

Patient choice in the NHS: How critical are facilities services in influencing patient choice?

MILLER, L. and MAY, D.

Available from Sheffield Hallam University Research Archive (SHURA) at:

<http://shura.shu.ac.uk/906/>

This document is the author deposited version. You are advised to consult the publisher's version if you wish to cite from it.

Published version

MILLER, L. and MAY, D. (2006). Patient choice in the NHS: How critical are facilities services in influencing patient choice? *Facilities*, 24 (9/10), 354-364.

Copyright and re-use policy

See <http://shura.shu.ac.uk/information.html>

Patient choice in the NHS

How critical are facilities services in influencing patient choice?

Lisa Miller, *Milton Keynes General NHS Trust, Milton Keynes, UK*

Daryl May, *Facilities Management Graduate Centre, Sheffield Hallam University, Sheffield, UK*

Abstract

Purpose – From December 2005, patients in the UK needing an operation will be offered a choice of four or five. These could be NHS trusts, foundation trusts, treatment centres, private hospitals or practitioners with a special interest operating within primary care. This is called “Choose and Book”. The purpose of this research is to discover how critical facilities management service factors are in influencing a choice of hospital. The aim is to find out what the most important influencing factors are to people when making a choice of which hospital to have their operation. If facilities services and the patient environment are influencing factors in the patient experience, which are considered critical.

Design/methodology/approach – Focus groups were used as the primary method of data collection.

Findings – The study finds that all three focus groups placed more importance on clinical factors than facilities factors. High standards of cleanliness and good hospital food were the two facilities factors that participants in all groups placed most importance on. Cleanliness was highlighted by all three groups as a top facilities priority for the NHS at the moment and there was a general perception that private hospitals have better standards of cleanliness.

Practical implications – By understanding how important facilities factors are in influencing patient choice and which ones have a critical impact, it will help NHS trusts focus on where they channel their resources.

Originality/value – This paper is of value to NHS trusts who want to make effective use of facilities services in order to be competitive in attracting patients through the new patient choice framework.

Introduction

In 2000, the UK Government published *The NHS Plan* which set out an ambitious strategy to create a health service that is more responsive to the citizens who pay for it and the patients who use it. A patient centred service demands more power for patients. *The NHS Plan* stated, “patient choice will be strengthened” and placed particular emphasis on patient choice over hospital treatment including a choice over “a convenient date and time rather than being assigned a time by the hospital”.

For the first time patients in the NHS will have a choice over when they are treated and where they are treated. The reforms will mark an irreversible shift from the 1940s “take it or leave it” top down service. Hospitals will no longer choose patients. Patients will choose hospitals. From December 2005, UK patients needing an operation will be offered a choice of 4 or 5. These could be NHS trusts, foundation trusts, treatment centres, private hospitals or practitioners with a special interest operating within primary care, this is called “Choose and Book” (Department of Health, 2004a, b). As well as choosing where to go, patients will be able to choose when, due to a national electronic booking programme. Appointments will be made at the GP surgery, by calling a contact centre, online and eventually via digital television. According to a MORI (2005) survey commissioned by the Department of Health, 76 per cent of patients wanted to be involved in decisions about their treatment, 42 per cent wanted to choose their appointment time and 31 per cent wanted to choose their hospital or doctor.

Choice is seen as acting as a driver for improving services by transforming the NHS into a more responsive patient centred service. Patient choice and the new Payment By Results (Department of Health, 2004a, b) funding system aims to provide incentives for hospitals to provide more responsive services that patients want to choose. The aim of the new financial system (payment by results) is to provide a transparent rule-based system for paying trusts. Its aim is to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix. Importantly this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and negotiating skills of individual managers. Under the reforms to NHS financial flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity they undertake. In other words the money will flow with the patients.

The purpose of this research is to discover how critical facilities management service factors are in influencing a choice of hospital. The aim is to find out what the most important influencing factors are to people when making a choice of which hospital to have their operation. If facilities services and the patient environment are influencing factors in the patient experience, which are considered critical.

Literature review

For more than a decade, the NHS and other health care systems have been under pressure to make their services more responsive to users, and they have reacted by introducing a wide range of measures including the extension of patient choice. Recent policies for promoting patient choice stem from the government's determination to explore every option for meeting the key NHS target of reducing waiting times for hospital treatment. In this context patient choice not only exploits short term spare capacity in the NHS and private healthcare sector, but also exerts consumer pressure on poorly performing hospitals (which will see their workload and importantly their income reduce as patients choose other hospitals) (Appleby *et al.*, 2003).

Hospitals will be paid per patient for the treatments and surgery they carry out. Where choice is exercised cash for treatment goes with the patient. If all patients choose to go to hospital A rather than hospital B because they have heard it is better or for another reason, hospital A will get more money than hospital B. Those hospitals that have capacity to do so will earn more resources as the money follows the choice made by the patient (Shifrin, 2003a). Shifrin states that opponents of the scheme fear that this will lead to competition that will drive weak hospitals to the wall.

Appleby *et al.* (2003) indicate that patient choice can exert competitive pressure on poorly performing hospitals. But although choice of provider may give an incentive to improve this is not the same as closing inequitable gaps in service provision and quality. In fact hospitals that lose patients to other establishments because of patient choice could face a spiral of financial decline. Such hospitals may then have a difficulty in responding to the “market signals” of patient choice, resulting in poorer services for those patients remaining with their home hospital – and a consequent widening of inequality.

Shifrin (2003b) thinks that NHS hospitals could start advertising for business as they compete to attract patients under the government's policy of increasing patient choice. She states that the new financial system where hospitals will earn money for each person treated could lead to hospitals marketing their services directly to patients, highlighting short waiting times or innovative treatments. Lewis (2003) describes this as the “New NHS Market” and adds that the old monopoly will give way to diversity.

Appleby *et al.* (2003) also agree that the linking of patient choice with the movement of money around the NHS in effect creates a market for the services in question, which in theory should put pressure on high cost providers to improve their performance. However, there is some evidence to show that in markets where prices are fixed, there can be trade off between quality and volume warns Lewis (2003), who fears hospitals driving down quality in order to compete.

Are FM services considered critical during the patient journey or are patient perceptions of the NHS-based purely on clinical treatment or outcome? *The NHS Plan* (Department of Health, 2000) was a ten-year strategy to transform every aspect of the service. The reason for this plan can be summarised in two words – patient power. *The NHS Plan* emerged in part from an exhaustive survey to discover what patients and the public saw as the top priorities for the service. Three of the top ten were facilities issues: cleanliness, hospital food and a safe warm and comfortable environment (Cole, 2004). The renewed emphasis on the healthcare infrastructure reflects a growing recognition that the environment can have a direct impact on patient care. It is also fuelled by the rise of consumerism; forcing managers to recognise they can no longer offer poor standard services.

Baldwin (2005), states that certain hospitals are favoured in their ability to attract potential patients, because of factors such as waiting times, convenience, certainty of treatment dates and the availability of transport. Although the reputation of the hospital is important, it does not seem to be based solely on clinical outcomes, which are generally seen as given. He states that specific health related issues will affect the hospital's reputation but it is the subjective assessments of the environment,

ease of parking, facilities for visitors and perceived cleanliness that patients base their choices on. However, the relative importance of FM factors are little understood. By understanding how important facilities services are in influencing patient choice and which ones have a critical impact, this will help trusts to focus on where they put their energies. For example, if a patient's television is not working, how much will that have an impact on the patient experience compared with a patient not seeing a nurse straight away – issue of medical care versus FM factors. This will then lead to where the resources are focused in facilities. Are they focused in the right areas? Baldwin states that through good management a trust can gain competitive advantage through initiatives such as clean hospital strategies, better hospital food and ensuring patients' privacy and dignity.

Interestingly, the London Patient Choice pilot scheme (Coulter *et al.*, 2004) found that as waiting times started to decrease, other factors started to become more important to patients such as the facilities, car parking, etc. They also found that patients tended to choose a hospital based on how well known it was, for example, many chose the Portland Hospital because Victoria Beckham had her baby there. There is also a concern that patients will want to choose the newer PFI hospitals over the older NHS trusts. This could have an impact on the older hospitals as the funding is diverted away. The question that commissioners will need to address is, do they invest and improve the facilities of the older hospitals?

Research carried out by Taylor *et al.* (2004) found that patients considered ease of access and quality of care as more important than waiting times in making their choice of hospital. During the research patients were asked a series of qualitative questions about their experience. The most commonly cited issue for patients was lack of information. When asked what information patients would like to have had to make their decisions, information about the quality of clinical care was overwhelmingly cited.

A quantitative research study conducted by MORI (2004) Social Research Institute on behalf of Thames Valley Strategic Health Authority, found that Thames Valley residents welcome the concept of more choice. The report states that the three most important factors in the choice of hospital for the general public are:

1. the hospitals reputation/star rating (39 per cent);
2. the distance of the hospital from home (32 per cent); and
3. the reputation of the consultant (31 per cent).

A survey carried out by Picker Institute Europe (Coulter *et al.*, 2004) on patients eligible for the London Patient Choice Scheme asked patients to quantify the relative value of factors influencing their willingness to go elsewhere. Quality of care was deemed to be even more important than fast access. Cleanliness was rated the second highest factor. Many patients were concerned about the risk of infection and information about hygiene standards in alternative hospitals would be likely to influence their decisions about where to be treated.

The NHS has recognised that the healthcare infrastructure and environment can have a direct impact on patient care. There is a general feeling that clinical outcomes are seen as given and that the public will therefore base their choices on their

subjective assessment of the environment especially as waiting times are starting to decrease. The research suggests that quality of care and ease of access are most important to people when choosing hospitals. There has to be a clear benefit to the patient in order to make it worthwhile putting up with the inconvenience of travelling further. In addition, in relation to the NHS facilities services, the research already conducted suggests that the most important facilities factors are cleanliness, hospital food, comfortable environment and privacy and dignity.

Methodology

The research was a phenomenological-based study. Phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved. A researcher applying phenomenology is concerned with the lived experiences of the people involved or who were involved with the issue that is being researched (Groenwald, 2004).

The main data collection method used was focus groups. This was the most appropriate data collection method given the need to facilitate discussion and gather information of participants' views. Focus groups are normally associated with a phenomenological methodology and are generally composed of seven to ten people (Marshall and Rossman, 1999) who are unfamiliar to one another and have been selected because they share certain characteristics relevant to the study's question. Under the guidance of the researcher, participants are stimulated to discuss their opinions, reactions and feelings about the topic, the emphasis being on the quality and depth of the data. It is therefore possible to conduct such research with very small samples. The data are often referred to as rich since it captures the richness of detail and nuance of phenomena being studied (Hussey and Hussey, 1997).

Since, the objective of qualitative research is to understand and give meaning to a social process, rather than quantify and generalise to a wider population, it is inappropriate to use random sampling or apply statistical tests. When selecting the group participants for this study one issue was whether to have one focus group with participants that have had NHS experience and another group of participants who have not yet had experience of being a patient in the NHS in order to see if there would be a difference in their choice criteria. Bryman (2001) has found that having or not having had a particular experience or a particular background does significantly affect the interpretation of a given text.

For this research study, participants for the focus groups were selected from the general public using a purposive sampling method. Hussey and Hussey (1997) talk about judgemental sampling in which participants are selected on the strength of their experience of the phenomenon under study. For this study, it was decided to use three groups. One group with minimal but recent experience of the NHS, one group with extensive and ongoing NHS experience, and the third group with private hospital experience.

The three focus groups were conducted in March and April 2005. All participants were sent information sheets prior to the study via a contact point for each of the groups, which provided clear information of the research and its objectives. With the

agreement of all participants, the three focus groups were taped and transcribed afterwards.

A total of 16 people attended the three focus groups. The first group consisted of six participants, four who had recently given birth and so had recent experience of maternity units and two who had their children 30 years ago. The second group had five participants who had mainly used private hospitals and who had very little experience of NHS hospitals between them. The third group consisted of five people who were current stoma patients.

The process of coding to analyse the transcripts from the focus groups was used for this study. This involved reading the transcripts and coding sections, breaking down and labelling the individual elements of information, making the data more easily recognisable and less complicated to manage. The initial coding process produced 57 individual codes. The codes were then re-examined and some codes were grouped together which resulted in 24 themes/categories.

Findings

Each focus group was started with a general introductory question about the NHS in order for the participants to start thinking about the topic and to encourage conversation. As the discussion progressed, key questions were used to move the conversation into the study topic.

The focus group participants are summarised in Table I.

Table I Summary of focus group participants

Focus group	Number of participants	Background of participants
A	6	All women. Ages between 30 and 60 years. Four participants had recently given birth (in the last ten months) and two had their babies 30 years ago
B	5	Three women and two men. Ages between 45 and 62. Very little NHS hospital experience. Had experience of private hospitals
C	5	All women who are current stoma patients. Ages between 50 and 65. Predominantly NHS hospital experience

Each focus group was given two exercises to complete as a team in order to find out:

1. how participants would rate the importance of clinical factors against facilities factors; and
2. which factors were more important to them.

The participants were specifically asked to complete the exercises as a group in order to engage the participants and to generate discussion and debate around the different factors. Each group was given a list of 13 factors that they may find important when choosing which hospital to go to. These factors were distilled from research previously referred to in the literature review and were as follows (facilities factors are in *italic*):

1. Ease of access (locality).
2. Good reputation/star rating.
3. Reputation of consultant.
4. Shorter waiting time.
5. High success rate of particular operation.
6. *Brand new hospital.*
7. *Old hospital.*
8. *Good décor.*
9. *Single rooms.*
10. *Comfortable environment.*
11. *Good hospital food.*
12. *Ease of car parking.*
13. *High standards of cleanliness.*

For the first exercise, the participants were asked as a group to pick out the five most important factors to them and then place them in order of priority with the most important being at the top of the list (number 1). The results are detailed in Table II.

All three focus groups placed more importance on clinical factors compared to facilities factors. Focus Groups A and B chose high success rate for a particular operation and reputation of the consultant as their two most important factors. Focus Group C chose reputation of the consultant and shorter waiting times as their two most important factors. High standards of cleanliness and good hospital food were the two facilities factors that participants in all groups placed most importance on. Groups B and C put high standards of cleanliness at numbers 3 and 4, respectively. Group A placed it as joint number 5 with ease of access. Groups B and C placed good hospital food at number 5 and Group A did not include it in their list at all.

Table II Results of exercise 1

Results for focus Group A	High success rate for a particular operation Reputation of the consultant Good reputation/star rating Shorter waiting time Ease of access/high standards of cleanliness ^a
Results for focus Group B	High success rate for a particular operation Reputation of the consultant High standards of cleanliness Shorter waiting time Good hospital food
Results for focus Group C	Reputation of the consultant Shorter waiting time High success rate of a particular operation High standards of cleanliness Good hospital food

Note: ^aJoint fifth place as group could not decide which was more important

For the second exercise, the clinical factors were removed from the list and the groups were asked to carry out the exercise again with only the facilities factors. The results are detailed in Table III.

Cleanliness was highlighted by all three groups as a top priority for the NHS at the moment and there was a general perception that private hospitals have better standards of cleanliness. From Table II, all three focus groups placed cleanliness as one of their five most important issues. The maternity group (Group A) placed cleanliness at number 5 in the first list which included clinical-based issues as well as facilities. The other two focus groups (Groups B and C) placed cleanliness at numbers 3 and 4. This could be because Groups B and C were held when the general election was in full swing and cleanliness in hospitals was very high on the political agenda. Interestingly all three focus groups placed cleanliness as the most important facilities issue (number 1) when they were asked to list the five most important facilities issues in order of importance (from Table III).

Table III Results of exercise 2

Results for focus Group A	High standards of cleanliness Single rooms Comfortable environment Good hospital food Ease of car parking
Results for focus Group B	High standards of cleanliness Good hospital food Comfortable environment Ease of car parking Single rooms
Results for focus Group C	High standards of cleanliness Good hospital food Comfortable environment Single rooms Ease of car parking

When participants were asked what information they would need from their GP to enable them to make a choice, cleanliness was one issue they all stated they would want information on. Some participants said they were frightened to go into hospital for fear of what they might pick up. When asked what might make them choose to go to another hospital other than their local one, one participant replied “reports on cleanliness”. Discussions took place in all three groups around how cleanliness is measured. Comments were made such as “It’s invisible” “you think my house is really tidy but it is probably a dream of germs”.

Participants expressed concern as to how they can find out if a hospital is clean. One group said that a low rate of MRSA proves the hospital is clean. There were also comments that a hospital can have a good star rating (which includes cleanliness) but it is very difficult to control visitors who do not wash their hands and then put germs onto door handles.

The general perception is that patients would get better food in a private hospital as opposed to an NHS hospital. Food was rated as not very important in the maternity

group (Group A), the general view being that their partners can bring food in for them. All participants in this group said that if they were given a choice of hospital, then food would not be a factor that they would ask about.

There was a general consensus that the longer one is in hospital the more important hospital food becomes, which could be why the maternity group (Group A) did not see it as an important factor. For people on special diets, i.e. diabetes, gluten free, etc. hospital food was more important to them. One participant who was a diabetic said that she would place good hospital food higher than shorter waiting time.

Most participants said they would choose a private hospital over an NHS hospital because they automatically get their own room and bathroom – they like the privacy. If offered a choice of two hospitals, one NHS and the other private and they would have the same consultant in both, all three groups said they would choose the private hospital for comfort and privacy. There was a general feeling that NHS hospital wards are noisy (including throughout the night).

Participants liked the privacy in private hospitals in that they automatically get their own room and bathroom. This was particularly important to the maternity group (Group A) and for the Stoma group (Group C). However, one participant in the mixed group (Group B) said that she really missed the company of other patients when she was in a private hospital. When she was very poorly, she was grateful for the privacy of a single room, but when she began to feel better she would have enjoyed some interaction with other patients. However, some participants expressed concern that many private hospitals may not be able to cope with the type of operation or the aftercare that some people may need.

The general perception is that one would get better treatment at a private hospital as in cleanliness, food, surroundings and comfort. Participants talked about private hospitals having a hotel feel about them, with relaxed carpeted receptions. There were comparisons made of relaxed atmospheres in private hospitals “orderly, calm atmosphere” with chaotic ones in general NHS hospitals (people running around with trolleys, patients being moved here and there).

Car parking was seen by all three groups as being a more important issue for visitors and not for themselves as patients. However, participants did recognise that it would become a more important issue when attending outpatient appointments after their operations. All three groups rated car parking as the fourth or fifth most important issue in the facilities list. Car parking did not make the top five in the list which included clinical issues in any of the focus groups.

Most participants stated that they would travel further if the waiting list was shorter at another hospital. Interestingly some participants said that they would be worried if a hospital could fit them in for an operation next week compared to their local hospital that could not fit them in for another four months. They would want to know why the hospital could carry out the operation so quickly. They would want to know the hospital's performance with regard to cleanliness, nurses and doctor's supply, and ward closures “I think a waiting list could indicate it is a good hospital”.

Conclusions

The aim of the research project was to explore the views of potential patients surrounding the patient choice scheme and to find out what the most important influencing factors are to people when making a choice of which hospital to have their operation. If facilities factors and the patient environment are influencing factors, which are considered critical? The paper is of value to UK NHS trusts who want to make effective use of their facilities services in order to be competitive in attracting patients through the new patient choice framework.

In general the study found that what would influence people varied from person to person depending on their illness. If a person was in severe pain or their illness was life threatening then they would want to go to a hospital that could see them more quickly. If a person had a very complicated illness, then they may want to choose a hospital which specialises in the field or which has a consultant with a fantastic reputation.

The London Patient Choice Scheme found that as waiting times decreased other factors became more important to people, such as the facilities and car parking. While shorter waiting time was important to the participants in the study, they all said that whether they will opt for quicker treatment depends crucially on, for example, whether they can avoid treatment at a hospital where the reputation is worse or unknown relative to their local hospital. Hence, they would particularly want to know the hospital's performance with regard to cleanliness. Information about the quality and reputation of alternative providers is likely to play a key role in the uptake of choice.

All three focus groups placed more importance on the clinical factors against the facilities factors. Participants wanted to know information on the success rates of their operations and the reputation of the consultant. This result challenges the theory that Baldwin (2005) has about clinical outcomes being generally seen as given. The most important facilities issues were cleanliness and good hospital food. All three groups placed hospital cleanliness as the most important facilities issue to them and most participants said that if a hospital was not clean then this would influence them into choosing an alternative hospital. The third most important facilities issue was a comfortable environment. All three groups said that it was not important if the hospital was brand new or old as long as it was clean and had a comfortable environment, i.e. comfortable beds, pillows, chairs and enough chairs for their visitors to sit on. When participants were asked if they would choose an NHS hospital or a private hospital, most participants said they would choose to go private because they perceive the facilities to be better in a private hospital.

Patients will choose where they want their treatment on the basis of availability, location, advice and perception. Where a patient is making a choice, the quality of care and outcomes are going to be the major factor. Perception should not be underestimated. Public expectation about health facilities can be very poor and as this study shows, patients will also seek out recommendations from friends and family when faced with making a choice. Experiences will also play a huge part. Introducing choice inevitably leads to measurement of the "experience" that the choice creates. In other words by having choice, the customer needs a reference point for comparison. Only by being able to compare and contrast the whole experience can a choice be made. Hospital Trusts will need to ensure that the

customer's experience is a sound one or else customers may stray to the competition.

Healthcare is not always something people want to make choices about. What they want by and large is to know that they will get nothing but the best and that there are enough well trained and highly motivated professionals available, near enough to where they live and work to provide it. They want clean, quiet hospital wards with appropriate privacy and good food.

References

Appleby, J., Harrison, A., Devlin, N. (2003), *What is the Real Cost of More Patient Choice?*, Kings Fund, London, .

Baldwin, E. (2005), "Patient choice: pick and mix", *Health Service Journal*, Vol. 115 No.5940, pp.38.

Bryman, A. (2001), *Social Research Methods*, 1st ed., Oxford University Press, Oxford, .

Cole, A. (2004), "Better late than never", *FM World*, pp.18-9.

Coulter, A., Henderson, L., Le Maistre, N. (2004), *Patients' Experience of Choosing Where to Undergo Surgical Treatment*, Picker Institute Europe, Oxford, .

Department of Health (2000), *The NHS Plan: A Plan for Investment. A Plan for Reform*, HMSO, London, .

Department of Health (2004a), *Choose and Book: Patients Choice of Hospital and Booked Appointment – Policy Framework*, HMSO, London, .

Department of Health (2004b), *Implementing Payment by Results: Technical Guidance 2005-06*, HMSO, London, .

Groenwald, T. (2004), "A phenomenological research design illustrated", *International Journal of Qualitative Methods*, Vol. 3 No.1, pp.1-26.

Hussey, J., Hussey, R. (1997), *Business Research: A Practical Guide for Undergraduate and Postgraduate Students*, 1st ed., Palgrave, Hampshire, .

Lewis, R. (2003), "Cutting edge", available at: <http://society.guardian.co.uk/nhsplan/story/0,7991,884101,00html> (accessed 11 November 2004), .

Marshall, C., Rossman, G. (1999), *Designing Qualitative Research*, 3rd ed., Sage Publications, London, .

MORI (2004), "Patient choice in Thames Valley: research study conducted for Thames Valley strategic health authority", available at: www.tvsha.nhs.uk/papers/MORlreport.pdf (accessed 11 April 2006), .

MORI (2005), "Health matters: choice ... how many hospitals will close?", available at: www.mori.com/events/index.shtml (accessed 10 January 2006), .

Shifrin, T. (2003a), "Q&A: patient choice", available at: <http://societyguardian.co.uk/nhsplan/comment/0,8005,1103300,00html> (accessed 11 November 2004), .

Shifrin, T. (2003b), "Hospitals may advertise to woo patients, says NHS report", available at: <http://society.guardian.co.uk/nhsplan/story/o,7991,997981,00html> (accessed 11 November 2004), .

Taylor, R., Pringle, M., Coupland, C. (2004), *Implications of Offering "Patient Choice" for Routine Adult Surgical Referrals*, Dr Foster Limited, London, .

Corresponding author

Daryl May is the corresponding author and can be contacted at: d.may@shu.ac.uk