirable to allow flexibility in the contract, for example by allocating control over decisions regarding how to respond to new events (Coase 1937).

there is little opportunity to reduce costs and public sector employees are able to derive significant benefits from improvements in quality, public provision may dominate (ibid). A key feature of this model is that demand comes from state procurement rather than directly from the consumers of the service, so that the for-profit provider has little incentive to respond to consumer demand in areas that are not fully specified in its contract with the government.

This model may apply to services supplied by ISTCs (all for-profit providers) in areas in which not all possible contingencies can be specified in the regulation. Among the aspects of quality that can be observed by patients, one such area might be answering patients' questions and generally providing them with information about their care and health. National Minimum Standards applicable to the independent sector provision of information specify mainly process requirements for information provision (Department of Health 2002b) as in one of the examples considered by Hart et al. (1997). While being difficult to specify, providing information to patients in a way that will satisfy them may require costly staff time. Given that referral decisions have tended to be made primarily by GPs or to be constrained by supply, profit objectives may therefore cause private providers to under-supply quality in the area of patient information, all else being equal. On the other hand, the prospect of increased patient choice may also provide ISTCs with sufficient incentives to supply increased quality in areas in which it can be measured by patients.

Better quality may be provided by the public sector if state employees are more intrinsically motivated and choose to work for organizations that will not expropriate in the form of profit the social benefits accruing from their work (Gregg et al. 2009). This possibility is ignored in the model proposed by Hart et al. (1997) though it can be accommodated in that model as one of the cases in which government employees receive high rewards from improving quality (a case only envisaged with extrinsic incentives in the model). A number of studies suggest that public sector employees behave like intrinsically motivated agents and that extrinsic incentives can be counterproductive with intrinsically motivated people (Benabou and Tirole 2006, Gregg et al. 2009, Georgellis et al. 2009; see also Besley and Ghatak 2003).

Studies of motivation in UK (public) Hospital Trusts have shown intrinsic motivation to be present not only among consultants but also Trust managers (Kendall et al 2003). However, Trust managers were found to be a heterogeneous group from the point of view of intrinsic motivation (Crilly and Le Grand 2004) and the balance of intrinsic and other motivation depended on the individual and local circumstances (Kendall et al 2003). Mannion et al (2007) suggest that the recent reforms did not always provide senior Trust managers with the degree of genuine autonomy or recognition in which intrinsic motivation can flourish (see Frey and Jegen 2005). The nature of incentives may still differ

between the two sectors, with more incentives to cut costs provided to senior staff in the private sector. At other levels, there have been regulatory limitations on ISTCs' capacity to hire NHS staff. Although these restrictions have been partly lifted (Sussex 2009) they may explain the better part of current differences between NHS and private-sector staff. It is thus unclear whether self-selection along intrinsic motivation and preference for the public sector could be a major feature differentiating NHS staff from private-sector staff at this stage (for example, extrinsically motivated staff currently with the NHS may not be able to join the private sector). .

The predictions of the theoretical literature regarding the compared quality of care provided in the two sectors as it is measured by patients' perceptions are therefore ambiguous, with the possible exception of cost-related but imprecisely regulated aspects of quality like patient information.

1.3. EVIDENCE FROM PREVIOUS RESEARCH

As the introduction of new forms of provider into the main stream of the NHS (apart from mental health and termination of pregnancy, where both profit making organisations and TSOs have been active for some years) is quite recent, there is very little evidence currently available to compare the performance of the three types of provider. There is some international evidence about comparative performance, however. In general, the evidence (which mainly comes from the United States and Canada) does not indicate that it is the ownership of the organisation which makes the most difference to performance. Krashinsky (1998), when looking at child day care in Canada finds that 'variation in quality within each auspice is more important than the differences in average quality of care among the auspices' (p 17). Schlesinger (1998), when looking at US healthcare providers, found that the environment in which the organisations operated was an important factor in their behaviour, irrespective of ownership form. Looking at the evidence concerning efficiency and quality, we can conclude the following. First, concerning the efficiency of providers, while at a system level, there is some evidence from the US that increasing diversity of providers may well decrease costs of each provider (Dranove and Satterthwaite, 2000), it is probably not the type of provider which makes the difference to efficiency, but the market conditions under which competition is increased. In general, studies of ownership have produced mixed results, indicating most of them similarities among hospitals. Eggleston, Shen, Lau, Schmid and Chan (2008) present a systematic revision of this literature and explain how the variability of responses in different studies depends on which confounders (variables that affect performance and are related to ownership) are considered when the researcher tries to isolate the effect of ownership. In sum, it appears that ownership matters in performance but not always in the same direction; this depends on the context (institutions, market, time and location).

Evidence on performance and average cost differences between for-profits and TSOs in the health sector is mixed and it has been argued that the level of competition which all organisations face is more important than the ownership of the organisation (Sloan, 2000; Sloan et al, 2001). There is no convincing evidence in the health care sector that for-profit organisations are more efficient than TSOs (Vining and Globerman, 1999; Sloan, 2001). While there is little evidence comparing quality of care between types of provider, there is evidence (from outside the UK) that competition with negotiated prices leads to falls in quality of care (Propper, 2007). This is relevant to the current policy environment in the NHS as the aim is to use a wider range of providers to stimulate supply side competition. Moreover, even in a situation with fixed prices (such as the current NHS) where unlike under price competition there are weaker incentives to reduce quality to cut costs, quality will not necessarily improve (Zwanziger et al. 2000). And, as quality of healthcare has many attributes, there will be over production of those which can be observed, as opposed to harder to measure aspects (Propper, 2007).

1.3.1. Foundation Trusts

As far as the performance of NHS FTs is concerned, one quantitative study has so far looked at their financial performance compared to other NHS hospitals which have not yet obtained FT status (Marini et al, 2007). This study focussed on two financial measures which would indicate the extent to which FTs are benefiting from their more autonomous status inside the NHS. The first was retained surplus, measured as a proportion of total expenditure. The surplus is regarded as a proxy for good quality financial management, and is encouraged by the regulator (Monitor). If having FT status were to be seen as beneficial to performance, one would expect the retained surplus to increase on hospitals obtaining FT status. The second measure is the Reference Cost Index which allows one to measure FTs' costs of production in comparison to all NHS hospitals' costs. This can be seen as a measure of relative efficiency, although it does not take account of the quality of care. One would expect FTs to be more efficient, as they are subject to greater incentives to retain surpluses. The results of the study did not show that obtaining FT status affected either of these two measures as one might predict. FT hospitals do perform better than non FT hospitals, but the better performance predates the change of status. In other words, there were long standing differential trends in performance between hospitals which are not significantly affected by becoming an FT. There are no quantitative studies of the quality of care provided by FTs, as opposed to other NHS trusts, currently available. One reason for this is that the situation is changing fast. High performing NHS trusts are becoming FTs as soon as they can, so that it is hard to make stable comparisons.

1.3.2. ISTCs

The most important form of entry of for-profits in the English health system has occurred through the creation of Independent Sector Treatment Centres (ISTCs). These are very specialized centres treating elective surgery, mainly in orthopaedics and eye hospitals that are the most occupied services in the NHS centres. This degree of specialization joint with the possibility of not running emergency rooms allows these centres to offer very profitable services and benefit from economies of scale. For example, for the U.S., Horwitz and Nichols (2007) find that emergency rooms are relatively unprofitable and capital intensive according to all the sources consulted (academic literature, interviews, insurance data, press, physician salaries). He also finds that orthopaedic surgery is profitable according to academic literature, interviews and the business press. In the U.S., the probability of for-profits and non-for-profits to offer orthopaedic surgery is significantly larger than in government hospitals, although there are not significant differences between for-profits and non-for-profits.

It has not been possible to compare the financial performance of for-profit organisations (primarily ISTCs) being used to treat NHS patients because the Department of Health will not release sufficient data about the ISTCs, claiming it is commercially confidential (HCHSC, 2006; Pollock and Goddon, 2008). The government has stated that a premium of an average of 11% above the NHS tariff is being paid to ISTCs (Hewitt, 2007)[7]. Pollock and Godden (2008) have attempted to use publicly available data to investigate the productivity of ISTCs. They report that there are insufficient data from the private sector to be able to make estimates – numbers of available and occupied beds are not reported. The routine admissions data about each episode of hospital care submitted by the private sector are seriously defective (Healthcare Commission, 2007) and cannot yet be used to produce reliable evidence of the quality of care delivered by these organisations.

Problems about how the ISTCs have been contracted have been reported by a number of sources. One problem has been that the siting of the new centres was not sufficiently sensitive to local factors (HCHC, 2006). Another problem has been insufficient demand in some local areas, and in cases where ISTCs operated below capacity, they were able to retain the full contractual price because payment was made (for the first wave) on a block basis, with no refunds for reduced volumes.

There is currently one pilot study comparing the quality of care given by ISTCs with that given by NHS hospitals in respect of a series of surgical procedures (Browne et al, 2008). This study involved

[7] This applies to first-wave ISTCs

the collection of original data directly from patients to be able to compare the outcomes of surgery in each type of organisation. When adjustment was made for pre-operative characteristics, patients undergoing three types of surgery in ISTCs achieved a slightly greater improvement in functional status and quality of life than those treated in NHS facilities, while the opposite was true of patients in respect one other type of surgery. Patients treated in ISTCs were also less likely to report post-operative problems than those treated in NHS facilities for three types of surgery. However, care must be taken in extrapolating from this study, as only six ISTCs participated and case-mix adjustment (i.e. taking account of the differences between the patient groups treated in ISTCs, as compared to NHS facilities) might have been insufficient.

1.3.3. Third Sector Organisations

There do not appear to be any robust quantitative studies comparing the performance of not-for-profit providers of health care to NHS patients with the performance of state owned NHS providers. This may be due to the fact that, until recently, there has been limited participation in mainstream NHS provision by TSOs. (It has mainly been in the areas of mental health and termination of pregnancy services). Another reason may be that many TSO providers are moving into areas of community health services provision, and the data concerning these services, whether inside the NHS or otherwise, is limited.

There is one interesting study of users' views comparing public, for-profit and TSO provision of services. The National Consumers Council undertook a study for the government Office of the Third Sector (Hopkins, 2007). This did not include any actual health services, but domiciliary social care for older people was included. The study found that older people thought that private sector providers were slightly better at providing what they wanted compared to the public sector and TSOs. There was little difference between the public sector and TSOs, except that the latter were distinctive compared to public sector providers in respect of two factors: keeping their promises and having staff who were prepared to go out of their way to help.

1.3 AIMS OF THE PROJECT

The aim is to assess the impact of provider diversity on quality and innovation in the NHS. The research objectives are:-

(i) to map and characterise provider diversity in local health economies

(ii) to identify differences in performance including quality and innovation, between Third Sector organisations, private enterprises, and incumbent NHS organisations as providers of health care services,

(iii) to investigate the factors that influence the entry and growth of new entrant providers, including the commissioning process.

(iv) to investigate the impact of entry of new providers on the performance and innovation capacity of incumbent providers.

CHAPTER 2: METHODS

2.1. QUALITATIVE METHODS

The results presented in this report are based on 48 semi-structured interviews with managerial and clinical staff from a variety of NHS organisations, including NHS Trusts, Foundation Trusts, and PCTs, as well as providers from the private and Third Sector. The interviews were conducted in the local health economies (LHEs) associated with four PCTS across England, herein referred to as PCTs A, B, C and D. (See Appendix A4 for details of the number and types of staff in each organisation and each LHE). The staff were selected to include both senior managerial staff and senior clinical staff dealing with our tracer conditions (see below). The choice of case study areas was made to reflect differences in relative levels of deprivation and demographic characteristics, including variation in the size of black and minority ethic (BME) communities, as increasing provider diversity is supposed to help address these needs. To facilitate the analysis, two tracers were used, elective orthopaedic surgery (replacement of hips and knees) and some health care for older people with heart failure, chronic bronchitis (COPD), or other medical frailty, which we expected to be covered by all three types of providers.

PCT A covers a large conurbation in the south west of England, with a population of around 380,000. According to the Census 2001, the largest ethnic group is white (91.8%), followed by Black Caribbean (1.5%), Indian (1.2%), and Pakistani (1.1%). On the Index of Multiple Deprivation 2007, PCT A ranks as the sixty-fourth most deprived local authority in the country. PCT B is an inner-city borough in London, with a population approaching 160,000. The largest ethnic group is White (78.6%), followed by Black African (3.8%) and Black Caribbean (2.6%). The borough has the highest life expectancy for men and women in England and Wales. On the Index of Multiple Deprivation 2007, PCT B is the least deprived area of the three under study in the research. PCT C is an inner-city borough in London, with a population of approximately 195,000. The borough is ethnically diverse, with just over half the population describing themselves as White, followed by Bangladeshi (33.4%), Black African (3.4%), and Black Caribbean (2.7%). According to the Index of Multiple Deprivation (2007), PCT C covers one of the most deprived local authorities in England. PCT D covers a town in the north of England with a population of around 200,000. The town is predominantly white (84%), but there are significant groups of Pakistani (6.3%) and Bangladeshi ethnicity (4.5%). The town is relatively deprived, ranking as the fortieth most deprived local authority in England on the Index of Multiple Deprivation 2007.

Prior to arranging the interviews, a series of interview guides were prepared that were geared towards different categories of interviewee, including NHS commissioners, and the CEO, finance director, clinical director, and frontline staff of provider organisations. The interview guides were designed to reflect the objectives of the provider diversity project, specifying questions related to mapping provider diversity; identifying differences in provider performance; factors that influence the entry and growth of new providers; and the influence of new providers on the performance of incumbent NHS providers. The average length of interview was around 45 minutes although some interviews lasted considerably longer. All of the interviews were recorded using a Dictaphone and transcribed in full.

The majority of the interviews were conducted between November 2008 and November 2009, although a handful of additional interviews predominantly in PCT D were completed in the first quarter of 2010. The empirical data was collected largely prior to the announcement on 17 September 2009 by Andy Burnham, the then Secretary of State for Health, that the NHS should be treated as the 'preferred provider', casting some doubt on the future role of diverse providers from the private and Third Sector.

The interviewees were asked to supply documentary evidence, such as their constitution and annual reports, an organigram, contracts, and routine performance and contract monitoring data. However, in some instances, our requests for this information were declined as interviewees cited reasons of commercial confidentiality. The types of documents received and analysed were contracts made by the PCTs with local providers, mainly NHS organisations; lists from each PCT of contracts with non NHS providers; and the PCTs' commissioning strategies and annual reports.

Additionally, a focus group was arranged to gauge services users' satisfaction with new forms of provider. This took place within the LHE surrounding PCT B and involved service users and volunteers related to two Third Sector providers of care services for older people. This provided information on quality of service provision, gaps in service provision and views about the relative merits of different types of provider organisations. Despite, strenuous efforts, it was not possible to arrange focus groups in the other LHEs.

2.2. QUANTITATIVE METHODS

Data from surveys of patient experience are used to investigate whether hospital ownership has an effect on the level of quality reported by patients and whether different aspects of patients'

experience are affected in different ways by hospital ownership. Severe informational asymmetries imply that patients may not be well placed to assess the clinical quality of health care. However, other dimensions of care quality such as cleanliness or privacy can be observed by patients. Indeed, it can be argued that certain aspects of quality are best measured by patients, as for example whether patients are given explanations they can understand about the operation or side-effects of medication, or whether they are treated with dignity. The data we use come from surveys carried out annually among in-patients of NHS hospitals by the Care Quality Commission and among ISTC patients by the Department of Health. The surveys include identical questions about the patient's experience, ranging from the cleanliness of facilities and food quality to explanations provided by medical staff, delays, privacy and dignity. The data also include information about patient characteristics, state of health and overall area of treatment (hospital specialty) but do not cover clinical quality.

The approach used is multivariate regression in order to test whether hospital ownership affects the quality of the experience reported by patients in areas other than clinical quality, once we take into account observed patient characteristics and other relevant factors that may influence the quality of patients' reported experience, including the selection of patients into a private or public hospital and individual hospitals' specific characteristics. Quality is measured using scores constructed from patients' answers along several "domains" of care quality defined by the Care Quality Commission from the survey questions, as well as three dimensions we identify using factor analysis. We estimate a switching regression model in order to test not only for an overall effect of ownership on the level of quality, but also for the possibility that patient characteristics, self-rated health, length of stay and hospital specialty play a different role in determining the level of quality reported by patients in public and private hospitals. ISTCs have been contracted to treat routine cases, while patients with more sever, complex or risky conditions, which may affect the quality of their reported experience, are directed to NHS hospitals. Non-random factors, such as co-morbidity and risk, can cause individual patients to be referred to a public or to a private hospital. We incorporate this selection into the model. Finally, we use hospital fixed effects to control for unobserved hospital-specific characteristics, such as resources, staffing or the age of the premises, which may determine patient-observed quality. Hospital fixed effects keep unobserved hospital-specific characteristics constant and focus the analysis on variations among patients in each hospital (Glick 2009). Our approach makes it possible to isolate ownership effects from the components of the level of care quality reported by patients that are attributable to observed and unobserved patient characteristics determining the choice of hospital; and from unobserved hospital-specific characteristics that are

present in both public- and private-sector hospitals but may be more frequent in one of the two sector (such as new premises, for example) for reasons other than ownership.

We find that the experience reported by patients in public and private hospitals is different, i.e., most dimensions of quality are delivered differently by the two types of hospitals, with each sector performing better in some areas of quality in certain specialties and/or for certain groups of patients. However, the sum of all ownership effects is not statistically different from zero. In other words, hospital ownership in and of itself does not affect the level of quality of patients' reported experience. Differences in average quality levels reported by patients in the private and public sectors are entirely attributable to patient characteristics, the selection of patients into public or private hospitals and hospital-specific characteristics that are not systematically dependent on ownership.

2.2.1. The patient experience surveys

The data we use come from the 2007 round of the annual NHS Trust Inpatient Survey and the 2007 and 2008 ISTC Inpatient and Day Case quarterly patient surveys. Both series of surveys are conducted by the Department of Health and the Care Quality Commission. The surveys collect data on questions concerning patients' experience in a range of areas including admission and delays, being given and asking for information about various aspects of the operation, comfort, cleanliness and food quality, etc. The NHS survey has been running since 2001 and the ISTC survey has been designed to produce results that are directly comparable with the NHS survey. For both surveys, consecutive recently discharged patients are sent a postal questionnaire a few weeks after discharge and two reminders are sent to non-responders. In each acute NHS trust, 850 patients are surveyed annually, and 300 patients per participating ISTC are surveyed every quarter. The ISTC surveys include both inpatients and admitted patients treated as day cases, whereas the NHS surveys do not include day cases. However, there is a wide variation among NHS trusts in patients' average length of stay and there is no conclusive evidence on the effect of length of stay on patients' evaluations of their care. Both surveys include adult patients aged 16 and over, and exclude maternity patients and patients who had a termination of pregnancy.

For the analysis, we selected elective admissions in the NHS hospital sample for comparability with ISTCs, where all patients are elective cases. We also remove London Strategic Health Authority (SHA) cases from the analysis because the ISTC sample doesn't include cases in the London SHA, and keep only cases in the nine specialties that are treated in ISTCs as well as NHS hospitals. The final sample includes 21,680 cases in NHS hospitals and 16,767 cases in ISTCs.

Patient experience data have not always been found to be systematically related to key aspects of clinical quality (Glick 2009; Leonard, 2008). However, this type of data is appropriate to assess other aspects of quality that are observed by patients. Because many of the questions are of a subjective nature, as for example questions about how the patients rate their care, this type of data may not provide the most precise estimate of absolute levels of care quality at a particular time--though surveys administered some time after discharge from hospital, as here, are less subject to the "courtesy bias" that inflates answers in exit surveys administered as the patient leaves the hospital. The measures of quality provided by patient experience data may incorporate varying patient expectations, though the limited effect of social and demographic patient characteristics (for which we control here) on this type of measure of quality suggests it does not simply reflect the expectations of different groups of patients (Hall and Dornan 1990, Westaway et al 2003). The interpersonal quality of care, in particular, seems reliably measured by patient experience (Kane et al 1997). In addition, patient experience survey data are sensitive to differences in quality among patients treated by the same provider and are reliable for analysing the determinants of patient satisfaction and making comparisons across providers (Leonard 2008, Glick 2009).

2.2.2. Analysis of HES data: ownership and emergency readmissions[8]

Emergency readmissions after discharge from hospital provide a standard measure of clinical quality in the literature. In the HES data set, it is possible to construct individual patient spells, which allows assessing the effect of hospital ownership on the probability for a patient of being re-admitted in an emergency *t* days after being discharged from the hospital, conditional upon having been out of the hospital since discharge (i.e., the hazard of being readmitted in an emergency at time *t*) while controlling for patient characteristics and morbidity. This type of duration model estimation produces more precise estimations of ownership effects than models looking at emergency readmissions rates at the hospital level (rather than the patient level) and has been used to examine the effects of hospital ownership for example in the US and Taiwan (see Sloan et al 2001, Lien et al 2008). The hazard of emergency readmission for patient *i* is modelled as a function of patient, condition and organizational factors:

> Hazard of being readmitted in an emergency at time *t* since being discharged = *f* (diagnosis/severity of case, patient characteristics, organisation characteristics).

The objective of the analysis was to investigate possible differences in clinical quality between public and private-sector providers and among NHS providers. We therefore selected a "tracer" set of

[8] We had proposed to investigate the effect of hospital ownership on clinical quality of care with Hospital Episode statistics (HES) data. However, due to delays in obtaining access to HES data and changes in the structure of the project, we were unable to carry out more than exploratory analyses, the findings of which we report below. Once both the theoretical framework (see Zamora et al 2008) and methodology (Pérotin 2008) for our investigation had been discussed, we applied for an extract of the HES data. The data set arrived in January 2009. Preliminary data analyses, the construction of variables and construction of individual patient-provider spells from patient hospital episodes were completed by Dr Bernarda Zamora at Bristol University by late summer 2009. However, staff changes in September 2009 made it necessary to re-allocate project work and contract a new researcher with the advanced econometric skills necessary to continue the analysis. We applied for data access for a new researcher (Dr Karl Shutes) and for permission to move the data to Leeds University, with remote access from Dr Shutes' university in Coventry, in August 2009. The HES Service Management Team responded on 12 November 2009 agreeing to our moving the data to Leeds but requesting more information regarding staff changes and our arrangements for Dr Shutes' access to the data. Unfortunately, Dr Shutes was no longer available by that time, so in early December we requested permission for another researcher (Dr Greenwell Matchaya) to access the data in Leeds, explaining the situation and stressing that we were pressed for time as the project was now scheduled to end in April 2010 (after an extension had been granted). The HES Service Management Team's response came on 11 January 2010 in the form of another request for more information and a suggestion that we put in a new application altogether in view of the many changes to our original application. Although the HES Team did offer to speed up the processing of a new application, it appeared very unlikely that Dr Matchaya would get access in time to perform the complex analyses we had planned before the end of the project. Dr Zamora agreed to spend several days in Leeds to carry out some more work on the data (since we did not have permission to access the data set remotely) and was able to complete the exploratory analyses we report below.

procedures that both NHS and private-sector hospitals carry out on NHS patients—elective orthopaedic surgery.

We have access to Hospital Episode Statistics (HES) data for the fiscal years 2004/05, 2005/06 and 2006/07[9]. In those years, we have selected the sample of patients whose clinical Treatment Specialty was Trauma & Orthopaedics. In the HES data set, this is the specialty in which the consultant treating the patient was working during the period of care. In most cases, this specialty coincides with the Main Specialty under which the consultant is contracted. This initial sample included 913,911 patient episodes for 2004/05; 959,175 episodes for 2005/06; and 992,401 episodes for 2006/07[10].

The findings from the analysis of the HES data are reported below in Section 3.5.

2.2.3. Survey of provider organisations

A survey was designed to collect data that would permit us to compare the performance of diverse providers of health care in the case study areas. Two questionnaires were developed, one focussing on the providers of orthopaedic surgery (the Hospital Questionnaire) and another that focused on providers of healthcare to older people in their own homes (Community Services Questionnaire). The target areas were four local health authorities in included the study. The study units/ the hospitals and establishments were obtained from the Care Quality Committee (CQC) website. The process of questionnaire designing and testing culminated in the months of August and September 2009. Both the hospital questionnaire and the community services questionnaire were drafted at the University of Leeds, with the help of the project advisory committee and other project members. Both questionnaires were available on paper as well as online. The online questionnaire was managed within the Bristol Online Surveys (BOS) system which is secure and user-friendly and is used by more than 200 institutions here in the UK.

The Questionnaire

The questionnaire contained three sections on (i) hospital ownership and governance, (ii) staff activity and resources, and (iii) innovation and quality monitoring. A link of the online questionnaire was sent to two project members for testing to identify any problems in the design and execution of the questionnaire. MsWord based questionnaires were sent to the advisory committee members for

[9] Before 2004, the presence of the private sector is not significant and not well captured in HES data.

[10] We would like to thank Roy Maxwell, Richard Cookson, Andrew Street and Mauro Laudicella for their helpful advice and discussions of the HES data set and variables.

comments. The questionnaires were also sent to two officials well-versed with health policy issues, and their recommendations were also considered and incorporated. Piloting did not take place because it would reduce the number of potential final respondents, and because of the rigorous design process which had been applied.

Hard copies of the questionnaires and their cover letters were mailed to organisations identified through the Care Quality Commission's website. The cover letters contained information on the links to the online questionnaires to complete them online. Around 250 community services questionnaires and 250 hospital questionnaires were mailed on 26th November 2009, and respondents were asked to complete either the online or paper-based version by January 31 2010. The questionnaires were deliberately sent to as many organisations as possible within the broad areas that related to the types of care we were targeting according to the Care Quality Commission's website, including organisations that provided home social care but might also be providing healthcare to older people[11]. When it became clear by Mid January that the response rate was going to be lower than expected, we commissioned a second stage of the mail-out which began with phone calls to the target establishments to find out whether they had received the first set of questionnaires. The phone calls also sought to gather further contact details about the establishments including names of contact persons and emails. The second stage of questionnaire mail out was launched in the third week of January 2010. Within this phase, electronic versions of the questionnaires together with links to online questionnaires and cover letters were sent to the respondents via email. Phone calls were also made after a few days to encourage the respondents to complete the questionnaires.

Low Questionnaire Response Rate

The response rate to both questionnaires and in both phases was low. Only three questionnaires out of the expected 39 were completed on paper, while 20 questionnaires were returned because the organisations were not providers of health care and at least five were returned as they establishments had closed down. Only two online questionnaires were completed, of which only one was correctly filled. During the calling stage, some respondents stated that the survey was of no relevance to their business, or that the survey questionnaire sought intrusive information that they were not willing to provide while others argued that the questionnaires were too long and costly to fill in terms of time and procedures they would need to follow to obtain the required data. Even for

[11] However, later comparison with the lists of organisations mentioned by commissioners showed very little overlap with the organisations listed by the Care Quality Commission: in our four LHEs the Trusts seem to commission care from organisations outside those listed by the CQC for their areas.

the respondents whose concerns were related to confidentiality, efforts to persuade them to tackle only those questions they felt safe to answer did not yield any real results. The low response rate precluded further analysis of the questionnaire survey data.

This lack of data means that we were not able to provide direct quantitative comparisons of governance and performance indicators between the organisations in our case study sites. This meant that we were not able to examine the effect of specific individual hospital characteristics, such as resources or staffing, on patient experience or on readmissions. We were also unable to examine possible variations in quality within each sector (public and private) that might be associated with differences in governance and levels of staff involvement in decisions. Instead, we used other survey data on patient experience and patient episodes in acute care in the NHS and the for profit sector to provide evidence on comparative performance; and on the qualitative research to provide evidence on aspects of governance.

CHAPTER 3: KEY FINDINGS AND RESULTS

3.1. MAPPING PROVIDER DIVERSITY IN THE FOUR CASE STUDY SITES

At the outset of the research, the PCT commissioning teams within each LHE were asked for a list of providers from the NHS and private and Third Sectors with whom they were contracting. The information we received varied in quality but indicated on the whole a relatively limited proportion of contracts by value going to diverse providers. There was greater involvement of diverse providers in the field of orthopaedic surgery than in the provision of home health care for older people. This appears to be the result of the national ISTC programme which encouraged private sector providers into the market to deliver orthopaedic surgery. In the absence of a similar programme in community health services, this area (e.g. District Nursing) remained dominated by the provider units of PCTs. The provider arms for community services within all four PCT were becoming arm's length entities, although none had registered an intention to become a social enterprise under the national 'right to request' scheme. In community health services, many of the relationships with non-NHS organisations were commissioned jointly with the local authority reflecting the work of these providers at the interface of social and health care. Despite these broad trends, there was some variation in provider diversity across the LHEs studied and this is described below.

In PCT A, there were two main NHS Trusts serving the city covered by the PCT, one of which had Foundation Trust status. There was also a Wave 1 ISTC offering elective orthopaedic procedures that had been operating within the area since 2005. There were also two independent hospitals within the area that provided a small volume of orthopaedic services to the PCT and Trusts on a spot-contract basis. The majority of services for older people at home were provided by the PCT directly or via the local authority. There were around 10 other organisations providing services for older people under contract with the PCT, including for-profit organisations and charities.

In PCT B, based in the London area, there were two major NHS Trusts offering elective orthopaedic services, one a Foundation Trust and the other an academic health science centre. In the area of home care for older people, we were unable to identify any alternative providers, however a number of charities operating in the area did provide more general services for older people such as community-based activities and a variety of care 'signposting' information. In PCT C, also within London, there were two main NHS Trusts with facilities for elective orthopaedic surgery, including one with Foundation Trust status. The care of older people was dominated by the PCT and the local authority, with alternative providers emerging more in primary care (a for-profit organisation and a

social enterprise were running GP practices). In the London area, there are no Wave 1 ISTCs offering elective orthopaedic procedures. However, a number of private companies were awarded Phase 2 ISTC contracts to deliver a range of clinical procedures in the area, including diagnostic services (e.g. MRI scans) and out-of-hospital care.

In PCT D, there was one NHS Trust in the town covered by the PCT, although the PCT also had a relationship with a nearby NHS Foundation Trust (a neighbouring PCT was the lead commissioner). The PCT also manages the contract with a Wave 1 ISTC operating within the area. With regard to services for older people, the PCT works with 15 alternative providers, the majority of which are for-profit providers.

An overview of the size of the NHS and independent sector in each case study area is shown in Table 3.1. The share of the independent sector is highest in PCT B by share of total beds, with over half of all beds in the PCT area and almost three quarters of all the beds operated by independent sector providers in the four case study areas.

Table 3.1: NHS and Private Beds by PCT

PCT	NHS beds	Independent beds	Total beds	Independent sector beds/total beds	Shares of all independent sector beds by PCT
A	4,070	337	4,407	7.6%	5.7%
B	3,061	4,253	7,314	58.1%	72.3%
C	2,437	425	2,862	14.8%	7.2%
D	4,406	868	5,274	16.5%	14.8%
All	13,974	5,883	19,857	29.6%	100.0%

Source: (i) Care Quality Commission website, (ii) the NHS Direct website, (iii) individual hospital websites, and (iv) Dr Foster's website (http://www.drfosterhealth.co.uk/hospital-guide/full-hospital-list/nhs-hospitals-w.aspx)

The share of the commissioning budget going to diverse providers across the case study areas was relatively small at the time the interviews were conducted. For instance, for PCT A, the commissioning director estimated that only a few million pounds of a budget in excess of £650 million was being spent on private and Third Sector organisations. In contrast, the two acute NHS Trusts in the area accounted for almost half of the total commissioning budget available. A similar perspective was offered by the commissioning director for PCT D:

> If you exclude GPs from being part of the independent sector, which, as subcontractors to the NHS they are, it's a minority, it's a very small minority of our budget that goes to the independent and Third Sector compared to what we spend within or with NHS providers.
>
> (D01, Commissioning Director, PCT D)

In PCT D, we were informed that from a budget of £365 million for 2008-2009, only 2.6% was awarded to private sector companies and a mere 0.6% went to Third Sector enterprises. The largest contract was held with the ISTC situated within the area, which accounted for over 50% of the budget allocated to private sector organisations. This was followed by a contract worth over £2 million for musculoskeletal integrated clinical assessment and treatment services (ICATS). The third largest contract (worth almost £1million) was for ICATS in urology. The largest contracts with Third Sector providers were for palliative care, young people's sexual health services, and mental health services. The largest Third Sector contracts were not as valuable as those awarded to private sector providers, with the largest being worth £110,000.

3.1.1. Health care for older people at home

The research sought to collect health care quality data from organizations drawn from four Local Health Economies namely; PCT A, PCT C, PCT B and PCT D. The aim of the exercise was to attempt to "map" the distribution of providers of domiciliary healthcare to older patients, in each area across ownership types—public sector organizations, private for-profit organizations and social enterprises. We started out from the database of the Care Quality Commission (CQC). That database also lists the date at which the organisation registered with it or its predecessor (the Commission for Social Care Inspection). Thus we were able to examine whether recent commissioning reforms had led to the entry of independent sector providers.

The CQC database presents health providers by local health economy (LHE). It distinguishes public, private (for-profit) and voluntary sector providers which are registered as charities (but not other types of social enterprises). The CQC lists domiciliary healthcare together with domiciliary social care, so we had to assess whether each provider was supplying healthcare on the basis of supplementary research using web and Companies House searches, and phone enquiries. Services provided by the NHS, rather than local authorities, are not listed separately from PCTs. Using the Care Quality Commission database of providers of healthcare, the research found the following.

Table 3.2 Number of Independent and Local Authority Healthcare Providers by Local Health Economy

		PCT A	PCT B	PCT C	PCT D	Total
Voluntary		1(6.3%)	2(22.2%)	2(28.6%)	2(28.6%)	7(17.9%)
Private	nurse owned	3(18.8%)	1(11.1%)	1(14.3%)	0(0%)	5(12.8%)
	other	9(56.3%)	4(44.4%)	2(28.6%)	3(42.9%)	18(46.2%)
Local Authority		3(18.8%)	2(22.2)	2(28.6%)	2(28.6%)	9(23.1%)
Total		16(100%)	9(100%)	7(100%)	7(100%)	39(100%)

In PCT A, there appeared to be a total of around 16 non-NHS organisations providing healthcare to older people at home. Out of the 16 organisations, 12 (75%) were run by private owners of which three were run privately by nurse agencies) and only one (6%) was run by the voluntary/charity sector and three (18.8%) were run by local authorities. A majority of these appear to have registered with the Care Quality Commission by 2004 but there are still quite a few (nearly one-third) that appeared to have registered with the Care Quality Commission more recently (2007 and 2009), indicating that there has been recent entry in the sector. Among the five organisations that registered between 2007 and 2009, four (80%) were from the private sector. The only voluntary sector organisation we have identified from the CQC list (20% of the entrants) entered in that recent period.

PCT B had a total of nine identified non-NHS providers of healthcare to older people at home. Among the nine providers, five (55.5%) were privately owned, two (22.2%) were owned by the local authority, and the remaining two (22.2%) were run by voluntary/charity organisations. Six (67%) of the organisations in PCT B were registered by the Care Quality Commission between 2003 and 2005 while the remaining 3(33%) registered with the Care Quality Commission between 2006 and 2009, indicating that the LHE has enjoyed some entry of new organisations into the provision of healthcare to older people. Among the new entrants, 33 % were from the voluntary sector.

In PCT C we identified seven non-NHS providers of domiciliary healthcare to older people, of which three (43%) were privately owned, two (28.6%) were voluntary and the other two (28.6%) were run

by the local authority. All these healthcare providers in PCT C appeared to have registered between 2003 and 2005 and there was no indication that there were any recent entrants of healthcare providers to older people at home. Among the seven providers, there was only one private provider that was run by nurses. It should also be mentioned that in some cases there seemed to be an overlap of provider types and in a few cases some organisations were reported as privately (for profit) owned by the Care Quality Commission and as charities on their respective websites. For instance, the two privately owned organisations in PCT C seemed to be parts of charity organisations too[12].

In PCT D, there were seven non-NHS organisations providing healthcare to older people, of which three (42.9%) were private providers, two (28.6%) were provided by local authorities while the other two (28.6%), were voluntary organisations. Unlike the cases of PCT A, PCT B and PCT C, PCT D did not have any care providers owned by nurses. Six out of the seven organisations that provided health care in PCT D registered with the Care Quality Commission between 2004 and 2005, while the remaining one had its registration in 2009 indicating that there was entry of at least one organisation in the for profit private sector. The four Local Health Economies together provided the following general picture:

Table 3.3.Total number of non-NHS health care providers to older people in the four Local Health Economies

	Voluntary	Private	Local authority	Total
Domiciliary	7	18	9	34
Nursing agency	0	5		5
Total	7	23	9	39
Per cent	17.9	59.0	23.1	100.0

In sum, it seems that together, the four Local Health Economies (PCT A, PCT C, PCT B and PCT D) had 39 non-NHS organisations providing healthcare to older people at home according to the Care

[12] http://www.acth.org.uk/ the website of Age Concern, reports Age Concern is a charity even though the CQC reports it as a private (for profit) provider and it states that the private part of Age Concern,which is called Age Concern PCT C Enterprises Limited, is an insurance company. This information is also available from the Company house website (www.companyhouse.co.uk)

Quality Commission's website. For-profit private sector providers accounted for 59 % of the providers followed by the local authorities which constituted 23 % of the providers, while the voluntary sector accounted for the remaining 18 %. Nursing agencies owned only five of the 39 organisations that seemed to provide healthcare in the four local health economies, representing a percentage of 12.8.

This account shows that the four local economies generally had a low number of non-NHS health care providers, and voluntary sector participation in the sector seems low but growing over time as evidenced by the new entries reported herein. In total, the new entrants accounted for nearly one fourth (23%) of the non-NHS healthcare providers. Out of the total new entrants, the voluntary sector accounted for 11% while the remaining 89% were from the for-profit sector. A larger proportion (35%) of the total number of for-profits, entered recently while only 14 % of the total number of voluntary organisations, were new entrants. This means a fair amount of entry among non- NHS providers were by for-profits and for-profits have higher entry rates than voluntary organisations.

Table 3.4. Post-2005 entry into home healthcare provision for the elderly, by ownership type

	For-profit	Non-profit	New entry out of total non-NHS
PCT A	4	1	31.3%
PCT B	2	1	33.3%
PCT C	0	0	0 %
PCT D	1	0	14.3 %
Share of entry	77.8 %	22.2 %	23.1%

Table 3.4 shows the proportions of new entrants per total number of service providers in each PCT and overall, and their distribution among the for-profit and non-profit sectors. New entrants accounted for about one-third of the total number of non-NHS service providers in PCTs A (31.3%) and B (33.3%). In contrast, there were no entrants in PCT C and only one (14.3%) in PCT D. New entry seems to have been overwhelmingly (about 80%) in the private for-profit sector, the remaining entrants being non-profit organisations. It is possible that some of the organisations categorised as for-profit in the CQC list were for-profit arms of non-profit organisations, so that entry may have

been less unbalanced overall. However, it is unlikely that the majority of entrants were non-profit organisations.

These figures are consistent with the information collected by the qualitative part of the research which shows that commissioning of diverse providers is limited in its scope and even where commissioning has taken place, the funds involved are a small proportion of the budgets of the concerned PCTs. For example, commissioning information showed that only about 35 independent providers within PCT A were commissioned against a total of 48 independent providers potentially available in the area as per the Care Quality Commission website (in all areas of healthcare). Lastly, none of those which were in contract were social enterprises.

The financial data shows that the money involved in the commissioning exercise in the private and Third Sectors in PCT A amounted to about £10 million against a budget of about £675 Million[13] for the whole PCT. In contrast, almost half of the commissioning budget went to NHS trusts and the picture is the same with the other PCTs. For instance it seems that in PCT D, from a budget of over £300 million for 2008-2009, only around 3% was awarded to private sector companies and a mere 0.7% went to Third Sector enterprises. The pattern is unchanged with respect to the 2009/2010 budget of around £334 million. In the 2008/2009 budget the largest contract was held with the ISTC situated within the area, which accounted for over 50% of the budget allocated to private sector organisations. This was followed by a contract worth over £2 million for musculoskeletal integrated clinical assessment and treatment services (ICATS). The third largest contract (worth almost £1million) was for ICATS in urology. The largest contracts with Third Sector providers were for palliative care, young people's sexual health services, and mental health services. The largest Third Sector contracts were not as valuable as those awarded to private sector providers, with the largest being worth £110,000. The spending in the private sector was substantially more than that of the Third Sector and accounted for about 82 % of the total expenditure in the private and Third Sectors.

[13] http://www.PCT A.nhs.uk/theTrust/Reports/annual_audit_letter/

3.2. DIFFERENCES IN PERFORMANCE AMONG DIVERSE PROVIDERS – EVIDENCE FROM QUALITATIVE RESEARCH

The empirical research aimed to identify differences in performance among different types of provider distinguishing between those already within the NHS, for-profit private sector providers, and not-for-profit Third Sector providers. The performance characteristics of each type of provider will be discussed in turn.

3.2.1 NHS providers

The study involved research on NHS organisations from the acute sector and community health services. In the acute sector, interviews were carried out with NHS Trusts and Foundation Trusts providing orthopaedics services in each PCT area. In community health services, interviews were conducted with managers responsible for provider services within the PCT in each area.

NHS acute sector providers

The performance of acute care providers within the NHS will be discussed according to the themes of comprehensiveness and user engagement.

Comprehensiveness

As expressed in the policy framework advocating the introduction of private sector providers such as ISTCs, there is a qualitative difference in the breadth of services being undertaken by incumbent NHS providers and the specialised or niche services offered by private sector organisations. For the managers of incumbent NHS organisations, the long tradition of providing public health care within the NHS was perceived to give them an advantage over new providers emerging from outside the NHS. For example, the CEO of the Foundation Trust in PCT A believed that the distinctiveness of his organisation stemmed from its historical embeddedness in the local area and communities as well as its ability to provide a wide range of services, including emergency care and tertiary services. This was in contrast to private sector organisations that had recently started contracting with the NHS and had a more precarious position, as he stated in interview:

> We're well sited in the city centre and we have strong links with the universities. People like the fact that we're involved in research and teaching, and patients take some comfort in that. We've been around for a few hundred years, so people know that we're going to be around, hopefully, for the next few hundred years and that we won't be gone in three or four years when things don't look as good financially. We have tertiary specialties, so things that not

> many other hospitals can replicate, and things like bone marrow transplants, cardiac surgery, you know, more complex and – which can't be recreated by the Independent Sector Treatment Centres without a lot of expense. Also we have three A&Es here, Eye, Children's and Adults, General Adults' A&E, and again, that's not replicated in the independent sector, because they can't currently hope to provide the necessary specialties to back up the A&E.
>
> (A03 CEO Foundation Trust March 2009)

This sense of possessing a distinct set of capabilities when compared with the private sector also extended to standards of clinical governance. According to the Foundation Trust within the LHE surrounding PCT B, private sector providers did not appear to have the same regime of clinical management as acute NHS organisations. With regard to an emerging partnership with a private sector provider in the field of sexual health services, the strategy director of the Foundation Trust described in interview the main areas in which the partner they were working with seemed to need the most support:

> I think a lot of it comes down to the clinical expertise and the infrastructure around governance and, you know, management in particular. So if you look at it, what they need from us on sexual health is what lots of organisations will need. If you're a private provider, it's not – we've got a lot of Consultants around, you know, you have to be a pretty large private provider coming up against us to be able to have the same level of, you know, clinical input, the same level of experience in clinical governance, and the same, kind of, infrastructure for being able to, you know, put queries back up the food chain if there is something that's not quite right. So I think a lot of that, they don't necessarily have. I think it'd be different if you were going up against a BUPA or something but, you know, where it's newer, smaller companies, they've got to buy a lot of that in.
>
> (B08 Strategy Director Foundation Trust 14/09/09)

Incumbent providers possess distinct capabilities when compared with new providers due to their longer history of providing health care services, affording the generation of established clinical specialisms supported by relevant staff and governance practices.

The managers of acute NHS providers that we interviewed remained committed to the NHS as an effective organisational model for producing a comprehensive system of health care. This was contrasted with private sector providers that were thought to focus more on generating innovation within profitable areas of care. This meant that incumbent Trusts and emerging private sector providers were delivering services in only partially overlapping areas of care. For instance, the Foundation Trust located within the area covered by PCT A did not carry out a high volume of elective orthopaedic procedures and was not therefore significantly affected by the arrival of an ISTC to the area. Instead, the orthopaedic work they did carry out tended to be more complex trauma work that involved specialist consultant care. According to the clinical director of the Foundation

Trust, the provision of complex care in orthopaedics and many other service areas was not something that the private sector would have an interest in replicating because of the higher costs involved and the need to develop broad standards of clinical governance and programmes of training:

> I have some considerable concerns about ISTCs and the potential for independent providers to destabilise the overall business of providing healthcare, and I think it's potentially worrying. And a good example is probably the Eye Hospital here where there is always easy cherry picking work that can be done, and any sensible business that was being set up totally privately, that had no overall responsibilities to a health community, would find it quite easy to identify bits of the workload that they could take off and do at less than cost over high volume work, whilst at the same time paying no regard whatsoever to a lot of the underlying factors that are involved in healthcare provision. So healthcare provision is about sorting out somebody's cataract, but it's also about training the other Doctors to do it; it's also providing the governance and structures behind it that ensure not only the cataracts, but all of the other bits in the Eye Hospital work well. It's also about providing care to more complex things, which aren't financially viable to do.
>
> (A02 Clinical Director Foundation Trust March 2009)

For consultants, the NHS was also seen as a prestigious place to work and one from which satisfaction could be derived due to the convention of sharing clinical practice within a community of colleagues, as the clinical director for orthopaedics from the acute Trust in PCT A stated in interview:

> I work pretty hard for the NHS and I wouldn't want to work full time private. I enjoy the Trauma, which is never going to become privately, I enjoy the teaching and I enjoy the, you know, the colleagues and the banter with the ability you've got to discuss it. You know, we have morning meetings for the Trauma and there's four Consultant's there, you know, and all of that. You know, in terms of training, you've got the Junior Doctors all there, you've got your medical students, and you all talk through the cases that came through the night before and it's a good format, and you don't get that in the private sector. So, you know, the private sector is very nice, you know, you get better facilities on the whole, get the equipment you want when you want it, you know, nice rooms for the patients with colour television, etc, having said that, it's probably in NHS now as well.
>
> (A07 Clinical Director Trust March 2009)

In summary, NHS providers are well placed to provide a comprehensive system of health care, from which innovation emerges in the areas of clinical specialty that different Trusts have developed over time. This system – often based on a combination of service delivery, research and teaching – appears to sustain the production of clinical communities of practice in which staff attach high importance to dialogue with colleagues over clinical practice to support learning and teaching. The links of NHS providers with research and teaching are discussed in further detail in section 3.4.

User engagement

The NHS providers that we interviewed increasingly saw patients as a group that they needed to engage with in order to improve their services. One of the acute Trusts that we spoke to, based in PCT A, interacted with patients via a 'patient panel', the administration of an annual patient survey, and with the support of a recently appointed marketing lead that aimed to improve the Trust's responsiveness to the views and experiences of patients. The CEO of the Trust, however, believed that the membership body associated with Foundation Trusts offered a more systematic model for tapping into the interests of patients and the local community, one that offered an opposing perspective on the running of the Trust's services:

> We've got lots and lots of patient groups associated with different specialties, but they're in the too grateful category, so they don't really want to challenge. So it's great that we've got them, and great that services use them, but they aren't quite so structurally involved as the FT membership.
>
> (A10, CEO, Trust, March 2009)

The following quotation from an interview with the CEO of a Foundation Trust operating within the same area illustrates how a membership body can be used in order to advise on the frontline delivery of services such as new service developments:

> We use members to advise on service developments, to be involved in improvement activities, to look through reading material, to look at all sorts of things, yeah, so we have a database of 16,000 members, half of which are our staff, and we can select them by their interest group, so if we wanted 50 members who are interested in Cancer Services, we can pull those off the database this afternoon, and write to them and say, "We're thinking of doing this, you know, what would you think to that proposal?" And we've done a fair bit of that since we started.
>
> (A03 CEO Foundation Trust March 2009)

However, when compared with health care organisations that serve particular niches of the community the interviewee saw a gap between the insights that the membership body could provide into health care needs, and the ability of a Foundation Trust automatically to address those needs through developments in health service provision. A Third Sector organisation, for example, might possess the skills required to address those needs, as the CEO of the Foundation Trust stated in interview:

> Well, the membership body gives us a perspective, a partner organisation gives us a capability, so, you know, the membership organisation might say, "You need to work with the prostitutes in this area for this particular service." And we'd be like, "Yeah, we agree." The Third Sector would say, "And this is how you do it," and we've got three workers in that area who know

> most of the prostitutes in that area and we know how to get to them, and what they like and dislike and how to involve them in, you know, in designing services, as an example.
>
> (A03 CEO Foundation Trust March 2009)

The interviewee recognised that there were complementarities between his own organisation and Third Sector providers of health and social care, particularly in areas of care that involve making connections with specific groups of service users in the community.

In summary, NHS providers are beginning to focus more attention on user engagement, with Foundation Trusts in particular making use of their membership to advise on service developments.

NHS providers of community health services

The field of community health services was an area of NHS care that many of the interviewees from the NHS recognised as having potential for improvement. The provision of community health services was undergoing change as provider units that were situated historically within PCTs were being separated from the commissioning function of the Trusts. The PCT provider units in the LHEs that we studied were all engaged in this process, although the emerging priorities and organisational form of each provider differed. Additionally, the provider unit serving PCT B was undergoing a horizontal merger with the provider units from two neighbouring PCTs. These changes in provision are described in this section.

One of the provider arms that we spoke to was involved in the Department of Health's Community Foundation Trust (CFT) pilot programme. The transition towards becoming a CFT, which involved setting up an independent provider board and separate financial accounts, had made the organisation more attuned to the needs of the community they were serving. As the managing director of the organisation stated in interview, the potential of this organisational form for improving engagement with the local community had attracted them to apply to be involved in the pilot study:

> I think if you go back to the origins of the Foundations Trusts as a movement it is, in essence, a social enterprise within the NHS. And the attraction for us, in part, of the FT is that we believe we would have an opportunity to engage with our community in new ways, and that we would genuinely be a community owned and based organisation. And that's because our staff probably touch the lives of every extended family in [town in PCT D] because of the age range and services we offer, and they have great credibility with local people. And I think for many of our local people - I mean we serve a very diverse population, very, very high levels of health inequality - they traditionally wouldn't have engaged in formal consultations around services and redesign, but we're finding that they are willing to engage with services that they're familiar with, that are very much a part of their lives and their communities. So we see that the

> real attraction is the governance arrangements of a Foundation Trust allow both the local population and our staff to hold the board to account, and to influence through their membership and the governors the priorities of the organisation and how we progress those.
>
> (D05 Managing Director PCT Provider Unit 12/09/09)

While precluded at this stage from establishing a formal membership body, the organisation had introduced a 'Friends programme' in which staff invited patients to become 'friends' of the provider arm allowing them to opt for a varying degree of involvement in how services are run:

> So local people and staff can become a Friend at three levels; they can just want to receive information about our services or what we're doing, they can express an interest in a particular service, say children's services or older people's services or diabetes, or they can be interested in formally sitting on groups, committees, focus groups, whatever. So we've built a database - that we're then very gradually growing - of local people who are actively engaged on our development and whom we call on to support us around various aspects, whether is was our Standard for Better Health declaration or if we're doing a review of a service. Or we've now got a number of Friends who we're training up to be quality champions who will go into services and engage with patients, families, clients, to ask them about their experience of the quality of the service.
>
> (D05 Managing Director PCT Provider Unit 12/09/09)

The creation of a new organisation – based on a new vision, set of values and strategic objectives – had also allowed the managers of the provider arm to set new expectations for staff regarding patient and community interaction:

> I think the advantage we've had is setting up as a new organisation, in essence, even though we've not yet formally separated completely, we've been able to start with staff saying this is how we do things and that we expect to engage with individuals, with groups, with communities, however they are designed. And that's just how we work with people; we're very clear that we're here to serve the community. So there's very much an ethos of engagement, co-production with the community and staff, and that things are not on a command and control top-down model, that's just not how we do things. So there are lots of examples where staff have engaged with patients and local people to change services, to check out whether those changes have been an improvement, you know, it's just what they expect to happen.
>
> (D05 Managing Director PCT Provider Unit 12/09/09)

At this stage, it is too early to comment on the impact that the renewed emphasis on patient involvement is actually having on the performance of services being provided by this organisation but it does illustrate a commitment to a process of learning and improvement through the involvement of local people.

The PCT provider arms in the other LHEs had also been through a period of organisational restructuring that aimed to grant greater autonomy to providers to deliver community health services. This has resulted in greater attention being paid to the strategic management of these services by the new managerial boards put in place to run these organisations. This process starts with managers making decisions about which services they should be focusing on themselves, and which might be better delivered by partner organisations or competitors:

> I think there's been a real cultural shift actually, particularly around Community Services, that I think we're clear that we don't want to be there providing all and everything. We want to be concentrating on what I would call core business and being really, really good at it, rather than trying to – well let's get big and viable, more viable, so let's just do anything, and then it just become – you become a weak organisation, I think. And we have got a lot of expertise in specific parts of the journey, patient journey, so let's build on that and sell that to other organisations or partner organisations, rather than trying to take over the one.
>
> (A06 Consultant Nurse PCT Provider Unit March 2009)

This emphasis on core competencies indicates that elements of a market culture are emerging in the field of community health services as providers aim to build up their own repertoire of marketable skills and know-how, as a source of competitive advantage against potential rivals. The sense of being a provider within a competitive market also extended to a new emphasis on the way that providers market themselves to PCT commissioners and other organisations, as the managing director of the same provider stated in interview:

> …we've done some marketing master classes. I've got some meetings in April [2009] to talk about how we market our strap lines and our logos; how we market ourselves to external providers. And then we've got some work about – once the market analysis work is complete, it's targeting services, you know, those potential partners, working with them, creative thinking sessions.
>
> (A05 Managing Director PCT Provider Unit March 2009)

This awareness of market competition was also visible in the strategies of the provider units that were separating from PCTs B and C. For instance, the managing director of the provider unit associated with PCT B stated that they were becoming a more 'commercial' organisation focused on income generation, rather than the budget allocated by the PCT:

> rather than talk about budgets now, we talk about what the income for a service is, so it's not just you're given money to run this service, we have to earn the income, you know, and that's all to do with performance and contracted activity. So we are moving to a much more, sort of, commercially minded organisation, both the services that we currently provide, but we're

> starting to respond to tenders put out for, I think, for new services outside of our geographical patch.
>
> (B02 Managing Director, PCT, Provider Unit, 10/06/09)

Similarly, the managing director of the provider unit at PCT C, who was a recently appointed interim director with significant experience gained in the public and private sectors, stated that the lack of commercial skills or knowledge had been an issue within community health services for some time and this was driving the current reforms to NHS providers:

> I think nationally there's a recognition that there is a skills / competency deficit in provider organisations, particularly, I think, in terms of commercial awareness, business development aspects. I think probably professionally in terms of we've got highly talented people, but I think in terms of business awareness and competitiveness and those sorts of things that it hasn't been well developed for various reasons. There isn't the skills and competency; there isn't the information supporting structures. And I think to some extent most people would agree that it's been an area that community services have not had the attention they deserve in terms of developing them into a more businesslike organisation.
>
> (C08, Interim Managing Director, PCT Provider Unit, 15/06/09)

Since separating from the commissioning function of the PCT, this organisation had focused on driving up productivity through an audit of its district nursing service. This involved the completion of timesheets by the staff that provided information on the time they spent with different patient during the day. The provider unit had also introduced performance management meetings for nurses and they are now made aware of how productivity varies across different teams within the service, with the aim of highlighting good practice and transferring it from team to team. These changes led to a reported 20% gain in productivity within district nursing, with further gains anticipated as the audit revealed opportunities to adjust the skill mix based on introducing lower banded staff to undertake many everyday nursing activities.

In summary, all of the providers of community health services that we spoke to were undergoing organisational change, involving the creation of independent reporting structures and a reflexive evaluation of capabilities and performance. As these changes are ongoing it would not be appropriate to comment on their effectiveness, but they do all indicate a more commercial focus being adopted by NHS providers of community health services.

3.2.2 For-profit providers

For-profit providers were delivering services in acute, primary and community health services in the case study areas. There were two first wave Independent Sector Treatment Centres (ISTCs) providing

elective orthopaedics procedures in the case study sites, one close to PCT A and another in PCT D. However, we were unable to gain access to the ISTC in PCT D so the results presented here on elective orthopaedics provision relate only to the ISTC in PCT A. We were informed that the contract pertaining to the ISTC in PCT D was coming to an end in March 2010. Additionally, we were able to arrange interviews with Wave 2 ISTC organisations based in London and other areas of England, as well as for-profit primary care and community health services organisations. The performance of these providers will be described according to a number of characteristics: technical efficiency, user orientation, organisation structure, and innovation.

Technical efficiency

The for-profit organisations that we interviewed were often committed to technical efficiency as a means for generating a financial surplus. The focus on efficiency was aided by the limited domain of services that many of these organisations provided (for example, a range of routine elective procedures or diagnostic services) allowing them to focus on the most productive means for delivering clear pathways of care. For instance, in PCT A we spoke to the chairman of a for-profit company that owns a Wave 1 ISTC which opened in July 2005. The enterprise is a private company owned by a consortium of UK and US institutional investors. The facility is staffed by 24 doctors and has 34 inpatient beds and 8 outpatient rooms. The centre undertakes 12,000 procedures a year, including orthopaedic surgery, endoscopy, radiology, MRI, and physiotherapy. By March 2009, the centre had undertaken over 33,000 procedures in total.

The centre reports a 'culture of clinical quality' and has had no cases of MRSA since opening and only two cases of hospital acquired C-difficile. The hospital's average length of stay for total joint replacements is 4 days, comparing favourably with the average in the NHS of 6.7 days. The centre reports a 'new service delivery model' that is 'designed from the basic principles of what patients need and what is important to them' (NHS Treatment Centre Outcomes Report 2008/09, p.5). The centre receives referrals via primary care or waiting lists for NHS hospitals according to pre-agreed criteria. Then, they are contacted by the bookings team and offered a choice of outpatient appointments. Prior to attending the centre, patients complete a pre-assessment healthcare questionnaire and, on the day of the operation itself, the patients are seen in timed slots one hour before surgery.

In an interview with the organisation's chairman, he indicated that their service delivery model affords a high level of technical efficiency. The centre provides its services via a carefully constructed patient pathway. This begins with clear admission criteria that excludes those patients with 'unstable

co-morbidities'. Once accepted for treatment, patients are educated about the treatment process at the centre:

> The innovation is that we have a very carefully constructed pathway for patients entering treatment and almost from the point of the first outpatient attendance patients become very aware of what to expect when, what the outcomes are likely to be, what their role in it is, how they can interact and/or change things. It's a very structured, very sensitised process so that patients, for example, will be advised and encouraged to prepare for the operation. They'll be advised and encouraged to understand what that means, and if they follow the pathway and work with us, the outcomes for them are far more effective than typically where those things aren't in place. For example, if we're doing a knee we'll ask people to exercise before the operation. We'll ask them – we'll advise them of what standards they can expect, what the pain thresholds will be, what the procedure will feel like. The Physiotherapist will help them work it up and – so that they come to the centre on the day of the operation fully aware of what's likely to happen during surgery and post surgery and when they can expect to go home and what their role is when they go home. You know, there's a lot of education in the pathway.
>
> (A13, Chairman, Independent Sector Treatment Centre, 5 June 2009)

The pre-sorting of patients allows the centre to operate a shorter length of stay than that found traditionally in the NHS and it can therefore perform procedures at a lower average cost. The ability of the centre to specialise in performing a limited range of procedures offered to a pre-defined group of patients creates an environment geared towards technical efficiency.

This ISTC's performance seems to emerge from a competitive motive, driving both efficiency and a 'the need to be seen to be better than anything that is provided in the public sector in terms of outcomes and quality'. This has been achieved by designing a technical system able to operate according to principles of efficiency – a system in which the clinician is rendered a component in the production process and holds little sway in how the hospital is run. Critically, the interpretative skills of frontline clinicians are not as important because the treatment centre only undertakes planned procedures and the pre-assessment of patients skews the case mix towards more routine cases. While committed to technical efficiency, the organisational culture of such organisations may only be appropriate for approaching a relatively limited range of clinical procedures.

A commitment to efficiency was also found among other private sector providers that we spoke to during the research. For instance, the chief executive of a privately owned provider that was not involved in orthopaedics services, but had recently been awarded a contract to deliver diagnostic services across London, thought that the difference in performance between NHS organisations and those from the private sector was due to a difference in 'culture' or 'mindset'. In relation to productivity, the chief executive of this provider told us the following:

> I think a lot of it is cultural. There's no magic way that we do things. It's almost a mindset. If you went to an NHS MRI scanner and looked at the productivity of it, you'd probably find that any private sector provider could certainly get another 20%, 30% just in the way that the equipment is utilised and is looked upon. The fact that we can actually deliver these services at the national tariffs in itself points to the fact that there's some efficiencies that can be taken out.
>
> (CO5, Chief Executive, Private sector diagnostic service, 01/06/09)

In summary, the desire to make an economic return on the delivery of services appears to compel privately-owned providers to make efficient use of equipment and the staffing of services.

User orientation

A key characteristic of private sector providers appears to be their attentiveness to the patient, often cast more as a knowledgeable 'consumer' than a 'co-producer' of services by these organisations. For example, the chairman of the ISTC in PCT A informed us that they aimed to 'continually refine the patient experience' in order to derive a competitive advantage over NHS providers. Not only did this involve making the experience of visiting the centre as comfortable as possible for patients, 'such that they enjoy that centre and they can talk about how it made them feel and how the management of their care was helpful and rewarding for them'. It also implied improving the knowledge and input that patients have on the centre, and on the performance of the surgeons practicing there, thereby raising the profile of the patient's perspective on the delivery of services, as the ISTC's chairman stated in interview:

> So what we're looking there for is developing outcome information so patients will be able to choose their Surgeon, will use technique information. So what we're doing now is moving to increasing patient knowledge and, you know, that's, if you like, our next challenge to the NHS. We won't keep it as a mystery, what Surgeons do, what their outcomes are, what patients feel about the services; we're going to actively encourage patient information and engagement in our services. So you'll see patients talking about their experience; we'll be inviting patients in the media to tell us what went wrong; really exposing ourselves to patient scrutiny in a way that the NHS has never done. That's our next innovation really.
>
> (A13, Chairman, Independent Sector Treatment Centre, 5 June 2009)

Being aware of patient needs was also seen as a source of innovation. For instance, a national private sector provider of home care contracting with PCT A designs their services from the patient's perspective. This organisation delivers pharmacy and healthcare services (including blood transfusions and chemotherapy) into people's homes. Based on the founder's awareness of home infusion therapy in the United States, the organisation was established in the early 1990s and now employs over 750 staff and delivers services to 100,000 patients per year. The distinctiveness of this

organisation lies in the delivery of services in people's homes that would otherwise be administered in other settings, including hospitals. In recent years, the services this organisation has been able to deliver in people's homes have become increasingly sophisticated, extending to a recent pilot programme for providing oral oncology services at home for patients in PCT A. As the managing director explained in interview, the services they provide are designed in accordance with what they believe would add value to the patient experience:

> What we do is we plan Patient Pathways, and we put – the way that we grow the services is that we put the patient right at the very middle of everything we do, and we plan Pathways as, if I was a patient, what would make sense for me? What would help me? And that doesn't sound terribly exciting, but believe me it's quite different from what a lot of people do. So we plan them along that way, and we did make interventions that count, so we take out a lot of the stress that adds no value, we just don't do, we just stop, and that's what makes a difference. Only do things that count.
>
> (A12, Managing Director, Home Healthcare, 22/05/09)

In summary, private sector providers tend to make use of patient or 'consumer' feedback as a means for providing high quality services, whether as a tool for managing the performance of staff or a perspective around which to design services.

Organisation structure

Among for-profit providers, there was diversity in the structure of the internal governance arrangements of these organisations. For example, the ISTC within PCT A was based on a hierarchical governance structure in which the decision-making of executive directors took precedence over the views of the clinicians delivering frontline care. As a new organisation independent of the historical social relations within the NHS, the creation of this enterprise provided an opportunity to reconfigure the relations between management and clinicians at the hospital. This allowed the ISTC's managers to focus on the organisational systems and processes they deemed necessary to treat patients efficiently, and then recruit surgeons who could slot into this predefined system of providing care. This was based on a belief that positive clinical outcomes were as much a product of the system as attributable to clinical judgement or autonomy. This was communicated to surgeons on joining the hospital, as the chairman of the ISTC stated in interview:

> So we don't just send an ad out and say, "Are you a good Surgeon?" We actually put them through quite a rigorous selection process. What we don't do is retrain them. If they're good enough, they're good enough, if you understand? What we would do is say, "In our centre we expect you to work under these practices, in this way," because it's the system and the practice

> process which we're confident in so you get more consistent outcomes, which again, is slightly different than the UK where Surgeons tend to develop their own thoughts and ideas about what's best for the patient.
>
> (A13, Chairman, Independent Sector Treatment Centre, 5 June 2009)

The priority of the system over the clinician also influenced the hospital's human resource practices. A rigorous performance management regime was in operation at the centre, with the severe consequences of underperforming made clear to the surgeons practicing there:

> I think one of the real differences between the treatment centre programme and perhaps some of the NHS family over years is that we won't tolerate poor performance. We look very, very carefully at clinical practice outcomes and Surgeons are asked to reflect on that all the time and if we feel that the Surgeon's falling behind with the level of outcomes that we would expect, then we would probably part company with the individual. Well, I don't want to put it too bluntly, but essentially we would not maintain someone whose practice wasn't consistently excellent.
>
> (A13, Chairman, Independent Sector Treatment Centre, 5 June 2009)

However, another for-profit provider that we interviewed possessed an alternative governance structure based on employee co-ownership. This provider runs a chain of ISTCs as well as purpose-built hospitals, clinics, and community services. On joining the company, members of staff receive a shareholding and have a combined ownership stake of 49.9%. (The remainder of the company is owned by institutional investors who provide investment capital to the organisation.) The purpose of providing staff with a stake in the business is to create an environment in which staff are encouraged to take ownership of the way services are delivered, as a partner within the organisation explained during interview:

> if you can align the incentive of a porter right across the general manager and the doctors and nurses in the same partnership model, we then turn around the whole system around. So, we knew the challenge, we knew we wanted a step change and I'm not going into details, I can go through it and we can talk more about it but the vehicle was very, very simple. We say, if the vehicle is professional services, if professional is the key driver, the biggest challenge you had, how you build up a business and a company that you give a substantial amount of company not to the private equity houses or external shareholder, we make the employees the biggest shareholders in this business. Today, they have 50% of this company owned by its employees.
>
> (M05, Partner, Private sector clinical partnership, 04/01/10)

In summary, while both of the organisations described above are for-profit enterprises, they differ according to how they value the contribution of professional staff. The first organisation ties success to the strength of the managerial board creating a hierarchical organisation in which systems and

procedures are issued from the top and designed for implementation by frontline clinical staff. The second is based on a bottom-up mode of organisation in which all partners of the company are understood to contribute to its success and are therefore given greater latitude to contribute ideas and to take responsibility for-profit and loss.

Innovation

Private sector organisations did not always describe themselves as being markedly innovative in comparison to the NHS. The difference lay instead in their ability to implement change, whether that represented innovation or merely a shift in the organisation of pre-existing services. The private sector – when contrasted with the caricature of the NHS as a slow and bureaucratic organisation – was effective at implementation, as the following interview quotation from a private sector provider illustrates:

> I think by innovative I don't mean the first person in the world to do it. I think I mean taking leading edge thinking and actually doing it consistently within our operational management framework whereas I think there's a lot of NHS innovation is done as a project and it doesn't stick. Many times when the Project Manager finishes or the Project Manager funding runs out the project falls over and the NHS is not very good at disseminating that type of good practice and I think we feel, as a very focused management team, we can take some of those best practice changes and the innovation, if you like, is actually making them happen and delivering consistently in practise, not necessarily having the original idea but actually implementing it.
>
> (C10, Managing Director, Private sector provider of acute and community care, 30/07/09)

In producing innovation, the independence of new organisations from the organisational culture associated with the NHS was cited as an advantage. For instance, one organisation we interviewed had recently won an award for setting up a pilot diagnostics service that was embedded within a chain of neighbouring GP practices that improved timely access to these services for local patients. Commenting on the award, the chief executive suggested that NHS acute organisations that have traditionally provided diagnostic services would find it challenging to provide a similar service in the community:

> the key innovation, if you like, is that you can turn up and have your ultrasound scan and your echo and your ECG actually within a GP surgery, so you're not having to travel, you don't have to go to two different places, and, of course, the other innovation is you can have it within two weeks. So, of course, the Acute Trusts could do the same thing, but they would have to have quite a shift in mindset operationally as to how they deliver their services currently.
>
> (CO5, Chief Executive, Private sector diagnostic service, 01/06/09)

The reason that this provider had been able to set up and expand a new diagnostics service so quickly, appeared to be due to the relative ease with which the management team were able to take strategic decisions over the future operational moves of the company:

> I think you asked me a question earlier on around whether the NHS could replicate what we did, and one thing I forgot to mention is the inertia within the NHS to making a decision. So we mobilised a service originally within a few months and had it all up and running on the date we said it would two years ago, and we've mobilised these extra sites. We only started them in June; we'll have another 20 odd sites, as I said, in a few months. The NHS would just not be able to act that quick because it hasn't got the command and control structure that can make decisions without going through umpteen committees, which only sit monthly of course.
>
> (CO5, Chief Executive, Private sector diagnostic service, 01/06/09)

When comparing this organisation with those of the NHS, it should be borne in mind that the high level of specialisation of this organisation (it possesses only one core competence) means that when making decisions it does not have to deal with the same breadth of stakeholders and competing demands for resources as a typical NHS trust. Tentatively, it might be suggested that the efficiency of service delivery by the NHS could be enhanced by commissioning the private sector to specialise in providing standalone services that can be split away from the more complex field of services (including emergency care and highly acute services) that remain in the NHS.

In the field of community health services, many of the smaller (locally based) private sector providers were not necessarily providing more innovative or effective care than traditional NHS providers. Many of the private sector organisations encountered during the research had traditionally provided social and other non-clinical forms of care to their users, with the provision of 'health' care being a relatively new domain. In this way, smaller Third Sector organisations looked towards the NHS and local authorities as the 'experts' in their fields from whom they needed to learn. For instance, the managing director of a private home care provider that has been established for five years described in interview how he viewed the NHS and the local authority:

> they're very professional services and that we, as a company, try to live up to that – we look up to them as a company; we look up to… you know, even though there are tension, but a lot of it's, you know… we can get over it, you know. But I think, generally speaking, we tend to look up to social services and… I mean, they're not perfect by any stretch of the imagination on both counts, but even so it's a massive organisation and things go wrong – but overall, we do look up to them, you know.
>
> (DO7, Managing Director, Private home care provider)

This view was reinforced by the fact that his organisation paid staff lower wages than their equivalents working in statutory organisations. This caused some animosity towards his organisation from employees working within the statutory sector.

3.2.3 Third Sector providers

This sector refers to a variety of organisational forms including charities, voluntary organisations, cooperatives, and social enterprises. The Third Sector includes a diverse range of enterprises that have different models of ownership and organisation but are, according to the Office of the Third Sector, united by a commitment to reinvest any surpluses primarily to further social or environmental objectives. Providers from this sector were delivering services in primary and community health services, but none of those surveyed was currently providing acute care. The performance of these organisations will be discussed according to the themes of stakeholder representation, community embedding, volunteers, and innovation.

Stakeholder representation

Third Sector organisations tend to be depicted as enterprises that are oriented towards the interests of their staff or other stakeholders such as service users. We found both orientations in our interviews with Third Sector organisations that possessed contracts to provide NHS services. With regard to staff representation, organisations involving clinicians providing primary care services had often developed governance arrangements for running an enterprise for the mutual benefit of their employees. For instance, we spoke to the operational director of an out-of-hours primary care organisation in PCT A that was made up by around 60 local GP practices. The organisation had recently won a bid to operate a vacant GP practice in the centre of the city covered by the PCT. The organisation, which became a limited company in 2005, awards a shareholding and voting rights to every GP that provides services to them (although ownership is weighted towards the board of directors who possess a 20% stake in the company). As well as providing access to a pool of capital, such a governance structure has allowed the organisation to bid for Alternative Provider Medical Services (APMS) contracts based on agreement about exploiting new opportunities. These had included, where necessary, the adoption of new working practices such as providing extended working hours and looking into offering lunchtime and evening appointments to patients.

Serving the interests of staff can also imply creating an organisation which adheres to particular values or ethics of care. For example, we interviewed the director of a primary care consortium of GPs and other primary care workers that had formed a society for the benefit of the community through which GP practices collaborate in order to improve the quality of practice based

commissioning. The enterprise is registered as a community benefit society and is governed by a Council that is elected from the membership of participating primary care staff and members of the public (the membership includes 60 to 70 people from the local community). As the director stated in interview, this mutual organisation was formed in part by the GPs because of the emergence of new providers of primary care from the business sector:

> I think the fact that the PCT has brought in the private sector acted as a real spur to our GPs to get their act together, and I think it, sort of, kind of, shook them out of complacency, and where it's – where that's not happened in other PCTs I think there's a bit more complacency from the GPs. So in a way, kind of, like, it's a horrible thing to say, but the wave of competition has made people stop and get their act together. I think the downside is that the arrival of the private sector makes care a lot more fragmented. I think that our experience locally within [X area] is that, as I said, you know, there are the three practices that are run by the private sector, there doesn't appear to be a consistent lead GP there, and so trying to – I mean, how far those practices engage in education, new service development, and therefore whether their practice patients benefit from that, I think for me the jury's still out on it.
>
> (C11 Director Social Enterprise Primary Care Consortium 160909)

Due to a perceived disjuncture between the values of traditional GP practices and those practices emerging from the business sector, members in the latter category were prohibited from joining the organisation:

> I think there's, kind of, like, a unifying force in that all of our practices are happy to collaborate with each other, and are happy for maybe one of them to put themselves forward to provide something at the expense of another local practice if that keeps the private sector out.
>
> Our rules specifically exclude the private sector from becoming members.
>
> (C11 Director Social Enterprise Primary Care Consortium 160909)

Understood in this way, forming a new mutual organisation was not only a way for incumbent primary care practices to build up a competitive advantage against new entrants running practices in the area but it was also a vehicle for expressing a particular ethos in the provision of health care services that these GPs did not recognise in the values of the business sector.

The other key type of stakeholder that some Third Sector organisations we interviewed sought to represent was patients or service users. For example, a local charity contracting with PCT B that provides over 160 activities per week for older people is run by trustees elected from the organisation's membership body. The management committee consists of nine older people elected

by the organisation's users, who then co-opt six additional directors. This structure creates an organisation that is led by the needs of its users, as the director stated in interview:

> I mean because our organisation is user-led and that our trustees are members they ultimately have the final decision on what we should and shouldn't be doing so they – you know, they lead the organisation but also because we work with so many, I mean, we try and include our members in – we have lots of focus groups and surveys and we're always having to report back to our funders so we're always questioning the older people we work with about the type of services they're provided – we're providing to them because we're required of, not just the PCT but many other funders to feed back and we do.
>
> (B03, managing director, local charity for older people, 28/07/09).

The benefit of the organisation being run by elected members is that this ensures the services they deliver are valued by the members, as a member of the management committee stated during a focus group:

> We the members are the ones that know what other people want. I meet with a lot of our members and I get feedback on exactly what they want. So I can feed that back into the committee.

As the examples above illustrate, Third Sector organisations can operate according to principles of mutuality and democratic governance as advocated by the government's healthcare reforms (e.g. see Hewitt 2006). However, only those organisational models geared specifically towards the stakeholders of communities give such groups, as Hewitt argued, 'a stronger voice in how local health and social services are developed. I believe social enterprise can play a crucial role in achieving this goal' (p.9). While different forms of mutual organisation have the potential to amass a 'stronger voice' (ibid) for underrepresented stakeholders, it is important to examine the new stakeholders that are being involved in the governance processes of these organisations to understand whether these arrangements do fulfil the government's objective of using Third Sector organisations to fulfil 'a wider social good' (p.8).

Community Embedding

Some of the Third Sector organisations that we interviewed were successful in engaging with the needs of the communities that they served. This was accomplished through two main mechanisms, bringing healthcare services into community spaces and transcending the boundary between healthcare and other forms of community activity. The first mechanism can be illustrated with reference to the work of the local branch of a national charity for older people based in the LHE covered by PCT B. This organisation's activities include funding from the PCT to perform outreach work in the community for potential and existing sufferers of dementia. The managing director of

the charity stated in interview that the PCT provided funding for this work because her organisation had the capacity to identify and interact with service users outside traditional NHS settings:

> The things that they're [the PCT] mostly interested in is, in both organisations, is around the prevention side, the low-level stuff, the community work. They're also very interested in the one-to-one stuff that we do with people going into homes because that's something obviously they're not – haven't got the capacity to do, so they're very interested in the work that we do in people's homes, one-to-one, health promotion at neighbourhood level and some of the stuff – we've just taken on doing some more work around dementia and awareness raising around that.
>
> (B04, Managing director, Charity for older people, 31/07/09)

The organisation's ability to perform this work in the community stemmed from their use of local volunteers and their links with neighbourhood-based groups that provided access to hard-to-reach individuals within the community:

> We're very rooted in the community that we work with. We've got a lot of local staff. We have about 150 to 200 volunteers from the local area, so we've got a really good feel and we've been around for a long time, so we've got a really good feel for the community. We're well known and I think we can get to places that the PCT maybe can't get to, you know, we've got links with Resident's Associations at that level so I think that's what they value and also, you know, with volunteers it extends our reach, helps us to get in, you know, to get to places, gives us extra resources really and, as I say, the one-to-one work, working with individuals in their homes is something that I think they value.
>
> (B04, Managing director, Charity for older people, 31/07/09)

The other mechanism of embedding – bridging health care and other forms of community work – is apparent in the philosophy behind an innovative GP health centre based in PCT C. The GP practice is situated physically within a broader community organisation that promotes the overall health and wellbeing of local people, including where necessary the learning of new skills and the identification of employment and enterprise opportunities. This holistic approach to healthcare relies on the integration of different services onto one site so that patients that visit the centre can access a variety of additional services (including art classes, job advice, and assistance with housing), supported by around 70 different funding streams. According to a GP working within the centre, what marks out this practice from others is an understanding of healthcare as being inextricably linked to the promotion of positive social conditions:

> I think what's clearly distinctive about it is it's a holistic approach to healthcare. I think as a Doctor trained in hospital, we were very much trained along the biomedical model of healthcare, but what this centre does, is actually addresses the whole person, and to give you an example of that, actually, we focus yes, on what you would see as traditional health services,

> but also employment, education, creativity and the environment. So the idea is that you deal with all those aspects of the patient's health at the same time, not just one aspect, which is the traditional biomedical model. So, for example, we have Employment Advisers here; we're a community university, so we run training courses. We put a lot of time and energy into the environment.
>
> (C03 General Practitioner Integrated Health Centre 29 April 2009)

Patients, and the wider community, were seen as partners in the delivery of healthcare, which extended from the use of curved tables in the consulting room to create the sense of a non-hierarchical space, through to having a patient representative on the management board of the centre, and supporting social enterprise projects that benefit patients and the local community.

The perceived independence of Third Sector organisations such as charities from statutory bodies like the NHS and the local authority appeared to make some of these organisations more approachable for service users. For example, the local office of a national dementia charity based in PCT C which received support from the PCT to employ two support workers, one supporting suffers of dementia under the age of 65 and the other dedicated to helping sufferers from the Bangladeshi community, the largest minority ethnic group within the PCT. In interview, the Bangladeshi support worker stated that members of the Bangladeshi community may be more comfortable accessing health and social services through a Third Sector organisation, rather than a statutory provider, as 'we aren't as threatening'. The support workers interviewed thought that the approach adopted by the organisation was, 'a more person sensitive approach and they said we were ahead of the game in terms of all the person and stuff that's coming through now, and, because we're part of a bigger brand, people understand where we're from'. This extended to being aware of language and 'cultural' issues that may face members of ethnic minority groups when accessing health services.

Volunteers

The Third Sector organisations interviewed also relied to a varying extent on the contributions made by local volunteers. For example, two charities for older people situated in the local health economy covered by PCT B used volunteers to help provide services free-of-charge or at a reduced cost to users. One of these charities, which provides support to older people in the community, uses over 200 volunteers to provide a range of practical services including befriending, escorts to hospital appointments, staffing information and advice lines, and participating in intergenerational learning and skills transfer projects. Many of the volunteers are themselves older people living within the borough and we learnt through a focus group with some of these individuals of the value that they

derive from assisting others through volunteering. A woman in her nineties, who had been a volunteer for almost ten years with one of these organisations, said the following:

> I get a tremendous kick out of volunteering for doing something for somebody else. It's marvellous isn't it? And the satisfaction can last for some time. The client I had a year or two ago who could barely walk following a disastrous hip replacement. I was on the bus the other day, and I watched her hurrying, I mean hurrying without a stick carrying a Tesco bag, I thought hurray I did something.

This underlines the importance of the opportunities that Third Sector organisations provide for volunteering to service users and the providers of care alike.

Innovation

In the actual delivery of health care, Third Sector providers were not necessarily providing more innovative or effective care than traditional NHS providers. In accounting for this, a lack of resources to provide innovative care was also found in some cases to a problem. A primary care practice that we spoke to (located outside our four case study areas) was distinctive because it was led by nurses, rather than the traditional GP. The practice moved into the hands of the existing practice nurse and nurse practitioner, supported by a retired doctor acting as a non-executive director, when the incumbent doctors retired in the mid-2000s. The nurses decided to bid to run the practice based on a fear that private companies or professional GPs that might have a different ethos of care would otherwise be awarded the contract. The nurses had a desire to run the practice as a social enterprise:

> We knew how we wanted it managed, but we didn't know how we could do it, but we also, you know, the way we wanted it managed was along the social enterprise principles. We wanted to make enough money to pay the staff well so we could keep good staff and provide some extra services for patients that they wouldn't get in other practices.
>
> (M03 Director Nurse Led Primary Care Practice 23/09/09)

The practice is run from a cramped three-bedroom semi-detached property and, notwithstanding a longstanding desire to move to a larger purpose-built primary care centre, the practice generates little in the way of surplus revenue to invest in improving the fabric of the building and providing innovative new services. Their sense of social purpose was enacted through more modest additional services offered to patients of the practice:

> Well, we have a Foot Clinic for the over 60s, which is very well used, which we pay the Foot Care Specialist to come in, but the patients don't pay. We run a Flu Clinic or Elderly Care Day. We did do it twice a year, but it's quite a headache to organise, so once a year we pay for community transport to bus in all the housebound patients, give them a health check, a flu jab and a cup of tea and it's – we do that all in one afternoon in October every year, we pay for that. Usually the staff are all here, Carol and I, and we don't get any extra money, but if we had to, we'd bring in extra staff, and we have the Foot Care lady she comes and we pay for the child support and we pay for the tea and biscuits. And I mention the tea and biscuits because actually from the very first day we did it, we realised that that was possibly the most important bit, the social bit 'cause these were people who don't usually go out, and we had this lovely one where two old ladies had been to school together or something, they're here, they haven't seen each other for years and every day, every time we do it, we get together and think God, that was wonderful, but there's this lovely, sort of, atmosphere of everybody has a good time, although we worked hard. So yeah, that's the social enterprise bit as well and if we could – if we had more space, we'd do more of that sort of thing.
>
> (M03 Director Nurse Led Primary Care Practice 23/09/09)

While it would be wrong to deny the value of everyday acts of social good such as those described above, this example also illustrates a need for socially enterprising behaviour to be underpinned by financial resources that can multiply its effect on those to whom it is directed.

3.3 THE ENTRY AND GROWTH OF NEW PROVIDERS

In interview, the representatives of diverse providers with NHS contracts highlighted a number of issues with the commissioning system that were barriers to gaining PCT contracts. Firstly, the operational director of a GP cooperative in PCT A said that the time and capital investment required to respond to a tender process was prohibitive. The interviewee suggested that it cost a significant amount of money to produce a competitive bid, including legal fees (which were in the region of tens of thousands of pounds). Secondly, the same interviewee suggested that smaller enterprises such as his did not possess the economies of scale enjoyed by larger organisations which would inhibit their own price competitiveness when submitting bids for contracts. Thirdly, a GP from an integrated health centre in PCT C stated that big businesses had an advantage over smaller enterprises in preparing (and therefore winning) bids due to a differential in resources, although he questioned their ability to then deliver the proposed service. Fourthly, from the perspective of incumbent providers, a community services provider unit that recently separated from PCT A feared they were not viewed favourably by the commissioners at the PCT because of a preference for provider diversity. As the managing director of the provider unit stated in interview – when tendering for contracts, 'we've been treated harsher because we're internal'. Finally, the corollary to this point is that diverse providers may receive a varying degree of support from commissioning PCTs depending on the attitude of local commissioners. For example, also within PCT A, a private

sector provider of home care stated that they had received a great deal of support from the senior management at the PCT to acquire a contract, as their managing director remarked in interview:

> I don't think it's necessarily been any contracting frameworks that's helped there; it's actually been the individuals involved who are determined to do the right thing in the right way.

This provider believed that the change in policy, articulated in the 2006 White Paper on '*Our Health, Our Care, Our Say*', had aided those PCTs that were already sympathetic to new providers, but had not necessarily changed the actions of others:

> …I think it's changed a bit, in that the PCT that wanted to do it anyway are – feel that they now have the mandates to make it happen. I think the people that don't want to do it are still dragging their heels, and there's still a lot of stuff that could happen that just doesn't. So I think for those that want to do it, they've used the framework; for those that don't want to do it, they're still largely ignoring it.

This indicates that the variation in use of diverse providers may reflect differences in the attitude of local PCTs. Overall, diverse providers were welcomed by commissioners because they were perceived to possess distinct characteristics. In relation to Third Sector providers, the commissioning director at PCT B said that they were used because they either possessed 'niche expertise' in specific areas of healthcare or because they had an understanding of, and access to, parts of the population not available to the PCT. Similarly, the commissioners at PCT C believed that Third Sector organisations had a better understanding of community needs, due to having roots within communities, and their expertise was a product of focusing on specific areas of care and developing competencies in relation to those areas over time.

This was echoed by the commissioning director at PCT A, who stated that the PCT was particularly interested in working with Third Sector providers because of the particular philosophy or values held by these enterprises which were linked to addressing inequalities in the area. She stated, for example, that the city covered by the PCT would be experiencing growth in the proportion of the population from black and minority ethnic communities and that the Third Sector may be more likely to recognise the value of recruiting staff with those backgrounds.

The views of commissioners on for-profit providers from the private sector varied. In PCT A, the commissioner interviewed referred to the example of the local Independent Sector Treatment Centre (ISTC) that had demonstrated efficiency advantages over the NHS by introducing 'leaner pathways' for patients and modern booking systems. She argued that the approach of independent providers was having a positive impact on the incumbent providers within the area, who had replicated some of the practices of ISTCs. The commissioners at PCTs B and C also referred to the

positive characteristics of ISTCs, such as a 'better hotel service' for patients (PCT C), but they also recognised that it is problematic to compare NHS organisations with the private sector because the latter tend to 'cherry pick' more profitable streams of work and operate with a lower cost base.

The PCTs also varied in their approach towards the use of diverse providers. For example, the commissioning director at PCT A stated that when a new service or a new provider was needed this would go to 'the market' through a procurement process in around eight cases out of ten, whereas before 'a conversation' would just have begun with a potential provider. At this PCT, the procurement team currently costs around £250,000 per year to run. Although there is a series of reasons why a procurement route would not be pursued in relation to a particular contract (as outlined in the PCT's contestability framework), the policy of the PCT was to provide an evidence-based case as to why such an approach should not be pursued, as contract tendering was now the default position.

Introducing competition for NHS provision was perceived by the commissioner at PCT A to be delivering two main benefits. First, the process of tendering for contracts was forcing providers to come up with more 'innovative' and higher quality responses. This was supported by the chief executive of the acute NHS Trust in PCT A who said that, in response to a recent tender for providing children's services in the community, the Trust Board sought to develop a proposal that went beyond their existing capabilities in the area, stimulated by the question: 'what's going to be new about the service model that we're proposing?'. In this case, the Trust identified access to services for disadvantaged families as an issue and the national children's charity Barnardo's were brought in as a partner because of their knowledge of disadvantaged children and their skills in service evaluation. Second, the commissioning director said the creation of a plural provider market ensured that providers continued to focus on their own performance, including innovation and quality, because providers are aware that GPs, for example, have a choice over the provider to whom they refer patients. A similar view was offered by the commissioning director at PCT D:

> I'm very much of a view that what we need to be commissioning as a PCT is best possible clinical outcomes for an individual or a population that delivers value for money, and if that can be secured from a non-NHS provider, then that's fine. I think the increasing number of private and Third Sector providers in the market is serving to drive up standards, drive up quality and from that perspective, the competition that they bring can only be a good thing, and I guess that's something that underpins our commissioning business.
>
> (D01, Commissioning Director, PCT D)

The other PCTs had not embraced market competition to this same extent at the time the interviews were performed. For instance, the commissioning director at PCT B stated that the approach of the

PCT was driven by 'getting value for money for everything we commission' and his view was that, in many cases, tendering for contracts would not be the best way of demonstrating value for money, given the significant transaction costs involved in running a tendering process. Instead, he believed that commissioners should concentrate on evaluating the performance of existing services, and not tendering out if they were deemed to be performing adequately.

In terms of the growth of diverse providers once contracts had been awarded by PCTs, a number of other issues was highlighted by new providers. Firstly, a GP from an integrated health centre in PCT C raised concerns about the ways in which PCTs evaluated the performance of healthcare providers, suggesting that the current emphasis on performance targets should be supported with other evaluative measures geared more towards social outcomes, such as listening to stories of success. Secondly, a number of providers, both new and incumbent, stated that the competitive tendering system discouraged the sharing and piloting of new ideas, for fear that the PCT would take promising service developments and translate them into a tender for a new contract, to be contested openly in the market. Thirdly, the operational director of a GP cooperative in PCT A stated that there were instances of resistance to his organisation from incumbent providers, particularly when providing new services that involved crossing the boundary between primary and acute care. For example, he referred to a project his organisation piloted which involved providing a mobile GP backup service to ambulance crews that failed due to a poor flow of referrals; 'they weren't keen to be seeing their work go off somewhere else'. Thirdly, a private sector provider of mobile diagnostic services across London complained that they were subjected to a higher level of performance management than NHS Trusts, including requirements to: submit a monthly list of staff with qualifications and experience; provide a full investigation report and follow-up plans after an untoward incident; and undergo a quarterly quality review. The COO of this organisation also reported that he met the SHA in London every week and one or other PCT every week in relation to monitoring the service.

In addition to the problems outlined by the providers, the commissioners also recognised other problems with involving different types of providers across the range of clinical services funded by PCTs. With regard to provider type, the commissioning director at PCT B pointed out that new, start-up organisations could be at a disadvantage because the procurement process will identify the absence of a track record as a 'big risk', and 'we're all very risk averse in the NHS'. In terms of services, the commissioning director at PCT A anticipated less involvement of private and Third Sector providers in the delivery of acute care because of the high costs of market entry, envisaging that most acute services would remain tied to the statutory sector. However, she did add that some existing acute services could potentially be provided within the community (for example, niche

orthopaedic services that could be provided by GPs with a Special Interest), and this area generally was thought to provide more opportunities to a diverse range of providers. A private sector provider of diagnostic services, that is making their services available in the community through attachment to GP practices, illustrates this shift and, in terms of the potential for replication by NHS Trusts, the COO of this organisation stated: 'I think culturally, they would find it very difficult because the main innovation that we're providing is the service being provided in the community'.

The commissioners from the different PCTs recognised that part of their role was to try to develop a level playing field for providers tendering for contracts that possess different human and physical resources. For example, the commissioning director from PCT B recognised that there were differences in the commercial awareness of large private sector organisations compared to Third Sector organisations. This was visible, for example, in their ability to respond to NHS tenders. For him, this meant that the PCT should not be 'too much more commercial' in how they commission services, in order not to disadvantage or exclude smaller Third Sector organisations. To address this issue, the commissioning director at PCT A stated that the PCT had organised workshops for potential providers from different sectors (including social enterprises, GPs, independent contractors, and pharmacists) geared towards responding effectively to NHS tenders, including 'top tips' for producing a good bid and information on the PCT's resource allocation and commissioning priorities.

A final issue that may influence the entry and growth of providers is the socio-economic characteristics of the area served by diverse providers. For example, within the boundaries of PCT C, which covers one of the most deprived local authorities in England, we spoke to the medical director of a large publicly quoted organisation that has recently been awarded a ten year contract to run a primary care practice. The medical director said that in running the practice they had encountered problems, in particular the consultation rate of patients was 17 per year, compared to the national average for practices he estimated at between three and seven. The intensity of the practice's use was linked to the high unemployment within the area and the ethnic diversity of the population, which affects perceptions of health and the way services are used. In response to this issue, the practice is trying to 'manage down' the consultation rate by, for example, moving some patients onto long-term health plans, but in order to cope with demand they have recently had to take on seven new administrative staff. There was no indication that the future viability of the practice might be under threat, but this example illustrates some of the obstacles profit-motivated healthcare providers might face in delivering care in challenging socio-economic environments, and this could act as a barrier to the entry and growth of these providers in those areas.

3.4 THE IMPACT OF THE ENTRY OF NEW PROVIDERS ON THE PERFORMANCE AND INNOVATION CAPACITY OF INCUMBENT PROVIDERS

The impact of new providers on incumbent NHS organisations will be discussed in relation to acute care and community health services.

3.4.1 Acute care

Prior to discussing the impact of the entry of new providers, it is worth noting the competitive relations among incumbent providers in the context of the internal NHS quasi-market. In relation to PCT A, competition among the two major NHS Trusts to provide different services in the area is only partial. For instance, the Finance Director at one of the Trusts estimated that only fifty per cent of the services that they provide are also provided by the local Foundation Trust. Furthermore, less than half of those activities could be described as elective care, where patients are able to make a choice among the Trusts and other providers of healthcare. In the area of orthopaedics, for instance, the Trusts do not compete with one another because the Foundation Trust only performs minor day-case work while the Trust performs all inpatient orthopaedic activity. In fact, the two Trusts were collaborating as, in order to meet the 18 week target, consultants from the Foundation Trust were also performing inpatient procedures at the Trust. The chief executive of the Foundation Trust stated that both Trusts collaborated at the frontline and middle management level, in terms of drawing on one another's resources to accomplish, for example, emergency work, but at a more strategic level the two Trusts remained separate.

During the period of research, new forms of provider in acute care appeared to have had only a limited impact on the level of activity undertaken by the incumbent NHS Trusts in each LHE. For example, the opening of the ISTC near to PCT A had only a marginal impact on the NHS Trust because the treatment centre is situated a significant distance away from the city covered by the NHS Trust. In relation to the local health economy surrounding PCT A, it is also difficult to draw comparisons between the performance of the nearby ISTC (which opened in 2005) and the incumbent NHS providers of orthopaedic surgery. This is because the ISTC performs routine work, while the two acute Trusts perform a greater proportion of non-routine and highly-specialised orthopaedic procedures.

However, the finance director at the Trust did anticipate that the opening of a new ISTC in the city (run by the same provider) would have a detrimental impact across several specialities, amounting to a fall in revenue of around £12 million, to which the Trust plans to respond by reducing capacity in those areas. Similarly, the chief executive of the Foundation Trust believed that the new ISTC would

lead to a £1.5 million loss of work, affecting in particular the viability of the local Eye Hospital. As the new ISTC only opened towards the end of 2009, it was not possible to trace its actual impact on incumbent providers during the period of research.

The small impact of the private sector on incumbent provision of orthopaedic surgery was mirrored by the experience of the incumbent NHS Trusts in PCTs B and C. For instance, the CEO of a Foundation Trust within the bounds of PCT C stated that the private sector has had little or no effect on their own waiting times for orthopaedics:

> at the [NHS Trust] we're not aware of an impact from independent sectoral service... sector providers of orthopaedics. So we've seen an increase in orthopaedic activity at the [NHS Trust] over the last couple of years, year on year; we haven't seen a decrease. But we only... I mean, our market share is [London Borough], and I don't think [London Borough] have got a... have a PCT... have got much in the way of an IS [Independent Sector] contract. But, certainly, we haven't seen a decrease in orthopaedic referrals or activity.
>
> (C12, CEO, Foundation Trust)

Similarly, another Foundation Trust within the LHE surrounding PCT B reported little impact on orthopaedics provision coming from new providers, with the strategy director from the Trust recalling the failure of a recent attempt by the PCT to create extra capacity by introducing a new provider in the area:

> Pressure on Orthopaedics, not so far, not recently, so I think – again, and this where a bit of it's pre my time, but there was an independent sector Treatment Centre that was established at […] and from my understanding of the situation, I think all the Acute Trusts were told to divert Orthopaedic activity to the Centre to make it work. I don't think we did. I think two Trusts, ourselves and another Trust chose not to send anything, maybe us and [Trust name], basically just didn't tow the line, and I think the view at the time was there was enough capacity and we didn't need to be diverting our existing business somewhere else and then it folded. So [name of ISTC], after a few couple of years, just stopped operating, stopped working.
>
> (B08, Strategy Director, Foundation Trust)

The limited impact of private sector provision on orthopaedics for these Trusts in the LHEs covered by PCTs B and C reflects the dearth of new providers being located in these areas. Furthermore, these providers report few problems with their existing capacity thereby confirming the lack of a need for new providers to be introduced in order to provide additional capacity.

Accordingly, the direct impact of new providers on incumbents identified during the research appears to be limited to change in particular clinical domains and specific aspects of service delivery. Of more concern to the Trusts in PCT A was the knock-on effect that losing a small proportion of

relatively straightforward elective surgery would have on the viability of other work, such as more complex trauma surgery and the hospital's emergency service. For example, the medical director at the Foundation Trust in PCT A said that, although their organisation specialises in tertiary referral work, the margin that is made on the routine elective work now performed within ISTCs allows them to make a surplus needed to cross-subsidise other work, as he stated in interview: 'it's our cataract work that generates that allows us to take hits on the more specialist stuff that we do in all the other divisions'. To further compound the problem, the clinical director at the Trust in PCT A stated that the ISTC specialised in simple, straightforward cases, while the Trust takes on more complicated cases too, which were much more expensive to treat. The tariff reflects the average cost of performing all procedures. The Trust has higher average costs than the ISTC, even on routine elective surgery, due to variation in the case mix undertaken by providers.

The same issue was identified by a Trust within the boundaries of PCT D. The Trust's CEO felt that an ISTC operating within the same area was established only to perform routine procedures, leaving potentially more expensive cases to be picked up by other providers:

> if you simply put all of the low complication easy volume stuff to [name of ISTC] then you disproportionately affect the more acute, the more difficult side of Orthopaedics. So, for example, you know, no revision surgery is done at [ISTC] and in some ways I can understand that because revision surgery per se is very unlikely to make a profit if you simply apply the tariff. And there are other elements of surgery which [ISTC] doesn't do, and we've said, "Well, you know, if you take all the profitable stuff and put it to [ISTC] and leave us with all the loss making stuff then you are disproportionately affecting us, and we therefore are very reluctant" – unless the PCT can engineer referrals direct to [ISTC], then we're not directing them there either. We will simply say, "No, if the referrals come to us under Patient Choice we will take of them." And that gives us that balance of orthopaedic surgery where we believe, and that's why we need to test out that under the service line reporting issue, we believe we probably stand a reasonable chance of being able to break even or even deliver a surplus. If all of the simple hips are taken away from us and knees, and all of the other non-complex orthopaedic surgery, we would simply run at a loss, and I think the PCTs are – well, sympathetic is probably the wrong word, but they understand that, and in any event they can't subvert Patient Choice.
>
> (D04 CEO Trust)

In order to counteract the impending competition from the ISTCs, the Trusts within PCT A were conscious of the need to consolidate their own position by identifying and maintaining a competitive advantage in the market. For example, the Foundation Trust appears to be focusing on specialist activity, including Tertiary care, based on the assumption that the significant investment in competencies this requires (such as building links with universities, developing a research and teaching ethos, attracting high-calibre surgeons, and providing intensive care to patients) cannot be replicated by the private sector. Similarly, the chief executive of the acute Trust was aware that part of her organisation's competitive advantage lay in the range of NHS-trained specialist consultants

that they employed and she feared this advantage might be eroded if those consultants are hired away by independent sector providers.

Although ISTCs were perceived to be 'cherry picking' low cost, routine work, the Trusts have also sought to mimic some of the operational practices employed by the ISTC. For example, the acute Trust in PCT A has focused on increasing the efficiency of the patient pathways associated with elective care. The chief executive of the Trust stated that a 'simple surgery pathway' had been introduced which aimed to mimic the 'service slickness' of independent sector treatment centres, including use of GP screening, pre-op assessment, and a concentrated recovery pathway once patients are admitted to hospital. Similarly, the Foundation Trust in PCT A has responded to the presence of an ISTC by introducing 'lean production methodologies', based on the Toyota production system, with support from a knowledge management consultancy. A private sector provider of diagnostic services in London believed that incumbent providers had tightened up waiting times and are trying to raise productivity by getting more scans out of each scanner, using them for extended hours each day and at the weekend. In response, the Trusts had also 'opened up their doors to GP direct access to MRI'.

The incumbent providers within PCT A have also attempted to replicate the emphasis that the private sector places on the patient experience, as well as the way in which they market their services to commissioners and potential partners. The chief executives of the Foundation Trust respected the 'greater focus on the patient experience' within the private sector, and in response his organisation is looking more closely at the experience of patients. This includes using the membership body to advise on service developments and improvements, such as consulting a group of members with an interest in cancer services.

However, other Trusts saw greater challenges in trying to replicate some of the operational changes that ISTCs have been able to implement. For instance, the CEO of a Trust in the LHE surrounding PCT D said that he saw the value in some of the new processes introduced by ISTCs, but his Trust has struggled to make similar changes because of resistance from consultants who perform the surgical procedures:

> Well certainly on the basis that, you know, when you give an appointment you keep the appointment is a mantra that we've, you know, we've tried to adopt with, you know, greater or lesser extent, depending on individual consultants, because a lot of our lack of ability to delivery that consistent service is because of the way in which we don't often and always have much forward planning in the terms of what we do. So one of the things they, you know, I understand they've got is, sort of, shared, you know, shared lists for certain elements of surgery. Now we do not have that, and that's the – that's been the subject of much debate

> that, you know, why should we not have a common waiting list for a range of conditions which are not complex, even if we allowed individual patient opt out of that for particular Consultant reasons, but there must be a way that, you know, simple hips and knees, and some other simple orthopaedic procedures, quite frankly it doesn't make any difference whether it's Mr A, Mr B or Mr C who's doing the operations? Whereas there maybe particular reasons for certain patients where Mr C would say, "Well I know this is just a straightforward hip but, you know, I've done previous procedures on this patient so I want to carry on operating on that patient," in which we could understand, but, you know, for new patient referrals, somebody requiring an orthopaedic intervention that is not complex and where the anaesthetic complication is low, why can't we create common waiting lists? And the answer is we just struggle to do that.
>
> (D04 CEO Trust)

Aside from any direct effect on the workload or performance of the Trusts, the threat of competition has also been used instrumentally by the management of both Trusts to drive change within the hospitals. For example, the chief executive of the Foundation Trust within PCT A stated that his organisation used 'the threat or spectre of competition' in order to push the consultant body and other internal stakeholders towards being more reflexive, particularly with regard to reviewing their own working practices and their level of productivity and efficiency. Similarly, the chief executive of the acute Trust said the consultant body was traditionally resistant to change and the discourse around competition has provided an opportunity to challenge those consultants: 'most of them think of reasons not to change unless it absolutely suits them and so, for a while, of course it is a lever'.

3.4.2. Community health services

The main change to incumbent providers identified during the research was that these providers were becoming more 'commercial' in their outlook. This was the product of organisational separation from PCTs – which encouraged providers to focus more on the income they generate through services rather than the budget available for them to be run – as well as the emerging need to compete for the provision of community services against other providers through the commissioning system. For example, the incumbent providers were focusing more on how they market their services. The devolved PCT provider unit within PCT A has started to concentrate on external marketing, developing their strap-lines and logos, and looking at how they market their services to external partners. This was also a feature of the arms-length provider unit in PCT B, as the managing director of the unit said that separation from the PCT had made them a more 'commercially minded organisation', that now focuses on the income generated through services, rather than on budgets available for them to be run.

From the point of view of incumbent providers, the introduction of competition has also changed the relationship with the local PCT. For instance, the chief executive of the NHS Trust within PCT A said she felt that the relation between the PCT and the SHA had grown in strength, while any sense of forward planning between the PCT and the Trust had diminished. She added that putting contracts out to the market had reduced the incentive to share knowledge about service developments with the PCT:

> if that's our intellectual property, how much we're going to share of that, because if they're going to go down a tendering route why would you share that? Because we wouldn't want to, sort of, put that into the public domain, and then that be available for somebody else to use our ideas for the tender.

This experience led the interviewee to suggest that the local provision of healthcare was becoming more fragmented in a context of increasing provider diversity. The sense of increasing fragmentation of NHS services was of concern to the managing director of the arms-length provider unit that separated from the commissioning function of PCT A in April 2008. In interview, she provided the example of District Nurses who are employed by the provider unit but have, traditionally, done a lot of work without payment for other organisations, including GPs, the local authority, and care homes, based on an altruistic mindset grounded in NHS values. In a competitive environment, the managing director feared that these practices might be difficult to sustain when the productivity and costs of different providers have to be managed more closely. The staff still perceived themselves as members of the NHS, rather than as employees of a separately constituted provider organisation, and they feared being transferred into another enterprise owned by an external organisation.

3.4. PATIENT EXPERIENCE SURVEY AND THE QUALITY OF CARE BY DIVERSE PROVIDERS

The impact of diverse provision in the secondary acute sector is assessed by analysing using data from patient experience surveys which were carried out in public and private hospitals. The data we use come from surveys carried out annually among in-patients of NHS hospitals by the Care Quality Commission and among ISTC patients by the Department of Health. The surveys include identical questions about the patient's experience, ranging from the cleanliness of facilities and food quality to explanations provided by medical staff, delays, privacy and dignity. However, they do not cover clinical quality. The data also include information about patient characteristics, state of health and overall area of treatment (hospital specialty).

Table 3.5. Score Comparisons between Acute NHS Trusts and ISTCs: Elective cases outside London, nine specialties °

	Acute NHS Trusts 2007	ISTCs Pooled 2007/8	*t*-ratio*
Admission to Hospital			
Choice of hospital	28.8	92.4	-120.00
Choice of admission date	28.6	60.6	-60.20
Waiting time to admission	48.8	61.7	-31.78
Feeling about waiting time	80.3	88.7	-22.95
Admission date changed by hospital	91.5	95.1	-18.98
The Hospital and Ward			
Shared room with opposite sex	89.3	85.3	10.71
Wait for bed since admission	89.2	98.1	-20.03
Noise from other patients	70.2	93.2	-29.98
Noise from staff	83.0	95.7	-20.15
Food rating	53.9	75.2	-38.45
Room cleanliness	84.4	97.1	-60.24
Toilet cleanliness	80.4	96.5	-65.77
Doctors			
Answers from doctors	86.9	93.8	-24.84
Trust in doctors	93.6	96.9	-17.07
Doctors talk in front of you	89.7	96.1	-25.41
Doctors clean hands	82.4	94.3	-26.97
Nurses			
Answers from nurses	84.7	94.0	-32.27
Trust in nurses	87.9	95.8	-31.41
Nurses talk in front of you	90.3	95.5	-20.94
Enough nurses	76.4	95.3	-55.90
Nurses clean hands	84.7	94.4	-26.57
Care and Treatment & Pain			
Contradictions between staff	84.2	94.0	-33.75
Patient involvement	76.7	88.0	-33.84
Family involvement	66.9	84.6	-34.45
Privacy	94.5	98.3	-20.68
Time since call button	67.7	78.0	-24.40
Help to control pain	86.2	91.6	-12.95
Operations and Procedures			
Explanation risks operation or procedure	91.9	94.5	-10.92
Explanation before operation or proc.	86.7	90.4	-12.40
Explanation after operation or proc.	77.8	84.9	-18.60
Leaving Hospital			
Reasons for delayed discharge	73.7	92.7	-40.56
Waiting time discharge	84.1	96.9	-41.97
Explanation purpose medication	88.6	95.7	-22.48
Explanation side effects medication	53.9	73.2	-30.43
Explanation danger signals	58.1	77.4	-36.11
Explanation contacts	82.1	93.6	-27.90
Copies letters between hospital and GP	40.2	53.8	-22.98
Overall			
Respect and Dignity	91.1	97.6	-29.90
Overall rating of care	81.6	92.3	-45.48
Maximum Number of Observations	21,680	16.767	

° Averages over all respondents across establishments and specialties. Max. score 100 (see Appendix A1) All differences statistically significant at the 1% level.* **Sources***: NHS trust Inpatient Survey ISTC Inpatient and day case patient surveys.*

Table 3.5 shows the average scores obtained in our sample by NHS hospitals and ISTCs on each of the 39 questions common to the two surveys. Answers have been coded so as to obtain scores that always increase with better quality, with 100 the maximum score (see Appendix A1 for survey questions and coding). Overall, the scores obtained by both types of hospitals are very high, in line with findings elsewhere (see, e.g., Nguyen Thi et al 2002, Säilä et al 2008). On all but one question, patients report a better experience in the private sector, and all the differences are statistically significant. The one exception concerns having to share a room with members of the opposite sex, which is significantly less frequently reported by patients in NHS hospitals than in ISTCs.

In order to assess whether these differences are the effect of hospital ownership or of other factors such as patients' characteristics, the choice that assigns certain types of cases to one sector or the other, or the individual hospitals' characteristics, several issues have to be addressed. The first issue is how to aggregate the data corresponding to different questions to make the analysis manageable and meaningful. Although the five domains defined by the Care Quality Commission have been designed to capture particular areas of quality, the groupings are to a certain extent arbitrary, take no account of possible statistical relationships between questions and only include about half the survey questions. The second issue is how to take into account the fact that different types of patients are selected into the two different types of hospitals (with lighter cases, which may be easier and/or cheaper to treat, directed to ISTCs for routine procedures and more severe cases to NHS hospitals). Finally, we also need to control for the characteristics of individual hospitals that are not observed in the survey but may affect the quality of patient experience, because they may be partially correlated with ownership but due to other factors. For example, the prices paid by the NHS to ISTCs were higher for the first wave of ISTCs than the prices received at that time by NHS hospitals; but the second wave of ISTCs may receive a higher or a lower price than NHS hospitals given the changes introduced in ISTC contracts between the two waves (see Sussex 2009). As a result, hospital resources may vary in a way that is correlated with ownership. The first-wave ISTCs also seem to have carried out a lower number of operations than they were contracted for, so that they may have had more spare capacity than NHS hospitals, and perhaps extra staff time. It is possible that private sector hospitals also have newer premises on average, given their recent entry, and thus look cleaner or more pleasant.

3.4.1. Aggregation of Survey Questions

The large number of survey questions means it might be difficult to interpret results if we were to analyse each individual question separately. We have aggregated answers in two different ways. We first used groups of questions defined by the Care Quality Commission (CQC). The CQC identifies five domains of patient experience, into which 20 different questions are grouped, their scores being averaged to obtain five corresponding indexes of quality. The first index of experience quality, entitled "access and waiting" (hereafter “access”) includes scores on changes in admission date, the patients’ feeling about the time spent on a waiting list, and feeling about the time spent waiting to get a bed once in the hospital (see Appendix A2 for the questions in each domain). The second dimension, "safe, high quality, coordinated care" (“coordination”) aggregates scores on whether there were contradictions between statements made by different members of staff, discharge was delayed, and whether the patient was given explanations about danger signals after leaving the hospital. The third dimension, "better information, more choice" (“information”) includes scores on patient involvement and on explanations received about medication and its side effects. The fourth dimension, "building relationships" (“relationships”) refers to scores on answers from doctors and nurses to patients’ questions and whether doctors and nurses talk in front on the patient as if the patient weren't there. The last dimension, "clean, comfortable, friendly place to be" (“comfort”) refers to scores on noise, cleanliness, quality of food, privacy, respect and dignity, and help in controlling pain.

In order to take into account the possible relationships between the questions inside each index in constructing an aggregate score for each of the five CQC dimensions, possible relationships between domains need to be taken into account. For example, if two questions actually measure the same thing, giving each the same weight as all the other questions in the average score computed for a given domain will amount to asking the same question twice. In order to take into account these possible relationships, we use principal component analysis on the scores on the individual questions in each dimension. The resulting principal component scores for the five dimensions produce the same ranking of hospitals as the ranking obtained with the average scores used by the CQC[14]. We use these five principal components scores as dependent variables in our regression analyses.

[14] We have obtained Spearman rank correlations of around 0.99 for each of the five pairs of CQC and principal component scores. To study the relationships among these five experience dimensions, we have performed a rank correlation test across these dimensions and observe positive rank correlation among the five factors. The access dimension ranks the hospitals from best to worse quite differently to the other dimensions (rank correlation of 0.23). The remaining pairwise correlations range from 0.5 to 0.6.

Table 3.6. Factor Loadings (sorted according to Factor 1)

Question	Factor1 (All-round Quality)	Factor2 (Prompt Discharge & organization)	Factor3 (+Inform/ Comfort
Overall rating of care	0.09993	-0.04854	-0.07138
Answers from doctors	0.06729	-0.07323	0.15448
Respect and Dignity	0.06649	-0.02903	-0.06682
Answers from nurses	0.06461	-0.05183	-0.07394
Explanation danger signals	0.06180	-0.05345	0.21432
Toilet cleanliness	0.05991	0.05749	-0.30196
Family involvement	0.05978	-0.04852	0.07408
Trust in nurses	0.05926	-0.05405	-0.16834
Doctors clean hands	0.05794	-0.02481	-0.06818
Nurses clean hands	0.05591	-0.04251	-0.17177
Explanation side effects meds.	0.05439	-0.03528	0.20600
Enough nurses	0.05373	0.05254	-0.13621
Explanation of procedure after operation	0.05315	-0.10532	0.25958
Help to control pain	0.05292	-0.01679	-0.02657
Explanations of risk and benefits before the operation	0.04859	-0.08704	0.22392
Room cleanliness	0.04802	0.03164	-0.29932
Explanation of procedure before the operation	0.04683	-0.11496	0.29687
Privacy	0.04643	0.00694	-0.04558
Explanation purpose meds.	0.04627	-0.05600	0.12018
Contradictions between staff	0.04577	0.01497	-0.05905
Noise from staff	0.04564	0.06030	-0.16944
Doctors talk in front of you	0.04512	0.00857	0.04097
Patient involvement	0.04489	-0.06344	0.08160
Time since call button	0.04470	0.04403	-0.13588
How long was the delay in discharge	0.04052	0.53943	0.18934
Nurses talk in front of you	0.03799	0.01292	-0.09191
Trust in doctors	0.03750	-0.06100	0.14032
Noise from other patients	0.03741	0.06896	-0.18438
Feeling waiting time	0.03373	0.00465	0.07153
Food rating	0.03113	0.03849	-0.11884
Explanation contacts	0.03070	-0.05857	0.13135
Choice of hospital	0.02765	0.02942	0.01325
Wait in the hospital since admission	0.02694	0.02650	-0.03194
Main reason for delayed discharge *	0.02484	0.50400	0.16123
Choice of admission date	0.02376	0.02162	0.04816
Waiting time	0.01548	-0.01038	0.09074
Change date admission	0.01401	0.01067	0.01078
Share room opposite sex	0.01038	0.01874	-0.05960
Copies letters	0.00916	0.00536	0.06198

**In the question on the main reason for delayed discharge, the highest score is given when the discharge is not delayed and the score is zero when the discharge is due to medical or hospital reasons.*

The second approach we use to aggregate questions is factor analysis. The objective of this approach is to find a meaningful way of aggregating all the questions. Although the five dimensions defined by the CQC (which only cover 20 questions) have been designed to identify particular areas of quality, the groupings are to a certain extent arbitrary. Factor analysis makes it possible to

identify patterns in the relationships between questions that define dimensions of care quality emerging from the dataset. The dimensions identified and the way each question enters each dimension (each factor) can then be used to aggregate questions. We carried out a factor analysis on all 39 questions. Table 3.6 presents the factor loadings of the variables for the first three factors. Overall, all 39 questions are positively related to each other, so that a factor reflecting the all-round quality of the patient's experience (Factor 1) explains 69 percent of the variability of the data. A second factor (9.6% of the variance) assigns the most important positive weights to questions on delayed discharge and some negative loadings to questions about explanations regarding the operation procedure. This second "prompt discharge factor" may thus score better for hospitals that are better organized. The third factor (7.1% of the variance) assigns the most important positive weights to questions on explanations relating to medicines, operation, danger signals, side effects, contacts after discharge, and explanations for delayed discharge. It also assigns high negative weights to questions related to comfort (cleanliness, noise and food). This factor, which we call "more information, less comfort", suggests a pattern according to which some hospitals score well on providing information in different ways to patients, but poorly on comfort aspects, while other hospitals, at the other end of a comfort-information axis, provide a clean and comfortable environment but are generally less good at supplying information. We also use the scores from these three factors as dependent variables in our model to capture other dimensions of experience emerging from the variability of the data. In addition to being useful ways of aggregating questions, scores are continuous, which allows us to use estimation methods that deal with unobserved hospital characteristics.

3.4.2. Empirical Methods

In order to estimate the effect of hospital ownership on scores in our eight dimensions (the five CQC areas and the three dimensions of experience quality identified by factor analysis) while controlling for patient and hospital characteristics (including gender, age, state of health, etc) we use multivariate regression. Dependent variables are the set of principal-component and factor-analysis scores obtained in the eight dimensions. As explanatory variables in the model, we include some of patients' demographic characteristics--gender and interval of age. We also observe the treatment specialty. To control for the severity of the patient's medical condition we use the patient's self-assessment of health, ranging from worst at 1 to best at 6, and length of stay at the hospital. This is a standard specification (Kane et al 1997, Quintana et al 2006). If the state of health and length of stay of the patient are affected by the quality of care, estimates of their effect on care quality may be biased. This might be the case if the dependent variables measured clinical quality, which may

affect both the patients' length of stay and their state of health, but is unlikely to be a major problem here. There is a strong correlation between patients' self-assessed state of health before and after a hospital stay, and patients' rating of the quality of care seems much more strongly affected by the constant component of their state of health (i.e., the severity of their condition) than by changes in their health between the times before and after their hospital stay (Kane et al 1997). We will nonetheless take into account, in our discussion of the results, the possibility that a bias may be present. We insert a dummy variable for ISTCs, and allow all estimated parameters to vary with hospital ownership, in order to test whether there are ownership effects specific to patient groups, hospital specialty, etc. For example, it is possible that intrinsically motivated staff in the public sector offer better care to groups that are less vocal, like the very old

Table 3.7a. Dependent Variables: Sample Means

	CQC Quality Dimensions					Factors		
	Access	**Coordin.**	**Inform.**	**Relation**	**Comfort**	**All-round Factor**	**Prompt Discharge Factor**	**+Inform./ -Comfort Factor**
Mean of dependent variable	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000	0.0000
	(1.1084)	(1.1721)	(1.3205)	(1.4059)	(1.6275)	(1.0214)	(1.0677)	(1.1915)
NHS hospitals	-0.0566	-0.2538	-0.2204	-0.2012	-0.1778	-0.1803	-0.0775	0.0363
	(1.1366)	(1.2251)	(1.3939)	(1.5239)	(1.6632)	(1.0483)	(1.1371)	(1.2752)
ISTCs	0.3278	0.5054	0.4284	0.3876	1.0213	0.7065	0.3038	-0.1422
	(0.8580)	(0.8586)	(1.0385)	(1.0408)	(0.8653)	(0.4467)	(0.6529)	(0.7665)
Mean difference: *t*-ratio	-19.3***	-48.6***	-32.1***	-32.7***	-34.3***	-15.2***	-5.9***	2.5**

*Standard deviations in parentheses *** Significant difference at the 1 percent level*

The mean scores obtained by NHS and private hospitals in each of the dimensions of care quality reported by patients appear on Table 3.7a (scores are normalized to sum up to zero for the whole sample). As with scores on individual questions, the ISTCs perform better in each of the five CQC areas. However, the picture that comes out of the factor analysis is slightly different. ISTCs offer better all-round quality and fewer delays in discharge, but provide less satisfactory information to patients, and more comfort, than NHS hospitals, which rate better on information and less well on comfort. The sample means of the explanatory variables for NHS hospitals and ISTCs are presented in Table 3.7b. Compared with NHS organisations, ISTCs treat younger patients who are in better health, more often men and stay in hospital for shorter periods of time. This is consistent with other evidence (Browne et al 2008) and with the policy of directing routine cases to ISTCs.

Table 3.7b. Explanatory Variables: Sample Means

	NHS hospitals		ISTCs		Mean Diff.
Variable	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**t-ratio**
General Surgery	0.26342	(0.44050)	0.20111	(0.40084)	14.3***
Urology	0.11481	(0.31880)	0.03644	(0.18739)	28.3***
Orthopaedics	0.34700	(0.47603)	0.57953	(0.49365)	-46.7***
Ent	0.06522	(0.24692)	0.02046	(0.14156)	20.9***
Ophthalmology	0.01688	(0.12883)	0.05266	(0.22337)	-19.7***
Oral surgery	0.01024	(0.10068)	0.00907	(0.09478)	1.2
Plastic surgery	0.03021	(0.17117)	0.00626	(0.07889)	16.8***
Gastroent	0.00752	(0.08638)	0.04425	(0.20566)	-23.7***
Gynaecology	0.14470	(0.35180)	0.05022	(0.21840)	30.5***
Length of stay	3.86854	(4.76067)	0.89867	(1.95284)	75.9***
Female	0.60424	(0.48902)	0.54190	(0.49826)	12.3***
Age 16 to 35	0.08044	(0.27198)	0.13735	(0.34423)	-18.1***
Age 36 to 50	0.16933	(0.37505)	0.23838	(0.42611)	-16.8***
Age 51 to 65	0.30604	(0.46086)	0.30518	(0.46050)	0.2
Age more than 65	0.44419	(0.49689)	0.31902	(0.46611)	25.2***
Self-rates state of health°	4.02540	(1.14352)	4.46114	(1.11750)	-32.0***
Number of obs.	21,680		16,767		

*° Maximum = 6, minimum = 1; *** Significant difference at the 1 percent level*

The non-random selection of patients into the two types of hospital may affect patient satisfaction and our explanatory variables may not fully control for this. The ISTC surveys include both inpatients and admitted patients treated as day cases, whereas the NHS surveys do not include day cases. There is a wide variation among NHS trusts in patients' average length of stay and we control for individual patients' length of stay. However, day cases are likely to be lighter. In order to control for the selection of patients into either of the two types of hospitals we incorporate the choice of hospital in our model. We thus estimate a two-stage switching regression model. This implies first estimating a probit model that explains the choice of hospital, using hospital specialties and patient characteristics as well as the number of specialties as explanatory variables to ensure identification. This estimation is used in the second stage to correct the main estimation (see Appendix A3).

Finally, we do not observe other aspects of individual hospitals that may also affect patient experience and may be correlated with ownership though not systematically so, such as the hospital's spare capacity, the age of the premises, etc. For example, new hospitals may be easier to clean and look more pleasant to patients. There are new hospitals in both the public and private sectors, but there may be relatively more in the private sector, though not because of ownership but because of to the recent entry of private providers into NHS care. The prices paid by the NHS differ

among hospitals in a way that is correlated with ownership but not necessarily uniformly higher in one of the two sectors given the changes introduced between the two waves of ISTC contracts (see Sussex 2009). In order to control for these factors, we use hospital fixed effects, which allow us to keep constant the unobserved characteristics of individual hospitals.

The estimates of model are presented in Table 3.8 for the five quality domains defined by the CQC and in Table 3.9 for the three factors. The first result is that for all dimensions of care quality, the equations estimated for the NHS hospitals and for the ISTCs are significantly different. In other words, the determinants of the quality experienced by patients in each dimension are not the same in the two types of hospital, or affect quality differently. The two types of hospital deliver quality differently, with each type offering better quality, all else being equal, in certain areas in certain specialties or to certain groups of patients. Being in an ISTC affects experienced quality, in each dimension, in a basic way (this is the ISTC fixed effect[15]) as well as in other ways that are specific to the hospital specialty, and/or to the patient's gender, age and state of health (the parameters corresponding to the variables entered in interaction with the ISTC dummy variable). However, among the factors identified by data analysis patient selection does affect the reported quality of experience in the More Information / Less Comfort dimension, i.e., the patients that are directed to ISTCs will report a better experience, all else being equal, in this dimension. This could be because patients with less complex cases generally require less explanations and information about their care.

The top halves of Tables 3.8 and 3.9 give the effects of the different determinants on the scores for public hospitals, and the bottom half the difference between those effects and the effects for ISTCs (ISTC fixed effect and specific effects). If we look at the top half of Table 3.8, we see that older patients generally report a better experience in the CQC quality domains than the reference group (men aged 16-35 in General surgery) in public hospitals, all else being equal. Being a woman is associated with a less good reported experience in four of the five domains, and being in better health with a better one, and experience in the Coordination and Information domains is better in some specialties, again all else being equal. These results are in line with recent international evidence, which shows age and being in better health to have positive effects on reported patient experience and conflicting findings regarding gender effects (Hekkert et al 2009, Säilä et al 2008, Quintana et al 2006, Veenstra and Hofoss 2003).

[15] The fixed effect of being an ISTC is measured by the coefficient of $\hat{\Phi}$ capturing the difference between the intercepts of the models for ISTC and NHS hospitals.

Table 3.8 Determinants of Patients' Experience in Care Quality Commission Domains, Provider Fixed Effects.

	Access		Coordination		Information		Relationships		Comfort	
Urology	-0.057	(0.040)	-0.015	(0.041)	-0.136**	(0.056)	-0.093**	(0.047)	-0.075	(0.076)
Orthopaedics	-0.191***	(0.029)	0.085**	(0.035)	-0.023	(0.037)	0.061	(0.039)	0.137***	(0.044)
Ent	0.006	(0.043)	0.329***	(0.055)	0.006	(0.056)	0.069	(0.062)	0.100	(0.076)
Ophthalmology	0.022	(0.080)	0.199**	(0.090)	0.194*	(0.108)	0.001	(0.105)	-0.014	(0.166)
Oral surgery	-0.068	(0.087)	0.012	(0.090)	0.193*	(0.107)	0.137	(0.148)	-0.058	(0.187)
Plastic surgery	0.006	(0.065)	0.144*	(0.073)	0.182*	(0.093)	0.049	(0.069)	0.310**	(0.131)
Gastroent	0.060	(0.090)	-0.005	(0.163)	-0.113	(0.140)	-0.221	(0.137)	-0.220	(0.231)
Gynaecology	0.120***	(0.033)	0.175***	(0.042)	0.040	(0.054)	0.188***	(0.048)	0.164***	(0.062)
Log(length of stay)	0.029*	(0.017)	-0.170***	(0.019)	-0.071**	(0.029)	-0.084***	(0.022)	-0.068**	(0.030)
Female	0.078***	(0.019)	-0.150***	(0.019)	-0.204***	(0.028)	-0.004	(0.024)	-0.140***	(0.033)
Age 36 to 50	0.126***	(0.045)	0.311***	(0.041)	0.225***	(0.051)	0.541***	(0.056)	0.249***	(0.073)
Age 51 to 65	0.225***	(0.041)	0.539***	(0.039)	0.501***	(0.048)	0.828***	(0.050)	0.670***	(0.061)
Age more 65	0.279***	(0.041)	0.684***	(0.038)	0.443***	(0.050)	0.899***	(0.055)	1.097***	(0.063)
Self-rated state of health	0.113***	(0.008)	0.247***	(0.010)	0.293***	(0.011)	0.330***	(0.012)	0.320***	(0.014)
ISTC fixed effect	-0.033	(0.210)	0.767***	(0.138)	0.371*	(0.192)	1.366***	(0.150)	1.307***	(0.268)
ISTC*Urology	-0.026	(0.275)	0.170*	(0.093)	0.264	(0.176)	0.043	(0.156)	0.172	(0.595)
ISTC*Orthopaedics	0.310***	(0.113)	-0.190***	(0.062)	0.099	(0.067)	-0.115*	(0.061)	-0.031	(0.169)
ISTC*Ent	0.150	(0.152)	-0.620***	(0.200)	0.004	(0.140)	-0.257*	(0.149)	-0.053	(0.338)
ISTC*Ophthalmology	-0.206	(0.215)	0.010	(0.103)	0.130	(0.137)	-0.010	(0.156)	0.675**	(0.311)
ISTC*Oral surgery	-0.579	(0.644)	0.072	(0.205)	-0.087	(0.245)	-0.537*	(0.291)	-2.344*	(1.329)
ISTC*Plastic surgery	0.032	(0.344)	-0.598**	(0.265)	-0.455	(0.339)	-0.697***	(0.245)	-0.666	(0.637)
ISTC*Gastroent	0.105	(0.591)	0.110	(0.190)	0.253	(0.239)	0.319	(0.196)	0.422	(1.103)
ISTC*Gynaecology	-0.067	(0.115)	-0.294	(0.184)	0.026	(0.154)	-0.530***	(0.112)	-0.680***	(0.227)
ISTC*Log(length of stay)	0.027	(0.057)	0.096	(0.065)	-0.074	(0.054)	0.077	(0.049)	0.154	(0.117)
ISTC*Female	-0.010	(0.047)	0.058*	(0.034)	0.068*	(0.038)	0.048	(0.035)	0.002	(0.060)
ISTC*Age 36 to 50	0.043	(0.111)	-0.143**	(0.066)	-0.027	(0.089)	-0.459***	(0.082)	-0.287*	(0.173)
ISTC*Age 51 to 65	0.074	(0.121)	-0.300***	(0.067)	-0.177**	(0.081)	-0.629***	(0.074)	-0.560***	(0.155)
ISTC*Age more 65	0.002	(0.130)	-0.410***	(0.070)	-0.034	(0.085)	-0.643***	(0.079)	-0.840***	(0.148)
ISTC*Self-rated state of health	-0.017	(0.026)	-0.130***	(0.017)	-0.124***	(0.026)	-0.191***	(0.019)	-0.190***	(0.031)
Selection term	0.036	(0.132)	-0.176	(0.140)	0.339*	(0.183)	0.170	(0.146)	-0.085	(0.231)
Constant	-0.729***	(0.061)	-1.278**	(0.066)	-1.361***	(0.085)	-2.052***	(0.093)	-1.890***	(0.106)
Observations		23840		22552		17693		25521		15772
Number of hospitals		160		164		164		164		159

Robust standard errors in parentheses, clustered at hospital level

**** p<0.01, ** p<0.05, * p<0.1*

Compared with this, being in an ISTC (bottom half of the table) has a positive basic effect in four of the five CQC domains (all except "access"). The magnitudes of these effects are substantial--of

around 1 standard deviation for the "relationships" and "comfort" domains[16]. In addition, there are more complex ISTC effects specific to patient characteristics and to six of the hospital specialties. Being older tends to have a less positive effect on reported experience in ISTCs than in NHS hospitals. In one case, that of 36-50 year-olds, being in that age category even has a negative net effect on quality in the "comfort" domain in ISTCs. This is quite unusual. It is possible that the generally lesser positive effect associated with age in ISTCs reflects a bias in favour of the public sector in older age groups. Being female may have a less negative effect on reported quality in the "safety" and "information" domains in ISTCs, but the difference is only weakly significant and the net effect of being female remains negative in ISTCs as in NHS hospitals. Rating oneself as being in better health has a much less favourable effect on quality in all domains except for "access" in ISTCs, though the net effect remains positive in all domains. If there was a bias to this estimated effect due to reverse causality (better quality care causing a better state of health) this finding would suggest quality defined in this particular way is less good in ISTCs (and is overestimated). Length of stay has the same effect in the two types of hospital. Specialty-specific ISTC effects concern the "coordination" domain (the ISTC effect is positive in Urology and negative in Orthopaedics, ENT and Plastic surgery); "relationships" (negative ISTC effects in Orthopaedics, ENT, Plastic surgery and Gynaecology); "comfort" (positive ISTC effect in Ophthalmology and negative effect in Oral surgery and Gynaecology); and "access", on which there is a positive ISTC effect in Orthopaedics.

Once again, the picture is slightly different if we look at the determinants of quality along the three dimensions coming out of the factor analysis (Table 3.9). In public hospitals (top half of the table) older age still has a positive effect on reported quality all-round (ages over 50) and along the "more information but less comfort" dimension. However, being female does not affect experience quality, and a better state of health only affects all-round quality positively. Ophthalmology is associated with a positive effect on all-round satisfaction, as are Orthopaedics, ENT and Gynaecology for the delayed discharge factor. However, Orthopaedics also has a negative effect on the score for "more information but less comfort", as has Urology.

[16] The standard deviation is compared to that of the distribution of the scores.

Table 3.9 Determinants of Patients' Experience along 3 Factors, Provider Fixed Effects

	All-round Satisfaction Factor		Prompt Discharge / Organization Factor		+Information/-Comfort Factor	
Urology	-0.128	(0.144)	0.208	(0.184)	-0.386**	(0.186)
Orthopaedics	-0.019	(0.075)	0.182*	(0.094)	-0.252***	(0.095)
Ent	-0.196	(0.163)	0.392**	(0.165)	-0.036	(0.194)
Ophthalmology	0.553**	(0.215)	0.307	(0.240)	-0.266	(0.589)
Oral surgery	-0.073	(0.475)	-0.480	(0.606)	-0.0001	(0.352)
Plastic surgery	0.154	(0.221)	0.199	(0.277)	0.117	(0.332)
Gastroent	-0.008	(0.365)	-0.806	(1.394)	1.380	(1.358)
Gynaecology	-0.143	(0.119)	0.346***	(0.121)	0.137	(0.150)
log(length of stay)	-0.007	(0.063)	-0.127*	(0.065)	0.112	(0.075)
Female	-0.042	(0.062)	-0.017	(0.084)	0.080	(0.089)
Age 36 to 50	0.172	(0.118)	-0.189	(0.123)	0.309**	(0.150)
Age 51 to 65	0.479***	(0.089)	-0.174	(0.128)	0.341**	(0.139)
Age more 65	0.662***	(0.104)	0.005	(0.114)	0.202	(0.149)
Self-rate of health	0.271***	(0.028)	-0.035	(0.037)	-0.016	(0.031)
ISTC fixed effect	1.229***	(0.425)	-0.096	(0.655)	-1.561**	(0.735)
ISTC*Urology	-0.159	(0.732)	-0.240	(0.934)	2.287***	(0.872)
ISTC*Orthopaedics	-0.0644	(0.369)	-0.400	(0.460)	1.174**	(0.460)
ISTC*Ent	0.416	(0.570)	-0.320	(0.696)	0.298	(0.822)
ISTC*Ophthalmology	-8.399	(8.331)	-21.110*	(11.25)	11.08	(13.86)
ISTC*Oral surgery	-9.280***	(2.982)	8.759***	(3.248)	1.260	(3.118)
ISTC*Plastic surgery	-0.093	(0.570)	1.977***	(0.737)	-0.475	(0.810)
ISTC*Gastroent	0.388	(1.007)	-4.497	(3.581)	-2.765	(3.472)
ISTC*Gynaecology	-1.540***	(0.505)	0.156	(1.015)	0.764	(1.201)
ISTC*log(length of stay)	0.150	(0.138)	0.308*	(0.175)	-0.232	(0.169)
ISTC*Female	0.055	(0.110)	0.018	(0.142)	-0.152	(0.141)
ISTC*Age 36 to 50	-0.222	(0.425)	0.960	(0.588)	-0.485	(0.472)
ISTC*Age 51 to 65	-0.660*	(0.334)	0.475	(0.543)	-0.149	(0.574)
ISTC*Age more 65	-0.782**	(0.326)	0.347	(0.518)	-0.038	(0.553)
ISTC*Self-rate of health	-0.150***	(0.057)	-0.019	(0.079)	0.245***	(0.071)
Selection term	-0.289	(0.426)	-0.150	(0.516)	1.095**	(0.489)
Constant	-1.420***	(0.182)	0.206	(0.216)	-0.379	(0.249)
Observations	1649		1649		1649	
Number of hospitals	157		157		157	

Robust standard errors in parentheses, clustered at hospital level
**** p<0.01, ** p<0.05, * p<0.1*

There is a positive basic ISTC effect on all-round quality of experience, but a negative one on the provision of more information and less comfort. Both effects are quite large. There remains a negative ISTC effect specific to the over-50 age groups on all-round satisfaction, so much so that the net coefficient even becomes negative in ISTCs. A better state of health has a less positive effect on all-round reported quality in ISTCs than in NHS hospitals, but the effect still is a positive one. However, it affects experience positively in the "more information but less comfort" area (as opposed to no effect in NHS hospitals). If there was a bias due to reverse causality in the estimated effect of patients' state of health, this would suggest that by this definition quality may be less good in ISTCs along one dimension, better along another and the same as in NHS in the third dimension. Length of stay has the same effect in ISTCs as in NHS organisations, except possibly in the Prompt Discharge dimension where the net effect may be positive in ISTCs—but both the (negative) effect for NHS hospitals and the positive one for ISTCs are only weakly significant. Specialty-specific ISTC effects are positive and large enough in the more information / less comfort area in Urology and Orthopaedics to give those two specialties a net advantage (towards information and away from comfort) in this dimension of quality, where they were associated with less good scores in NHS hospitals. Oral surgery is associated with very large ISTC effects—a negative one in all-round satisfaction but a positive one along the delayed discharge factor. A positive ISTC effect is also observed for this factor in plastic surgery. Gynaecology is associated with less good all-round reported quality in ISTCs (but not in NHS hospitals).

In order to find out whether hospital ownership has a statistically significant effect overall on the quality of patients' reported experience, we have to evaluate the sum of the basic and specific ISTC effects at the sample means. The resulting effects are presented in Table 3.10 for each of the five CQC domains and each of the three factors. For comparison, we present the same total estimated effect for a model in which we do not control for unobserved hospital characteristics (model without provider fixed effects) in the bottom half of the table. The total estimated ISTC effect is not significantly different from zero in any of the domains or factors considered. The only possible exception is the CQC's "information" dimension along which the ISTC effect is weakly significant (at the 10% level) and negative. The differences in quality levels reported on average by patients in the two sectors, which we looked at earlier, are therefore entirely attributable to factors other than ownership, including hospital choice and unobserved patient and hospital characteristics specific to individual hospitals.

Table 3.10 Total Hospital Ownership Effect: ISTC Effect at Sample Means

	CQC Domains					Factors		
	Access	**Coordin.**	**Inform.**	**Relationsh.**	**Comfort**	**Global factor**	**Prompt Discharge factor**	**+Information -Comfort factor**
Model with provider fixed effects								
Average effect	0.0758	-0.0662	-0.1770*	0.0050	0.0411	-0.3304	-0.2744	0.1061
Standard error	(0.0963)	(0.0973)	(0.0969)	(0.0793)	(0.1572)	(0.3535)	(0.4702)	(0.5353)
Model without provider fixed effects								
Average effect	0.3988***	0.6641***	0.5183***	0.4961***	0.9129***	0.3580	-0.0085	-0.1963
Standard error	(0.1055)	(0.0722)	(0.0850)	(0.0604)	(0.1191)	(0.2832)	(0.3615)	(0.3743)

**** Statistically significant at the 1 % level*

The bottom half of Table 3.10 shows that for the CQC domains, the estimated ISTC effect would be positive in the absence of hospital fixed effects, i.e., if we did not control for unobserved characteristics specific of individual hospitals. These characteristics could concern each hospital's resources, its equipment, staffing, etc. It is interesting to note that this effect is not observed for the equations explaining the three factors identified by the data analysis. This suggests the positive ISTC effect could be an artefact of the selection of the questions included in the CQC's domains and the way these domains are defined.

Given the role of patient selection into each type of hospital in explaining certain aspects of the average level of quality of patients' reported experience it is of interest to examine whether the process sorts patients in such a way that patients that would be happier in a particular sector are sent there. It could simply be that patients that would have a better experience anyway, for example because they suffer from only one, straightforward condition, are sent to ISTCs; and/or it could be that patients better suited to a given sector are sent to that sector.

In order to investigate this issue, we have computed, for each group of patients (i.e., those treated in NHS hospitals and those treated in ISTCs) the quality scores the estimated models would predict for each type of hospital. We take the values of explanatory variables for all the patients that were treated in NHS organisations and combine them with the coefficients estimated for each type of hospital to calculate and test whether these patients would give a higher score to NHS hospitals or to ISTCs in each CQC domain and each of our three factors. In other words, we test whether patients treated in NHS hospital would report a better experience, as predicted by our estimated

model, if they had been treated in ISTCs. We then repeat the exercise with patients treated in ISTCs. The compared scores and corresponding tests are presented in Table 3.11.

The top half of Table 3.11 presents the scores predicted for patients treated in NHS hospitals, first as predicted by the model estimated on NHS hospitals and then below as predicted by the model estimated on ISTCs. The significance of the difference between the two scores is tested for each dimension with a *t*-test, presented below the two scores and their standard deviations. The bottom half of the table presents the same values computed for those patients that were treated in ISTCs. None of the differences are significantly different from zero in the top half of the table: patients that were treated in NHS hospitals would have been no happier and no less happy in ISTCs. Patients treated in ISTCs would also have been just as happy in NHS organisations in all dimensions except for the CQC Access domain, in which they would give NHS organisations a significantly lower score. Two of the three questions in this domain concern change of admission date and time on a waiting list. This result is consistent with the fact that the introduction of ISTCs aimed at creating capacity for routine elective surgery for which there were long waiting lists. There does seem to be successful sorting into ISTCs of patients that would have risked having their date of admission changed and/or been unhappy with the time spent on a waiting list. The Coordination domain shows ISTC patients might have been happier in NHS hospitals, but the difference in scores is only weakly significant (at the 10% level).

Table 3.11. Compared Predicted Scores for Treatment in the Two Types of Hospitals

	Access	Coordin.	Inform.	Relation.	Comfort	All-round Factor	Prompt Discharge Factor	+Inform./- Comfort Factor
Patients Treated in NHS Hospitals								
Predicted scores in NHS hospitals (B0X0)	-0.0181	-0.0430	-0.0391	-0.0588	-0.0458	-0.0617	-0.0376	-0.0286
	(0.1767)	(0.3496)	(0.3827)	(0.4308)	(0.5041)	(0.4178)	(0.2335)	(0.2357)
Predicted scores in ISTCs (B1X0)	0.0309	-0.0297	-0.2205	-0.0314	0.0818	-0.1508	0.2756	-0.2602
	(0.1033)	(0.1037)	(0.0921)	(0.0700)	(0.1852)	(0.2902)	(0.4081)	(0.3817)
***t*-ratio for H_0: B1X0-B0X0 = 0**	0.44	0.11	-1.70	0.32	0.64	-0.29	0.75	-0.57
Patients Treated in ISTCs								
Predicted scores in ISTCs (B1X1)	0.1011	0.0851	0.0788	0.1188	0.2399	0.2188	0.1478	0.1180
	(0.1559)	(0.2183)	(0.2547)	(0.2203)	(0.3352)	(0.2174)	(0.1356)	(0.2394)
Predicted scores in NHS hospitals (B0X1)	-0.0861	0.2164	0.1504	0.0921	0.1276	0.1637	0.0152	-0.2307
	(0.0695)	(0.0523)	(0.0563)	(0.0463)	(0.1037)	(0.4538)	(0.6226)	(0.7387)
***t*-ratio for H_0: B1X1-B0X1 = 0**	2.17***	-1.65*	-0.76	0.34	0.85	0.12	0.21	0.44

Predicted scores from Provider's Fixed Effects Model.

t-tests run with the standard deviation measured at the mean of X.

Standard deviations in parentheses

**** Difference is statistically significant at the 1 percent level * Difference is statistically significant at the 10 percent level*

3.4.3. Conclusions from the patient experience surveys

The quantitative research investigated the impact of diverse providers in the hospital sector on the level of quality reported by patients in patient experience surveys. Looked at question by question, the surveys we analysed—2007 data for NHS hospitals and 2007/08 data for ISTCs—almost entirely gave a statistically significant advantage to ISTCs. Interestingly, the picture was a little different when we considered the average scores obtained by the two types of hospitals along three dimensions identified with factor analysis among the 39 survey questions. ISTCs scored better on the "All-round Quality" and "Prompt Discharge" factors, but the analysis revealed a pattern in the data in which some hospitals score higher on a series of questions regarding the information provided to patients and relatively lower on questions regarding comfort—cleanliness, noise, etc. Along that dimension, which we called More Information/ Less Comfort, public sector hospitals were closer to the "more information" end and private sector ones to the "comfort" one.

Our empirical approach aimed at separating out, in the observed differences, ownership effects from what could be attributed to patient characteristics that may affect patient experience, to the selection of patients into one of the two types of hospital and to other factors that might affect patient-observed quality, such as the characteristics of individual hospitals other than ownership. For this purpose, we estimated a series of switching-equations models explaining scores obtained at the patient level in several areas of quality, including five domains defined by the Care Quality Commission and the three factors identified by our data analysis. In the estimations, we incorporated a model of hospital choice and hospital fixed effects in order to keep constant the unobserved characteristics of individual hospitals.

Our findings indicate that patients' experiences in the two types of hospital are different: the two series of estimated equations are different. Hospital ownership affects experience both generally and in ways that are specific to groups of patients and hospital specialties, with certain aspects being better in one type of hospital or the other for certain groups of patients in certain specialties. All else being equal, women report a rather less good experience in both types of hospital, but a little less so for two of the CQC domains in ISTCs. NHS hospitals are associated, all else equal, with a better experience for older patients than ISTCs. Certain areas of quality are reported by patients to be better in some specialties in NHS hospitals, others in ISTCs.

Overall, however, the total effect of hospital ownership on the quality of experience reported by patients is not statistically different from zero. The average differences in the scores of hospitals in the two sectors can be entirely attributed to differences in the types of patients attending the two

hospitals, to the selection of patients into hospitals of one sector or the other, and/or to the characteristics of individual hospitals.

Our results indicate a degree of successful sorting of patients that would benefit from faster access to care by being treated in an ISTC into that sector. However, in all the other quality dimensions we considered, our findings suggest that, once individual hospitals' characteristics are controlled for, patients of either sector would report a similar level of experience if they had been treated in the other sector.

When we analyse the scores obtained on the five CQC domains, we can attribute some differences in experience to observed patient characteristics and specialties, and to the choice of hospital and individual hospitals' characteristics as captured by hospital fixed effects (the selection term does not have a significant effect on those scores). However, we do not know which hospital-specific characteristics are involved in determining the higher level of quality reported on average by patients in ISTCs. These factors could include hospital resources, staffing levels and spare capacity, the age of the premises, etc., though not hospital ownership. It would be interesting now to find out precisely which hospital characteristics are involved and how.

Interestingly, when we analyse the scores on the three factors identified by the data analysis we performed on the 39 survey questions, we find the characteristics of individual hospitals have no significant effect (whereas the selection of patients into one or the other type of hospital significantly affects the score on the More information / Less Comfort factor). It seems that factor analysis teases out patterns in these data that are independent from individual hospital characteristics. This finding also suggests that the aggregation method used to summarise multiple survey questions and the selection of questions may be more important than has been thought until now.

3.5. FINDINGS FROM ANALYSIS OF HES DATA: DIVERSE PROVIDERS AND EMERGENCY ADMISSIONS

The HES Admitted Patient data set comprises patient hospital episodes, i.e., patient stays under the care of a particular consultant in a particular hospital. A patient can have different episodes during his/her stay under the care of a given Health Care Provider. In order to capture this patient's stay in hospital, we construct each patient's Hospital Provider Spells (HPS). The HES definition of a HPS is *the total continuous stay of a patient using a Hospital Bed on the premises controlled by a Health Care Provider during which medical care is the responsibility of one or more consultants, or the*

patient is receiving care under one or more Nursing Episodes or Midwife Episodes in a ward[17]. Therefore, a patient is readmitted when she/he enters a second or successive HPS.

Our analysis requires identifying emergency readmissions. We define emergency readmissions as those HPSs that are a patient's second HPS and for which the method of admission is emergency. In order to identify emergency readmissions in the data, we first select patients for whom the first admission is an elective admission. This amounts to a total of 1,295,342 patients, out of whom 1,004,705 had a unique HPS in the three fiscal years and 290,637 had more than one HPS in the same period. For those patients readmitted in a second HPS, we choose those patients whose second HPSs method of admission is considered an emergency readmission[18]. In total, we have 32,173 patients whose first HPS resulted from an elective admission and who had a second HPS following an emergency admission[19]. These patients may be readmitted in a third HPS, but we do not consider the information contained in the third or successive HPSs. However, we keep information on the number of HPSs for each patient.

We have constructed a variable measuring the duration to emergency readmission (*Duration*) as the duration in days from the discharge day in the first elective HPS to the emergency admission day in the second HPS (uncensored sample). For those patients not readmitted during the sample period (censored sample) we construct *Duration* as the duration in days from the discharge day in the first elective HPS to the last day of the sample period (i.e., day 1,186, corresponding to 30 September 2007). After eliminating invalid observations, the final sample we analyse comprises 1,008,301 patients, of whom 981,334 patients with a unique elective HPS and 26,967 patients with more than one HPS, the second of which results from an emergency readmission[20].

[17] The HPS has been constructed according to the HES variable *provspno* (Hospital Provider Spell Number)

[18] Emergency admissions include admissions via Accident and Emergency (A&E) services including the casualty department of the provider; admissions via a general practitioner (GP); via a Bed Bureau including the Central Bureau; via a consultant outpatient clinic; and admissions by other means, including patients who arrive via the A&E department of another healthcare provider.

[19] For this exploratory analysis, we do not include patients who have more than one consecutive spell with elective admission because of the potential difficulty of attributing a subsequent emergency readmission (or the absence thereof) to the first or subsequent elective spells. The following HPSs have been dropped from the sample at this stage: 27,189 HPSs with an invalid admission date for the first episode; and 467 HPSs with more than four episodes per HPS, for which the data is very cumbersome to process—although these HPSs are not randomly distributed, they represent less than 0.05% of the whole sample and it was thought safe to exclude them for our preliminary analysis.

[20] The following HPSs have been dropped from the final sample: 1,052 HPSs with negative or zero duration to emergency readmission between the first patient HPS and the second patient HPS; and 4,524 HPSs with missing duration to emergency readmission (due to invalid date of admission and/or discharge) between the first patient HPS and the second patient HPS.

In the HES data set, public- and private-sector providers are classified into nine types. Public providers comprise five categories: "Foundation Trusts, NHS Trusts, PCTs, NHS Treatment Centres", and "Care Trusts". Private providers comprise three types: "independent provider, independent-sector provider site", and "treatment centre at an independent-sector provider site" (ISTC). A residual category includes "other providers". Table 3.123. describes the distribution of the sample among these provider types. Table 3.12 confirms that the bulk of the patients were treated in public-sector organisations, in particular NHS trusts and Foundation trusts, in the sample period. The bulk of NHS patients treated in private-sector organisations were treated in ISTCs[21]. To ensure that private ownership is accurately measured, we only keep those observations corresponding to ISTCs and Independent provider categories in the private providers group, and do not analyze the observations for the few patients treated in the residual categories "other providers" "independent sector provider site", the definitions of which are not entirely clear[22].

Table 3.12. Sample Distribution among HES-Defined Provider Categories

	All Patients		**Non-readmitted patients**		**Readmitted patients**	
	No. of Patients	**Percent**	**No. of Patients**	**Percent**	**No. of Patients**	**Percent**
NHS TRUST	729,960	74.38	708,737	0.74	21,223	0.79
FOUNDATION TRUST	190,417	19.4	185,553	0.19	4,864	0.18
NHS TREATMENT CENTRE	21,898	2.23	21,469	0.02	429	0.02
PCT	8,976	0.91	8,869	0.01	107	0.00
CARE TRUST	163	0.02	162	0.00	1	0.00
INDEPENDENT SECTOR TREATMENT CENTRE	23,384	2.38	23,149	0.02	235	0.01
INDEPENDENT PROVIDER	4,810	0.49	4,743	0.00	67	0.00
INDEPENDENT PROVIDER SITE	211	0.02	208	0.00	3	0.00
OTHER PROVIDER	1,515	0.15	1,477	0.00	38	0.00
TOTAL	981,334	100.00	954,367	100.00	26,967	100.00

We group the providers into two types: (i) public providers, comprising the five types described above; and (ii) private providers, comprising independent providers and treatment centres at independent sector provider sites (ISTCs). Table 3.13 presents the average values of the Duration variable (i.e., the number of days from discharge until emergency readmission or the end of the sample period, whichever occurs first) by sector. The information is broken down between patients with a unique elective HPS (952,682 patients, or 97.2% of the sample) and patients with an emergency readmission (26,926 patients, or 2.8% of the sample).

[21] However, it should be noted that a number of ISTCs did not code the hospital specialty well in that period, so that we may be missing a substantial proportion of ISTC patients (see Healthcare Commission 2007).

[22] These groups represent 1,726 patients in total.

The average duration appearing in Table 3.13 is significantly different between the two types of providers, but this is only due to the longer duration observed for elective patients with a unique HPS (censored sample, middle data columns of Table 3.13) for whom duration is measured to the end of the sample period. When we look at the censored sample, i.e., those patients that are not readmitted in the sample period, the average duration is much shorter for private-sector providers (390.54 days) than for public ones (546.52) which primarily reflects the later entry of private providers as well as any possible difference in quality. This happens because the pattern of admission of patients to the public sector is uniform during the sample period, whereas the pattern of entry of patients to the private sector is more concentrated at the end of the sample period. In addition, we do not know who, among these patients for whom we do not observe a second HPS, died during the sample period.

In contrast, among patients readmitted in an emergency (uncensored sample, last two columns of Table 3.13 to the right) we observe *no statistically significant* difference between the average duration to readmission between the public (176.43 days) and the private sector (184.46 days).

Within the public sector, the mean duration to emergency readmission for NHS Trust patients (182.98 days) is significantly different (statistically) from that of Foundation Trust patients (150.57 days) which may be due to the fact that Foundation Trust are more recent organisations and/or to their taking in more severe cases in addition to any possible difference in quality.

Table 3.13. Means of *Duration* Variable by Patient Group and Hospital Ownership

	All Patients		**Non-readmitted patients**		**Readmitted patients**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
PUBLIC PROVIDERS	536.16*	(325.42)	546.52*	(321.83)	176.43	(231.23)
NHS TRUST	566.52**	(322.66)	578.00**	(317.87)	182.98**	(234.80)
FOUNDATION TRUST	438.95**	(318.69)	446.50**	(317.43)	150.57**	(216.36)
NHS TREATMENT CENTRE	388.08	(262.88)	393.41	(261.58)	121.53	(175.75)
PCT	490.96	(321.66)	493.56	(321.63)	275.10	(240.99)
CARE TRUST	575.99	(97.08)	579.53	(86.16)	2.00	(0.00)
PRIVATE PROVIDERS	388.33*	(295.58)	390.54*	(295.51)	184.36	(222.14)
ISTC	311.47	(240.28)	313.11	(240.01)	150.26	(210.63)
INDEPENDENT PROVIDER	762.01	(251.15)	768.48	(245.51)	303.99	(221.54)
TOTAL	531.91	(325.54)	541.96	(322.16)	176.52	(231.13)

*Notes: *Statistically significant difference between mean durations in public and private providers (t-test) at the 1% level; **Statistically significant difference between mean durations in NHS Trusts and FTs (t-test) at the 1% level.*

3.5.1. Duration Model Estimations

We estimate a Cox Proportional Hazard model in which the Probability of being readmitted in an emergency at time t after discharge subject to having been out of hospital since discharge is a function of hospital ownership, patient characteristics and condition—unfortunately we do not have any other information on hospital characteristics, such as staffing for example. In addition to patient age, gender and ethnicity, we use several proxies to capture the severity of the patient's condition. These include whether at the time of admission the patient's stay was intended not to be overnight (a value of 1 indicate a lighter case, and 0 a case in which it was thought an overnight stay would be required) the number of pre-operative care days and the patient's number of HPSs in the sample period. Finally, we also include the income part of the index of multiple deprivation (IMD) score for the area corresponding to the first part of the post code of the patient's address. This score represents the proportion of the population experiencing income deprivation in the area[23].

Table 3.14. Sample Statistics

	All Patients		**Public Providers**		**Private Providers**	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**
Duration in days	531.91	(325.54)	541.96	(322.16)	176.52	(231.13)
Female	0.524	(0.50)	0.525	(0.50)	0.487	(0.50)
Age	52.747	(19.15)	52.610	(19.22)	57.048	(15.98)
Background other than white British	0.081	(0.27)	0.083	(0.28)	0.004	(0.06)
Intended Management not overnight	0.527	(0.50)	0.524	(0.50)	0.643	(0.48)
Pre-operative days	0.301	(1.20)	0.303	(1.21)	0.144	(0.53)
Index of Multiple Deprivation (IMD): Income	0.130	(0.11)	0.131	(0.11)	0.122	(0.10)
Number of Hospital Provider Spells	1.043	(0.32)	1.044	(0.33)	1.016	(0.19)
Private provider	0.029	(0.17)	..	..	..	..

Notes: Observations with missing values for any of the variables have been dropped

The mean values of these variables are presented in Table 3.14. We observe that patients treated by private providers are more likely to constitute "lighter" cases (more often not intended to stay

[23] For information on the IMD and its components, see http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/

overnight, less preoperative days and less HPSs) are older, less likely to be female and from an ethnic minority background, and slightly less likely to experience income deprivation.

Table 3.15a: Duration Model Estimations, Uncensored Sample, All providers

Variable	Marginal probability	*t*-ratio
Female	-0.12905	-7.81
Age	0.00110	2.59
Background other than white British	0.09641	2.93
Intended Management not overnight	-0.31770	-22.13
Pre-operative days	0.00361	0.58
IMD Income	0.04173	0.59
Number HPS	0.13300	16.45
Private provider	0.01888	0.18
Number of observations	25,489	
Number failures	25,489	
Log pseudolikelihood	-232820.89	
Wald Chi2(8)	1106***	

Note: Cox Proportional Hazard model

Table 3.15b: Duration Model Estimations, Uncensored Sample, Public providers only

Variable	Marginal probability	*t*-ratio
Female	-0.13159	-7.65
Age	0.00112	2.54
Background other than white British	0.09526	2.78
Intended Management not overnight	-0.32815	-21.8
Pre-operative days	0.00459	0.72
IMD Income	0.02659	0.36
FT	0.19488	7.74
NHS Treatment Centre	0.52700	5.97
PCT	-0.15523	-1.91
Care Trust	24.87925	25.02
Number of observations	25,337	
Number failures	25,337	
Log pseudolikelihood	-231217	
Wald Chi2(8)	12501***	

Notes: Cox Proportional Hazard model; Observations with missing values for any of the variables have been dropped

Table 3.15 presents the duration model estimates for the uncensored sample (i.e., those patients that were readmitted) first for all providers, in order to estimate the effect of ownership on the hazard of being readmitted at time t after discharge (Table 3.15a) and then for public-sector providers only (Table 3.15b).

The key finding in Table 3.15 is that *the effect of ownership on the hazard of being readmitted in emergency at a given time is not significantly different from zero*, which suggests that, at least on the basis of these preliminary results, clinical quality is not affected by whether the care provider is public or private. The other estimated effects make sense: lighter cases (intended management not overnight, less HPSs) have a lower hazard of emergency readmission at a given time, whereas older patients and patients from minority backgrounds are more likely to be readmitted. Women are also less likely to be readmitted, all else being equal, and the number of pre-operative care days and poverty have no significant effect separately (but may be jointly significant).

Table 3.15b shows the findings obtained for the public sector only. Foundation Trusts and NHS Treatment Centres appear to treat patients that are more likely to experience an emergency readmission at a given time. As we remarked above, this may be due to sample construction and perhaps to the fact we do not control very precisely for morbidity (rather than to differences in clinical quality). The other estimated effects are consistent with the results obtained on all providers. The set of results presented in Tables 3.15a and b is obtained without including the patients that were not readmitted, which may affect the reliability of the estimates. However, given the different lengths of time since entry for different types of providers in this sample period (between public and private providers, and between foundation trusts and other public providers) and the fact that we do not have death data, these estimates are likely to be more accurate than the estimates we have obtained over the whole sample.

Results obtained for the whole sample (i.e., including censored observations) are presented in Table 3.16, with once again the estimates for all providers in the top half of the table (Table 3.16a) and estimates for public-sector providers only in the bottom half (Table 3.16b). Substantial differences appear in comparison to the uncensored-sample estimates. Private sector providers now appear to provide better clinical quality—being treated in a private provider decreases the hazard of emergency readmission at a given time. This is likely to result from our poor controls for case severity, which may make much more difference for censored observations, but may also come from the fact we do not observe deaths as well as from better clinical quality.

Table 3.16a: Duration Model Estimations, Including Censored Observations, All providers

Variable |	**Marginal Probability**	***t*-ratio**
Female	-0.107218	-9.41
Age	0.0062465	12.99
Background other than white British	-0.1226474	-6.12
Intended Management not overnight	-0.8406261	-44.52
Pre-operative days	0.0121782	6.14
IMD Income	0.62137	10.82
Private provider	-0.4303154	-10.29
Number of observations	932299	
Number failures	25489	
Log pseudolikelihood:	-341024	
Wald Chi2(8):	5348***	

Note: Cox Proportional Hazard model

Table 3.16b: Duration Model Estimations, Including Censored Observations, Public providers only

Variable |	**Marginal Probability**	***t*-ratio**
Female	-0.1095439	-9.51
Age	0.006319	13.02
Background other than white British	-0.1271828	-6.32
Intended Management not overnight	-0.8370895	-43.86
Pre-operative days	0.0122395	6.12
IMD Income	0.6227223	10.74
FT	0.001093	0.07
NHS Treatment Centre	-0.1599793	-4.22
PCT	-0.3096545	-4.96
Care Trust	-0.7641945	-4.81
Number of observations	918194	
Number failures:	25337	
Log pseudolikelihood:	-338708	
Wald Chi2(8):	5248***	

Notes: Cox Proportional Hazard model; Observations with missing values for any of the variables have been dropped

The other estimated effects are consistent with those for the uncensored sample, but slightly different: a higher index of deprivation and number of preoperative care days both increase the risk of emergency readmission, while the effects of gender, age and background are sensibly the same as with the uncensored sample. The findings for the public sector (Table 3.16b) are again consistent

with other findings as far as patient characteristics and severity variables go. Foundation Trusts are again associated with shorter durations to emergency readmission, which may be due to their comparatively recent entry, but NHS Treatment Centres are now associated with lower hazards of emergency readmission, which may have to do with insufficient controls for morbidity, unobserved deaths and/or better clinical quality.

Overall, these preliminary results do not suggest that clinical quality is poorer in the private sector. However, our estimated differences in the hazard of emergency readmission may be due to several factors in addition to clinical quality, especially when we consider the estimates obtained on the whole sample including censored observations. The analysis that uses the whole sample would need to be replicated with data incorporating death records. In addition, sample construction may affect average durations for different types of providers. Further analyses with different starting dates for the sample period on the basis of the distribution of private sector and Foundation trust admissions may lead to different estimates. Case severity would need to be controlled for more systematically than we were able to do here, by using diagnosis variables. Finally, it is possible that the poor data reporting by some ISTCs (Healthcare Commission 2007) introduces a serious selection bias in the sample, as better-run ISTCs may have both better data collection and better clinical quality. A model incorporating provider fixed effects might be necessary to correct for this.

CHAPTER 4: CONCLUSIONS

4.1. SUMMARY OF FINDINGS

The research was concerned to identify the characteristics of the case study areas. One of the surprising findings was that only a relatively small proportion of care is delivered to the NHS by diverse providers. This is despite the fact that the independent sector has quite a significant presence in PCT B. The NHS commissioners have only as yet made marginal efforts to engage the Third Sector or private sector providers in the provision of health care. There has been a somewhat larger involvement in the form of Independent sector Treatment Centres, but even these have only increased capacity at the margins and the programme of contracting ISTCs was quite limited, once the capacity needs had been fulfilled.

4.1.1. Findings from qualitative research

The qualitative component of the research has involved interviews with both commissioning and provider organisations from public, private and Third Sector organisations. One of the clear messages to come out of the research is the key importance of the strategy of the commissioning organisations towards market making. Commissioners hold the key to the extent of diversity of provision, and their varying strategies have strongly influenced the degree of diversity in each case study area.

Concerning quality, private organisations have improved the quality of service delivery by introducing more efficient patient pathways, and through a greater emphasis on patient experience. Third Sector organisations have emphasised the latter aspect, adopting a holistic approach in which patients and the wider community are seen as partners in a joint effort to improve well-being. Concerning innovation, while the NHS organisations have greater resources to drive innovation in clinical practice, private and Third Sector organisations have innovated more in organisational and working practices. An important area of innovation among the Third Sector providers has been to extend health care services throughout a broader range of community activities than has been possible through traditional NHS organisations. Thus the evidence shows that, while product innovation is greater in the NHS organisations, process innovation has been greater in the private sector and Third Sector organisations.

A further focus of research has been the drivers of entry and growth of new providers. This has revealed the strong barriers to the entry of new organisations, especially from the Third Sector due

to economies of scale in the bidding process which disadvantage small niche providers. Resistance from incumbent providers has also been observed. Similar factors have also inhibited the growth of new providers. The growth of private sector providers has been inhibited in more deprived areas by the more extensive demands of patients, suggesting that business models of private providers were not appropriate for the type of population served. Third Sector organisations in such areas have been inhibited from growing their services by the short duration of their contracts.

Finally the research has investigated the impact of new entrants on the strategies and practices of incumbents. NHS Trusts have responded to the entry of new ISTCs by introducing new surgical pathways, and have placed a greater strategic emphasis on improving the patient experience. However, information sharing among incumbents has diminished as competition has intensified. The entry of new Third Sector providers in the community health care field has led to a sense of fragmentation in the provision of community health, and to a more competitive orientation of traditional NHS organisations which are themselves being spun off into independent arms length organisations.

4.1.2. Findings from analysis of HES data

Private Independent Sector Treatment Centres (ISTCs) were introduced in 2002 to provide routine elective surgery and diagnostic procedures for NHS patients. They were intended to increase capacity, increase patient choice, and reduce waiting times. In order to identify quality differences between these and NHS acute hospitals, we carried out preliminary analyses on Hospital Episode Statistics for NHS patients treated either in NHS hospitals or in ISTCs. We looked at the factors determining the time between a patient's discharge from hospital and emergency re-admission, as an indicator of clinical quality. Preliminary results based on those patients that were readmitted during the sampling period suggest that hospital ownership does not affect this aspect of quality, once patient characteristics are taken into account. However, this finding is only tentative. Analyses using data on patients that were not readmitted during the sample period suggest there could be differences but are less reliable because of the sample construction and the fact that death records were not incorporated into the data. In addition, there still si a substantial missing data problem with ISTC hospital episodes.

4.1.3. Findings from analysis of patient experience data

In order to examine possible quality differences between NHS hospitals and ISTCs in other areas than clinical quality, we analysed a patient experience survey carried out by the Department of Health and the Care Quality Commission. The survey compares patient experience ratings in areas

such as the cleanliness of facilities, food quality, explanations provided by medical staff, delays, privacy and dignity (but does not cover clinical quality). Simple comparisons of means reveal a better patient experience in ISTCs compared to NHS providers (see Appendix, Table 1). However, missing information such as the resources available per patient at each provider may lead to biased estimates of the true effects. Further analysis to correct for unobserved sources of bias show that, taking into account the characteristics of the patients, the selection process, and the individual hospital characteristics, whether the hospital is private or public does not affect the overall level of quality that patients report (see Appendix, Table 2). At the level of individual hospitals there are significant differences in patient experience, and unsurprisingly individual hospitals do certain things 'better' than others. For certain groups of patients, the quality reported by patients in ISTCs is better. Other groups of patients report a better experience in NHS hospitals.

4.2. Recent developments

The White Paper of 13th July 2010, *Equity and Excellence: Liberating the NHS* puts increasing emphasis on diverse provision, which makes our findings pertinent to the new agenda. For example the White Paper states that "Our ambition is to create the largest and most vibrant social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises" (p.5). The White Paper further proposes changing the governance structure of FTs to allow for a range of different forms of governance, in particular that some community services providers may prefer to have only employees as members. This might help to deal with some of the issues that we raised about the lack of clarity of ownership of FTs. However, the stimulation of the entry of new social enterprises will clearly need the encouragement of purchasers (which will become GP consortia). A substantial education and training programme will be needed, to inform purchasers about the benefits of social enterprises, and also to train the NHS employees in the methods and purposes of employee participation in managerial decision making. As we will now have consortia of GPs in charge of commissioning instead of PCTs, and there will be less central control of the NHS, different methods to persuade GP commissioners to trust social enterprises to provide high quality services, and to engage in a dialogue with them to enable them to respond adequately to patient needs.

4.3 Overall conclusions

Thus far the extent of involvement of diverse providers in supplying services to NHS patients is extremely limited, especially in the social enterprise sector. Nevertheless, there are larger numbers of Third Sector organisations operating outside the NHS in each LHE, which indicates there is capacity for further growth of supply to NHS patients from this sector.

Private providers of inpatient services (specifically ISTCs) supply health services of at least as good quality as traditional NHS providers of the same type of care. ISTCs are able to deliver improved organisation of patient pathways. However, there is little evidence of significant difference between NHS and these private providers in respect of overall patient experience. In some aspects of patient experience ISTCs perform better, while in others, NHS providers offer a better experience. This suggests that ownership of healthcare organisations may not be the determining factor of quality of care. Thus, concerns about quality of care may not be a barrier to expanding the scale and scope of private providers of services commissioned by the NHS. Furthermore, it appears that Third Sector providers have brought about quality improvements in respect of a more holistic approach and a greater degree of community involvement, consequently there would seem to be good reasons to encourage greater involvement in particular areas. This coincides with current Coalition government policy to increase to use of social enterprises across the public sector (Maude, 2010).

Innovations in the form of technical improvements in products and techniques (e.g. new surgical methods) have continued to be a strong point of traditional NHS providers, while significant process innovations have been introduced by new private providers (e.g. better patient pathways). Third Sector providers have been able to innovate by filling gaps in service provision (e.g. services for vulnerable groups).

Strategies adopted by commissioners are an important determinant of the extent and nature of diversity in local health economies. The extent to which new providers can stimulate performance improvements throughout the NHS is limited by the barriers they face to entry and growth. This will continue to be the case once GP commissioning consortia are established, and thus the decisions at local level will be increasingly influential in the development of diversity of supply.

Entry of new private providers has driven a response among incumbents which have sought to match them with equivalent improvements. This is particularly marked in relation to ISTCs, whose presence has encouraged nearby NHS Trusts to improve patient pathways. As concerns the Third Sector, there appears to be no equivalent effect of entry on the performance of NHS incumbents because, on the whole, Third Sector providers have entered into sectors of provision which were not

covered by the NHS. This may change as Third Sector providers expand their scope, for example into community health services, due to the programme of Transforming Community Services as it develops in the future.

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APPENDICES

A.1 The Patient Experience questionnaire

The questions used for the ISTC survey are a subset of those of the NHS inpatient survey, which is attached. The coding of individual answers is indicated in the questionnaire.

Questionnaire_for_the_2008_Inpatients_survey.pdf

A.2. Questions included in care quality commission's domains:

Access and waiting

- Was your admission date changed by the hospital?
- How do you feel about the length of time you were on the waiting list before your admission to hospital?
- From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Safe, high quality, coordinated care

- Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?
- On the day you left hospital, was your discharge delayed for any reason?
- Did a member of staff tell you about any danger signals you should watch for after you went home?

Better information, more choice

- Were you involved as much as you wanted to be in decisions made about your care and treatment?
- Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?
- Did a member of staff tell you about medication side effects to watch for when you went home?

Building relationships

- When you had important questions to ask the doctor, did you get answers that you could understand?
- Did doctors talk in front of you as if you weren't there?
- When you had important questions to ask a nurse, did you get answers that you could understand?

- Did nurses talk in front of you as if you weren't there?

Clean, comfortable, friendly place to be

- Were you ever bothered by noise at night from other patients?
- Were you ever bothered by noise at night from hospital staff?
- In your opinion, how clean was the hospital room or ward that you were in?
- How would you rate the hospital food?
- Were you given enough privacy when being examined or treated?
- Overall, did you feel you were treated with respect and dignity while you were in the hospital?
- Do you think the hospital staff did everything they could to help control your pain?

A.3 the empirical model for patient experience

We assume that patient i and her GP have a choice between private and public hospitals (j being the hospital subscript) and that this choice is informed by the observable characteristics of the hospital Z_{ij}, and by unobservable tastes of the patient and unobservable characteristics of the hospital captured by the random term ε_{ijD}. In these terms, we model the binary choice by the classic dummy variable of an index

(1) $D_i = 1\left(\delta' Z_{ij} \geq \varepsilon_{ijD}\right)$

where the indicator function 1(*A*) takes the value 1 if the event *A* is true, denoting in our case the choice of an Independent Sector Treatment Centre, i.e., a private hospital, and 0 otherwise.

The outcome vectors Y_{1i} and Y_{0i} denote the scores of patients experience in the different dimensions of quality in a private hospital and in a public hospital, respectively. By grouping the conditioning variables (observable hospital and patient characteristics) in the matrix X_{ij} and the model parameters in the vectors β_1, and β_0 we can write the basic equations as:

(2) $Y_{1i} = X'_{ij}\beta_1 + \eta_j + \varepsilon_{1ij}$ if $D_i = 1$

(3) $Y_{0i} = X'_{ij}\beta_0 + \eta_j + \varepsilon_{0ij}$ if $D_i = 0$

where η_j captures unobserved hospital characteristics affecting experience (e.g. number of beds, staffing levels and staff composition, equipment, etc.). These unobserved hospital characteristics are

assumed to follow the same distribution in public and private providers. The error terms ε_{1ij} and ε_{0ij} capture unobserved patient factors such as tastes affecting the choice of hospital. Note that we allow the patient's unobservable heterogeneity to follow different distributions for private and public providers. This assumption allows us to use provider fixed effects to control unobservable provider characteristics –following the same distribution in the two sectors- and some unmeasured and common differences in patients who were treated by different providers. At the same time, we leave room for selection between public and private providers according to unobservable patient characteristics that vary across providers but are common to a given provider's patients. If, on the contrary, we had assumed complete homogeneity of patient's unobservable characteristics across providers, we would be implicitly assuming random assignment between private and public providers. In formal terms, we assume that the unobservable patient's heterogeneity is related to the choice of type of hospital so that $E\left(\varepsilon_{ijD,}\varepsilon_{1i}\right)=\sigma_{1D}$ and $E\left(\varepsilon_{ijD,}\varepsilon_{0i}\right)=\sigma_{0D}$ are different from zero.

The importance of considering hospital fixed effects is twofold. On the one hand, it identifies the unobserved hospital characteristics and any omitted variable at hospital level. On the other hand, as Glick (2009) notes, hospital fixed effects offer an additional way of controlling for patient selection since the fixed effects estimation holds 'constant unmeasured aspects of providers or their patients that may be correlated both with regressors and outcomes'.

In these terms, and given the allowance for selection, the identification of the model relies on a distributional assumption on ε_{iD} which we assume has a Standard Normal distribution, and on an exclusion restriction in the vector Z_{ij}; that is, there is a variable affecting the choice of the type of hospital that is excluded from the outcome equations[24]. We use the number of specialties of the hospital, a factor that restricts the choice of hospital but does not affect the patient's experience once we have controlled for the treatment specialty.

We can obtain estimates of β_1 and β_0 by following the two-stage estimation method for switching regression models (Maddala, 1983). In this model and allowing provider's fixed effects, the predicted score for patient experience is obtained as:

(4) $E\left(\hat{Y}_i\right)=\hat{\beta}_0^{'}X_{ij}+\hat{\Phi}_{ij}X_{ij}\left(\hat{\beta}_1^{'}-\hat{\beta}_0^{'}\right)+\hat{\eta}_j+\hat{\phi}_{ij}\left(\hat{\sigma}_{0D}-\hat{\sigma}_{1D}\right)$

[24] Assuming the validity of the exclusion restriction, we do not need to assume any functional form for the distribution of the errors in the outcome equations.

where $\hat{\phi} = \phi(\hat{\delta}' Z_{ij}.)$ and $\hat{\Phi} = \Phi(\hat{\delta}' Z_{ij})$ are, respectively, the density function and the cumulative distribution function of the standard normal determined in the probit model of choice of type of hospital. The selectivity term $(\hat{\sigma}_{0D} - \hat{\sigma}_{1D})$ can be interpreted in terms of Roy's comparative advantage: if patient experience with private providers is greater in the case of selection than in the case of random assignment, this coefficient is greater than zero.

The estimation of the model is done in two stages. In the first stage, we estimate the probit model of choice between NHS hospitals and ISTCs and we allow for different variances for different hospitals. In the second stage, we estimate the switching regression model for each one of the eight dimensions of experience considered. We estimate this model both with and without hospital fixed effects.

The estimates of the choice equation appear in Table A3.1. The estimation successfully explains the selection of hospital. The negative coefficient of the instrument, hospital number of specialties, shows the negative association between number of specialties and the probability of being an ISTC[25].

Table A3.1 Probit Estimation, Hospital Choice

	Marginal Prob. (standard error)	
Hospital number of specialties	-0.0529***	(0.0125)
Urology	-0.0244	(0.0200)
Orthopaedic	0.0288	(0.0359)
Ent	-0.0137	(0.0206)
Ophthalmology	0.0499	(0.0540)
Oral surgery	0.0902*	(0.0524)
Plastic surgery	-0.0475	(0.0337)
Gastroent	0.140**	(0.0688)
Gynaecology	-0.0878***	(0.0274)
log(length of stay)	-0.191***	(0.0523)
Female	-0.000984	(0.00443)
Age 36 to 50	0.0577***	(0.0166)
Age 51 to 65	0.0695***	(0.0199)
Age more 65	0.113***	(0.0289)
Self-rated state of health	0.0238***	(0.00652)
Observations	31529	
Pseudo R2	0.7419	

*Notes: Robust standard errors in parentheses, clustered at hospital level; *** p<0.01, ** p<0.05, * p<0.1*

[25] The number of specialties is defined over the whole range of specialties and not restricted to the nine specialties analyzed. The negative association does not mean causation since in this case less available specialties should mean lower probability of choice and then a positive sign.

Hospital choice is not affected by the specialty except in the case of Gastroenterology which favours the choice of an ISTC and in the case Gynaecology with a 9 percent lower probability of ISTC choice. The higher the length of stay, the lower the probability of being treated in an ISTC. With regard to patient's characteristics, patients older than 35 are more likely to go to an ISTC.

Table A.3.2 Determinants of quality - Estimates without hospital fixed effects

	Access	Safety	Inform.	Relation.	Comfort	Global factor	Delay factor	+Information/-Comfort Factor
Urology	-0.0608	-0.0149	-0.145***	-0.0814*	-0.0598	-0.245*	0.173	-0.226
	(0.0404)	(0.0407)	(0.0540)	(0.0462)	(0.0769)	(0.129)	(0.174)	(0.195)
Orthopaedic	-0.184***	0.0852**	0.0177	0.0972**	0.199***	0.0343	0.219**	-0.242**
	(0.0294)	(0.0350)	(0.0461)	(0.0448)	(0.0717)	(0.0796)	(0.0886)	(0.0932)
Ent	0.0118	0.329***	0.00626	0.0755	0.120	-0.198	0.361**	-0.00786
	(0.0443)	(0.0547)	(0.0567)	(0.0631)	(0.0788)	(0.155)	(0.156)	(0.174)
Ophthalmology	0.0312	0.199**	0.173	-0.0215	-0.00332	0.429*	0.146	-0.412
	(0.0798)	(0.0904)	(0.118)	(0.116)	(0.164)	(0.241)	(0.252)	(0.424)
Oral surgery	-0.100	0.0123	0.201*	0.166	-0.0360	-0.0515	-0.536	0.226
	(0.0893)	(0.0902)	(0.108)	(0.144)	(0.184)	(0.384)	(0.504)	(0.312)
Plastic surgery	0.0616	0.144*	0.163**	0.132*	0.429***	0.186	0.172	0.0198
	(0.0779)	(0.0731)	(0.0773)	(0.0782)	(0.146)	(0.186)	(0.194)	(0.272)
Gastroent	0.104	-0.00474	-0.102	-0.194	-0.216	-0.173	-0.812	1.665
	(0.0928)	(0.163)	(0.144)	(0.136)	(0.252)	(0.365)	(1.626)	(1.199)
Gynaecology	0.132***	0.175***	0.0593	0.223***	0.254***	-0.0336	0.332***	0.0760
	(0.0335)	(0.0416)	(0.0526)	(0.0480)	(0.0672)	(0.108)	(0.106)	(0.126)
log(length of stay)	0.0326*	-0.17***	-0.0554**	-0.0730***	-0.00405	0.0240	-0.114**	0.0715
	(0.0182)	(0.0187)	(0.0274)	(0.0213)	(0.0305)	(0.0544)	(0.0556)	(0.0622)
Female	0.0762***	-0.15***	-0.208***	-0.00451	-0.14***	-0.0671	-0.0350	0.0825
	(0.0189)	(0.0194)	(0.0279)	(0.0239)	(0.0324)	(0.0580)	(0.0787)	(0.0793)
Age 36 to 50	0.126***	0.311***	0.221***	0.540***	0.225***	0.146	-0.141	0.254*
	(0.0446)	(0.0411)	(0.0518)	(0.0572)	(0.0744)	(0.118)	(0.116)	(0.142)
Age 51 to 65	0.220***	0.539***	0.490***	0.824***	0.634***	0.453***	-0.222*	0.346***
	(0.0407)	(0.0394)	(0.0476)	(0.0500)	(0.0611)	(0.0849)	(0.122)	(0.130)
Age more 65	0.275***	0.684***	0.435***	0.895***	1.053***	0.731***	-0.00217	0.155
	(0.0397)	(0.0382)	(0.0492)	(0.0549)	(0.0666)	(0.0963)	(0.108)	(0.138)
Self-rate of health	0.111***	0.247***	0.294***	0.333***	0.316***	0.280***	-0.0347	-0.00298
	(0.00832)	(0.00962)	(0.0109)	(0.0117)	(0.0138)	(0.0250)	(0.0331)	(0.0306)
ISTC fixed effect	0.183	0.767***	1.137***	1.895***	2.311***	1.402***	-0.0788	-1.634***
	(0.233)	(0.138)	(0.187)	(0.154)	(0.354)	(0.415)	(0.702)	(0.552)
ISTC*Urology	-0.150	0.170*	0.297	0.106	-0.473	0.198	-0.369	1.189
	(0.294)	(0.0933)	(0.195)	(0.117)	(0.472)	(0.758)	(1.062)	(0.747)
ISTC*Orthopaedic	0.0715	-0.19***	-0.0880	-0.234***	-0.483**	-0.0199	-0.70***	0.657***
	(0.125)	(0.0618)	(0.0924)	(0.0638)	(0.215)	(0.177)	(0.237)	(0.248)
ISTC*Ent	0.213	-0.62***	-0.246	-0.210	-0.0421	0.865	-0.0700	-0.404
	(0.180)	(0.200)	(0.164)	(0.140)	(0.325)	(0.616)	(0.562)	(0.698)
ISTC*Ophthalmology	-0.204	0.00951	-0.0311	-0.100	0.334	-4.106	-15.44*	8.870
	(0.184)	(0.103)	(0.146)	(0.135)	(0.321)	(7.359)	(8.988)	(10.33)
ISTC*Oral surgery	-0.668	0.0717	-0.446	-0.745**	-2.587*	-9.64***	8.322***	1.203
	(0.658)	(0.205)	(0.275)	(0.343)	(1.501)	(2.608)	(2.674)	(2.437)

Table A 3.2 cont'd	Access	Safety	Inform.	Relation.	Comfort	Global factor	Delay factor	+Information/-Comfort Factor
ISTC*Plastic surgery	0.806**	-0.598**	-0.324	-0.397	-0.144	0.407	1.849**	-1.926
	(0.322)	(0.265)	(0.405)	(0.305)	(0.788)	(0.984)	(0.916)	(1.219)
ISTC*Gastroent	0.147	0.110	0.256	0.313*	-0.113	-0.620	-2.782	-2.282
	(0.470)	(0.190)	(0.255)	(0.168)	(0.997)	(0.979)	(4.174)	(3.100)
ISTC*Gynaecology	-0.115	-0.294	-0.117	-0.483***	-0.94***	-0.304	-0.668*	0.323
	(0.0955)	(0.184)	(0.218)	(0.131)	(0.328)	(0.417)	(0.357)	(0.519)
ISTC*log(length of stay)	0.124	0.0957	-0.000690	0.0880	0.0897	0.0891	0.257	-0.0713
	(0.0799)	(0.0647)	(0.0672)	(0.0547)	(0.116)	(0.122)	(0.165)	(0.162)
ISTC*Female	-0.0167	0.0582*	0.0763*	0.0526	-0.0210	0.0566	-0.00204	-0.177
	(0.0495)	(0.0335)	(0.0418)	(0.0361)	(0.0648)	(0.115)	(0.135)	(0.127)
ISTC*Age 36 to 50	0.0537	-0.143**	-0.0483	-0.468***	-0.234	-0.294	0.999*	-0.173
	(0.108)	(0.0655)	(0.0907)	(0.0824)	(0.197)	(0.441)	(0.573)	(0.434)
ISTC*Age 51 to 65	0.150	-0.30***	-0.191**	-0.634***	-0.421**	-0.466	0.829	0.0644
	(0.108)	(0.0667)	(0.0909)	(0.0736)	(0.188)	(0.321)	(0.566)	(0.530)
ISTC*Age more 65	0.0828	-0.41***	-0.0734	-0.665***	-0.66***	-0.594*	0.750	0.189
	(0.107)	(0.0703)	(0.0969)	(0.0821)	(0.204)	(0.350)	(0.571)	(0.520)
ISTC*Self-rate of health	-2.38e-05	-0.13***	-0.125***	-0.191***	-0.16***	-0.122**	-0.00963	0.224***
	(0.0370)	(0.0166)	(0.0259)	(0.0208)	(0.0473)	(0.0603)	(0.0800)	(0.0611)
Selection term	-0.0251	-0.176	0.0297	0.0678	0.460	0.213	0.00918	0.334
	(0.208)	(0.140)	(0.173)	(0.162)	(0.318)	(0.333)	(0.367)	(0.370)
Constant	-0.768***	-1.28***	-1.577***	-2.24***	-2.16***	-1.68***	0.175	-0.234
	(0.0680)	(0.0658)	(0.0794)	(0.0927)	(0.105)	(0.158)	(0.195)	(0.213)
Observations	23840	22552	17693	25521	15772	1649	1649	1649
R-squared	0.039	0.076	0.120	0.108	0.142	0.250	0.048	0.033

*Robust standard errors in parentheses, clustered at hospital level; *** p<0.01, ** p<0.05, * p<0.1*

A.4 . LIST OF INTERVIEWEES

Code	Role	Organisation	Area	Date
A01	Commissioning Director	PCT	A	Nov 08
B01	Commissioning Director	PCT	B	Mar 09
C01	Associate Commissioning Director	PCT	C	Mar 09
C02	Associate Commissioning Director	PCT	C	Mar 09
A02	Clinical Director	Foundation Trust	A	Mar 09
A03	Chief Executive	Foundation Trust	A	Mar 09
A04	Medical Director	Foundation Trust	A	Mar 09
A05	Managing Director	PCT Provider Unit	A	Mar 09
A06	Consultant Nurse	PCT Provider Unit	A	Mar 09
A07	Clinical Director	Trust	A	Mar 09
A08	Finance Director	Trust	A	Mar 09
A09	Operational Director	GP cooperative	A	Mar 09
A10	Chief Executive	Trust	A	Mar 09
A11	Service Manager, Home Care	Local Authority	A	Dec 08
M01	Research Manager	Business Association	London	Sep 08
M02	Business Manager	Public Private Partnership	London	Oct 08
C03	General Practitioner	Integrated Health Centre	C	April 09
A12	Managing Director	Private sector home healthcare	A	22/05/09
C04	Medical Director	Private sector diagnostic service	C	01/06/09
C05	Chief Operating Officer	Private sector diagnostic service	C	01/06/09
A13	Chairman	Independent treatment centre	A	05/06/09
B02	Managing Director	PCT Provider Unit	B	10/06/09
C06	Medical Director	Private sector primary care provider	C	12/06/09
C07	Service Director, Adult Care	PCT Provider Unit	C	12/06/09
C08	Interim Managing Director	PCT Provider Unit	C	15/06/09
C09	Various	National charity for dementia	C	16/06/09
B03	Managing Director	Local charity for older people	B	28/07/09
C10	Managing Director	Private sector provider of acute and community care	C	30/07/09
B04	Managing Director	Charity for older people	B	31/07/09
B05	Service Manager	Charity providing home care	B	05/08/09
B06	CEO	Orthopaedic Specialty Trust	B	25/08/09

B07	Commissioning director	Orthopaedic Specialty Trust	B	25/08/09
D01	Commissioning director	PCT	D	28/08/09
B08	Strategy Director	Foundation Trust	B	14/09/09
D02	Associate Commissioning Director	PCT	D	15/09/09
C11	Director	Social Enterprise Primary Care Consortium	C	16/09/09
D03	Associate Commissioning Director	PCT	D	18/09/09
D04	CEO	Trust	D	21/09/09
M03	Director	Nurse led primary care practice	M	23/09/09
D05	Managing Director	PCT Provider Unit	D	12/10/09
D06	Medical Director	Trust	D	26/10/09
C12	CEO	Foundation Trust	C	04/11/09
M04	Community lead	Nursing Association	M	28/10/09
D07	Managing Director	Social care organisation	D	26/11/09
M05	Partner	Private sector clinical partnership	M	04/01/10
D08	Finance director	Orthopaedics triage service	D	07/01/10
M06	Health policy lead	Union	M	15/01/10
D09	Director of performance	Foundation trust	D	20/01/10