

**Abstract No: 007-0175**

**Title: An Empirical Investigation into Service Strategy within the UK Health System**

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**POMS 18<sup>th</sup> Annual Conference**

**Dallas, Texas, USA**

**May 4 to May 7, 2007**

# **An Empirical Investigation into Service Strategy within the UK Health System**

## **Abstract**

*An empirical case study was undertaken that investigated the impact the United Kingdom (UK) Department of Health (DH) 18-Week Patient Pathway (18 WPP) had on a specific outpatient department (OPD). The research analysed existing patient pathway procedures in place within a UK Hospital Trust Cardiology OPD. From the collected data, it was established that the OPD was not managing patient demand and was struggling to meet the remit of the 18 WPP. At the invitation of the OPD Manager, a revised pathway was recommended for the Trust's consideration.*

*From the research, other key influences were identified to have a significant impact on service improvement and managing change within the National Health Service (NHS). The core contribution of this research has added to the general body of knowledge about the management of organisational change. This paper is of value to those working in the healthcare and wider public sector.*

## **Introduction**

The UK NHS was formed on 5<sup>th</sup> July 1948 with the founding principle that the NHS would provide healthcare for all the UK population, based on need, not the ability to pay (NHS, 2006). The formation of the NHS was a major undertaking set within the backdrop of the struggling post-World War Two economy, when food was rationed and there was a shortage of building materials. Today the NHS is the largest organisation in Europe and is recognised by the World Health Service as one of the best health services in the world. For years the NHS had been poorly funded and tied-up in bureaucracy; however, the NHS is now in the midst of undergoing substantial modernisation to cope with the demands of the 21<sup>st</sup> Century.

It was acknowledged in 1997 that the NHS would soon be a 1940's system operating in the 21<sup>st</sup> century with rigid institutional boundaries that meant the needs of the individual

patients came a poor second to the needs of the individual service. Similarly, there was considerable waste and inefficiencies due to little co-ordination between the NHS and other healthcare organisations. In 2000, the '*NHS Plan: a plan for action, a plan for reform*' was published. This NHS 10-year modernisation plan intends to provide far-reaching changes that give the population of Britain a health service that is fit for the 21<sup>st</sup> century: a health service designed around the patients (DH, 2000a). Additionally, the plan ensured restructuring, modernisation and considerable investment for the NHS in England. These initiatives brought about to shift the balance of power within the NHS and was complemented by the Health and Social Care Act that imposed a duty for NHS Trusts to consult with patients and the public on NHS issues (Binley, 2006). New GP and consultant contracts were negotiated with the remainder of the NHS workforce pay and conditions reconfigured through the 'Agenda for Change' programme along with 'better ways of working' initiatives.

This paper investigates the impact that the UK Department of Health (DH) 18-Week Patient Pathway (18 WPP) had on one specific NHS outpatient department.

## **The Literature**

According to Burnes (2004) the concept of strategy may have originated from the ancient Greeks and Bracker (1980:219) argued the word came from the Greek *stratego*, meaning '*to plan the destruction of one's enemies through the effective use of resources*'. The term, or use, of strategy remained in the military environment well into the 19<sup>th</sup> century when it was first used in the business world. According to Bracker (1980) and Chandler (1962), strategy was first used in the civilian environment to exploit opportunities and needs of the changing population created through the increase of income and new technology: employ existing or expanding resources more profitably.

After the Second World War, Burnes (2004), comments that the USA experienced an unexpected trading boom and American companies were forced to rethink their business planning systems using established long-range planning techniques. However, they found that these techniques were now too rigid as they were based on previous business trends. Consequently, as they were unable to accurately forecast future demand, the concept of *strategic management* emerged in place of long-range planning. Elliott and Lawrence (1985); Mintzberg and Quinn (1991), identified strategic management as one that focuses on environment issues that underlie market trends allowing for the possibility that changes in market trends can and do take place. This methodology was not based solely on the internal growth of an organisation, but also on winning market share from competitors. This in turn created hard-nosed business decisions by management collating quantitative data on their organisations and using this information to make rational decisions on their future business intentions. Some adopted the approach that if they could not be leaders in their chosen field, the business was either sold off or closed down. A development from this 'looking in and out' strategic discipline is the popular SWOT (Strengths, Weaknesses, Opportunities and Threats) critical appraisal technique developed by Kenneth R Andrews (Burnes, 2004).

Consequently, strategy in the business environment, as defined by Johnson and Scholes (1993), incorporates the following six statements: i) Concerns the full scope of an organisation's activities; ii) Matches the organisation's activities to its environment; iii) Matches its activities to its resource capability; iv) Affects the operational decisions; v) Is affected by the beliefs and values of the personnel with authority in an organisation; vi) Affects the long-term direction of an organisation. This is further defined by Slack, Chambers, Johnston (2004: 778) '*strategic decisions are those which are widespread in their effect, define the position of the organisation relative to its environment and move the*

*organisation closer to its long-term goals'*. Whereas, Porter (1996) defines strategy as being the creation of a unique and valuable position, involving a different set of activities. He also points out if there was only one ideal position, there would be no need for strategy and it would be a race amongst competing organisations to discover the commodity first in order to gain the competitive advantage.

Dale (2003) identifies the Japanese Hoshin Kanri concept: management control of the company's focus, or in Western terms, Policy Deployment, as a method of strategic management. This involves strategic planning and management processes involving setting direction and deploying the means of achieving that direction. A focal part of this concept is the use of Deming's PDCA (Plan-Do-Check-Act) cycle (Dale, 2003). Hoshin Kanri was developed in the early 1960s and was used effectively to communicate an organisation's policy, goals and objectives throughout its hierarchy with its main benefit being to focus on key activities for success. The five main characteristics of this concept are as follows: i) Clear organisational goals, understood by all; ii) Involving employees in the development of action plans; iii) All departments and employees work in the same direction to achieve objectives; iv) Regular reviews of the objectives using PDCA cycle; v) A high level of publicity and displays within the organisation.

Porter (1996) identifies that there is a contrast to that of strategic positioning (performing different activities from rivals or similar activities in different ways) to operational effectiveness (performing similar activities better than rivals perform them). He points out that the differences in the operational effectiveness of the Japanese challenge to Western organisations in the 1980s. The Japanese operational effectiveness was considerably more developed and effective than their rivals along with offering products at lower cost and superior quality.

With over 30 years of strategy in one form or another, Hambrick and Fredrickson (2005) argue that the original concept has been some what lost in translation. They point out that consultants and scholars have provided an abundance of frameworks, powerful analytical tools, but guidance has been lacking on the implementation and use of these frameworks and tools. Consequently, some executives headline everything with strategy to such a point that they create confusion and undermine credibility, for example, '*our strategy is to be the low-cost provider*'. Strategy has in some ways become a common term used to mean whatever one wants it to mean. However, what is clear to the Author is that strategy and management of strategy is not about capacity decisions, setting budgets and pricing mechanisms in isolation; but are components of an overall strategy that endeavours to give an organisation competitive advantage over their rivals through operational effectiveness.

### **The NHS Literature**

Considerable financial investment has been provided by Government with an increase of the NHS budget from £54.2 million in the FY00/01 to £84 million for the FY06/07 and the highest allocation will be £92 million in FY07/08. This will have seen an increase of approximately seven and half percent per year and in 2008 will reach nine percent of Gross Domestic Product (GDP) which will be comparable to healthcare spending in European countries (King's Fund, 2005). In return, new hospitals (funded through PFI and leased back to the NHS) are being built; one-stop (walk-in) primary care clinics are being established in prominent public locations; GP practices are being modernised; hospitals equipped with up-to-date equipment including improved feeding standards for patients. The NHS is also promoting preventative treatment, such as healthy eating lifestyles, along with a 24-hour 365-day telephone and internet facility known as NHS Direct. This initiative allows the public to

contact qualified personnel to discuss minor ailments or be given advice on courses of action should they need access to the NHS. Additionally, the public can access the NHS Direct internet site (see [www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)) to research information so that they can make more informed choices about their healthcare.

Consultation with the population showed that patient waiting times were one of the major concerns within the NHS. Data revealed that in 1997 there were over 280,000 patients waiting more than six months for elective inpatient or day case treatment with over 335,000 patients waiting more than three months for outpatient consultations. Additionally, some patients were waiting more than eighteen months or longer for surgery (DH 2005a). Consequently, the DH set about imposing rigid targets to ensure that waiting times are not exceeded. Accident & Emergency (A&E) departments must now treat and either discharge or arrange inpatient admission within four hours of the patient's arrival at A&E. By the end of 2008, all outpatients will have a maximum wait of 18 weeks from GP referral to secondary care prior to the start of definitive treatment. Elective inpatients will have a maximum wait of six months prior to their admission. Serious conditions, such as cancer and heart disease, will have 'fast track' diagnosis facilities in-order that treatment programmes are implemented at the early stages of the condition. To facilitate these initiatives, the NHS has increased its workforce by some 39,000 and the NHS is now the largest employer in Europe with around 1.3 million employees in over 300 careers (Hyde *et al*, 2006). To assist in reducing the waiting times, the NHS has also negotiated contracts to treat patients using private healthcare providers with treatments costs remaining free to the NHS patient.

Whilst the NHS may benefit from unprecedented amounts of financial provision from Government, the NHS is also now under a strict regime of financial accountability. NHS organisations are now accountable for their incurred costs and are expected to balance their

books through income generated by a system known as 'Payment by Results' (PbR). The aim of PbR is to provide a transparent rules-based system that will reward efficiency with payments linked to activity rather than through historical budgetary bids (DH 2006a). Therefore, patient treatment will be attributable to a financial cost code that is recovered by provider of the treatment from the organisation that 'supplies' the patient. An example being a referral of a patient from a GP practice to a hospital outpatient department clinic, the hospital will recover a fixed price cost for attending to the patient from the Primary Care Trust (PCT) who administers the GP practice where the patient is registered.

Whenever possible, the NHS will now provide a patient with an informed choice of treatment options; treatment providers; location for receiving care; and, with ongoing care including choice through to the patient's end of life. Patient Choice has already been introduced within elective care surgery, and as additional capacity is required, this may also include surgery overseas to ensure that targets are not compromised (DH, 2005b). From 2006, PCTs as a transitional step towards free choice, offer a choice of four or five local NHS providers including NHS Foundation Trusts and NHS approved Independent Sector Treatment Centres (ISTC). Ultimately, a patient will be able to choose any provider that can meet NHS standards and GP practices should not influence the patient's choice of treatment provider. Appleby *et al* (2003) argue that promoting choice within the NHS may sit uneasily in an institution that has previously relied on funding, structure and objectives determined by Government on behalf of the nation. However, promoting choice does provide benefits in that if a service provider performs unsatisfactorily, the purchaser (or patient in this case) can go elsewhere. This should put pressure on the provider to be efficient and effective in the provision of their services. Consequently, patients who are referred to a specialist consultant by their GP, now use the NHS Choose & Book (CB) system. In theory, this allows a patient to



not only choose where they want to have their specialist appointment but also they can choose the date and time. Since January 2006, GP practices have been mandated to use the CB system and to offer a patient of up to five secondary care service providers that can provide consultation and treatment for the patient's condition.

Underpinning CB and patient choice is the 18 WPP, a DH Public Service Agreement national target, in that by the end of 2008 '*no-one will wait more than 18 weeks from GP referral to hospital treatment*' (DH, 2004a). This pathway will also include all diagnostic treatment that may be required prior to the start of treatment. Concurrently, the introduction of PbR market mechanisms into this integrated publicly funded organisation will require considerable financial management and behavioural change for the whole NHS workforce. The intention is to improve patient throughput and to ensure the timely use of any extra capacity in return for payment set by a national tariff. This ambitious attempt by the NHS of adopting PbR, according to Mannion and Street (2005), will not only offer providers high-powered incentives to expand capacity but will also increase dramatically the importance of managing patient demand. However, access to extra capacity and care is not the same as access to high-quality care and the ability to choose to be treated is not the same thing as choosing how and where to be treated (Appleby *et al*, 2003). Whilst income may no longer be a barrier to an NHS organisation, public expectations of what the NHS should provide, and the speed that it is provided have now become higher.

Additionally, the Modernisation Agency has identified ten high impact changes that through service redesign would promote best practice and efficiency within the NHS; these ten points are highlighted in Table 1.

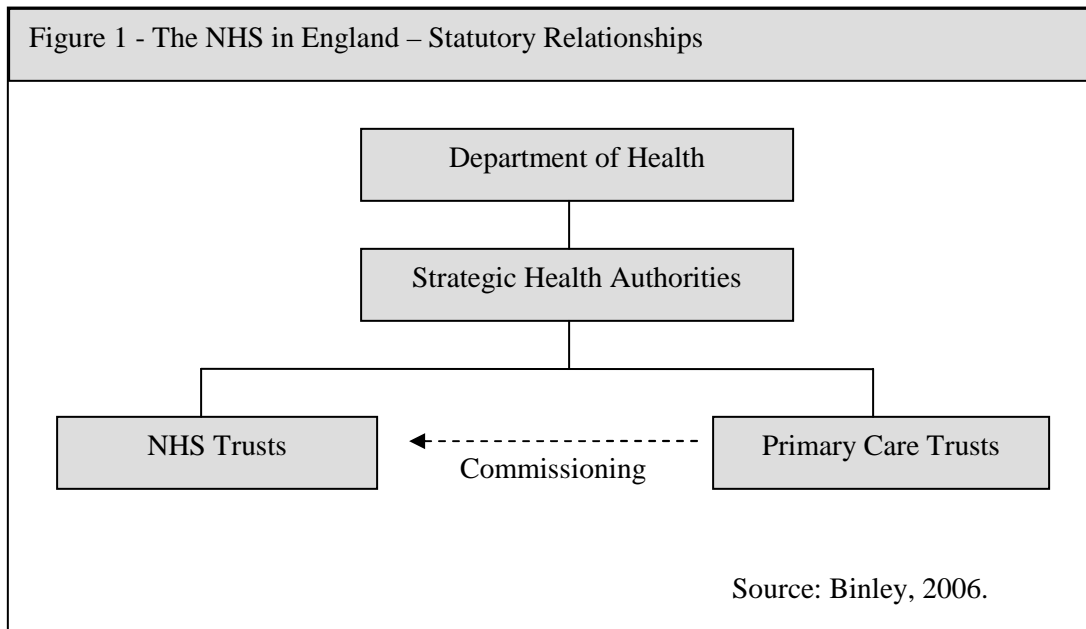
<b>Table 1 - Ten High Impact Changes Through Service Redesign</b>	
1	Treat day care surgery (rather than inpatient surgery) as the default system for elective surgery.
2	<i>Improve patient flow across the NHS system by improving access to key diagnostic tests.</i>
3	Manage variation in the patient admission process.
4	Smooth variation in patient length of stay and patient discharge.
5	<i>Avoid unnecessary follow-ups for patients.</i>
6	Increase the reliability of therapeutic interventions through a 'care bundle' approach.
7	Apply a systematic approach to care for people with chronic conditions and prevention of disease.
8	<i>Minimise the number of queues by redesigning schedules.</i>
9	<i>Optimise patient flow through service bottlenecks using process templates.</i>
10	<i>Redesign and extend roles to develop effective patient pathways.</i>
Note: the points in <i>italics</i> are relevant to the Authors field research project	

Source: DH (2004).

In tandem, the DH launched in 1998 the National Service Frameworks (NSF) and these frameworks tackle major health issues. They are the DH highest priorities and by publishing these frameworks, they set out long-term strategies to improve specific areas of care with set measurable goals within agreed time frames. Each NSF has been developed with the assistance of an external reference group that brings together health professionals, service users and carers, health service managers, partner agencies, and other advocates (DH, 2006c).

The Strategic Health Authorities (SHA) were formed in 2002 by the DH under their '*shifting the balance of power*' initiative when they reduced the 99 health authorities down to the current level 28 SHAs. The SHAs are an essential conduit for the DH in the management of the NHS at local level. The SHAs implement national and local strategies and have the responsibility for the performance of their local NHS Trusts and organisations.

The SHA does not commission services but will ensure that there is financial balance within their area of responsibility and can broker between NHS organizations. The statutory relationships are shown Figure 1.



The Primary Care Trusts (PCT) intentions are to deliver efficiencies and improved levels of service within the local NHS. The first PCTs were formed in April 2000 and General Practitioners, nurses and other health professionals are actively involved in the running of these organisations (Binley, 2006). They are responsible for providing primary care, for example, GP practices and district nurses. They may also run community hospitals and are responsible for maintaining strong links with the local health and social care community. The PCTs are lead NHS service planners and implement local health and service plans for their area mindful of national priorities and local environmental conditions. PCTs commission the majority of the healthcare based on population health need and develop service agreements with providers based on anticipated need. The PCTs receive their funding direct from the DH

with budgets set over a three year period; if overspends occur in one area, balancing is achieving by cutting back in another area.

## **Research Method**

Research into business and management is subject to much rigour to ensure that a contribution of *'material and valuable has been added to the body of accumulated knowledge'* (Remenyi et al, 1998: 30). It is generally agreed that research is a process of enquiry and investigation which is systematic, methodical and increases knowledge (Ghauri and Gronhaug, 2002). According to Remenyi *et al* (1998), the various approaches to research can be classified under different taxonomies with the most commonly used forms of research being empirical or theoretical studies. Empirical research is the dominant paradigm in business and management with some commentators associating empirical research as a positivist view only; however, Remenyi *et al* (1998) argue that this type of research can be either positivist or phenomenological in nature. In comparing the two philosophies, positivism usually takes a reductionist approach in order to be able to control an experiment or an investigation; whereas, a phenomenological approach is holistic allowing for more complicated situations to be examined (Remenyi *et al*, 1998). For this project an empirical phenomenological approach delivered through a case study was the preferred methodology.

To ensure effective validity (triangulation) of the case study, this research project drew on evidence collected from the primary field and was correlated with the data collected in the secondary field. The primary evidence was obtained using a 'gateway' who arranged interviews with key personnel ranging from the acting Chief Executive, Management Board Executives, Directorate Managers, Consultants, Specialist Clinician Managers, Administrative Managers and their Clerical Staff. This access afforded a rich cross-section of opinion from

the hierarchy that was either involved with developing policy, interpretation of the policy or implementing the policy on a day-to-day basis. By having access to the hospital locations, the Author also undertook direct observation, to further understand the workplace and working conditions, culture and behaviour of staff employed within the NHS.

To examine and recommend solutions to a revised patient pathway, three research questions were proposed: i) How is strategic planning considered at NHS Trust level and how is change being articulated to the workforce?; ii) Who are the agents of real change and who are the actual agents of change?; iii) How easy is it to change a process, for instance a patient pathway, and for whose benefit?

## **Findings**

The field research encompassed an NHS Trust that had responsibility for two hospitals covering a geographic area of 1,150 square miles with a population of around 2.38 million. The Trust was part of a SHA that included in their area 15 PCTs, nine acute hospital NHS Trusts, five specialist tertiary NHS Trusts, three specialist mental health/learning disabilities NHS Trusts and one ambulance service NHS Trust (CM SHA, 2006). Of the 15 PCTs, two PCTs were located in traditional industrial areas and provided the primary source of cardiology patients for the two subject hospitals OPDs. Statistics had shown that overall this area had a lower than average life expectancy against the national average with men having a shorter than expected lifespan of 2.2 years, whereas, females have a shorter life span by 2.5 years. It had been estimated in one of the PCTs that 39 percent of the 125,000 population will die from cancer or coronary heart disease, and of which 45 percent will be likely to die from heart disease before the age of 75 (Seddon, 2004). Whereas in the other PCT there were

significant ill health problems with, for example, 48.3 percent of the adult population overweight, of which 13 percent are classified obese (Warrington PCT, 2006).

Both hospitals have OPD facilities and they undertake numerous clinics of various specialisations during the standard working week. One of the OPD Managers has responsibility for the management of the routine cardiology clinics that are held at the two hospital sites with the day-to-day resource management of the OPDs undertaken by a senior nursing sister at both locations. This OPD manager is responsible to the Director of Nursing & Service Development.

Patients with an emergency cardiology condition are attended to in the A&E Department, whereas patients that have a suspected condition that requires urgent attention are seen in a Rapid Access Chest Pain Clinic (RACPC). The RACPC is part of the Coronary Heart Disease (CHD) NSF initiative and a patient with an urgent classification has to be seen within two weeks from GP referral.

The OPD clinics are managed by three resident specialist cardiology consultants and, if they are not available, the Clinical Director for Medicine & Elderly Care will normally stand-in. The OPD provide the resources along with nursing staff and the Cardio Respiratory Department (CRD) provide diagnostic resources and technicians to undertake diagnostic tests and to interpret the results. Over the years, the consultants have developed their own preferred procedures for attending to patients that have been referred to them by GPs or patients who may have been referred by another consultant. However, whilst it is apparent that these procedures may suit the needs of the consultant, they do not meet the DH Public Service Agreement '*The 18 Week Patient Pathway*' that was published in 2004. The PSA states that '*by the December 2008, no one will have to wait more than 18 weeks from GP referral to start of hospital treatment*' (DH, 2005a). Within the 18 WPP, it is further expected that the average

outpatient appointment waiting time to see a consultant will be six weeks and nine weeks to the start of treatment including encompassing diagnostic procedures and tests. The belief in this initiative is that the shorter the waiting time, the better the outcome for the patient (DH, 2004b). Allied to this requirement is the introduction of the patient CB system and PbR.

The OPDs were now attempting to manage the clinics under the new 18 WPP remit whilst using legacy procedures. This has resulted in a perceived 'bottleneck' whilst patients waited for diagnostic tests including attending appointments with consultants to ensure that waiting time targets were not breached. Additionally, it was not clear if the clinics were being used to their best potential including maximising the available capacity. The OPD Manager was understandably concerned that the OPD Department was not articulating the DH policies in the interests of both the patient and the hospital management. Therefore, at the invitation of one of the OPD Managers, undertaking a study of the procedures within the Cardiology Clinic would allow for a revised procedure that met the remit of the 18 WPP and CB whilst acknowledging the impact of PbR.

The Royal College of Physicians (RCP) guideline recommends that there should be one consultant cardiologist per 50,000 head of population. This would equate to six consultants to cover the two PCTs; however, the hospitals had only three consultant cardiologists and this understandably restricted the number (capacity) of patients that could be seen. Consultants are also known as physicians who are concerned with the practice and diagnosis of medicine, carry out investigations and procedures but do not perform operations. It is clear that they are respected professionals who are experts in their field of knowledge. Their contractual obligations are based on 'programmed activities' (PAs) and a cardiologist is expected to use 7.5 PAs as follows: coronary care unit ward rounds: 0.5 -1; inpatient care plus

referrals: 1-2; outpatient work: 2-3; specialist investigative or therapeutic clinical duties: 2-6; clinical administration: 1 (RCP, 2005).

One of the hospitals had recently opened a Cardiac Catheter Laboratory for invasive angiography diagnosis and angioplasty treatment. These procedures are performed by the consultants who see this nature of practice as the most rewarding part of their employment. The consultants are expected to forecast up to six months in advance of their availability and any changes should not happen within six weeks of their agreed clinic timetable and other commitments. However, this is not always the case as the consultants have been responsible for a number of short-notice cancellations (other than illness) leaving the OPD appointment office to arrange new patient appointments.

When interviewing the consultants, it was clear the rapid changes happening within the NHS are for the good and they were concerned that there should not be any further deterioration in quality of care for patients. However, this was not always possible. They also understood the financial pressures that now faced the Trust as a result of reduced funding at 'shop floor' level despite what has been an enormous increase in funding by Government. The expectation is to 'achieve more with less'. The consultants saw themselves as physicians working with patients and not as managers or administrators. As long as a director had clinical experience, they would accept leadership and change management direction from that person. From others, in particular NHS fast track management, they would question their intentions. Whilst the consultants may be the clinical experts, some of them also expect that 'world moves around them' with the image that they are always very busy. Understandably this may sit well in a not-for-profit financially unaccountable organisation; however, this is not now the case of the modern NHS where financial accountability sometimes appears more important than qualitative patient care.



For the OPD clinics, the consultants, based on RCP guidelines, have agreed 'job plans' that allow them to see between four to six new patients and up to 14 follow-up patients. The 'rule of thumb' is 30 minutes for a new patient encounter and 10 minutes for a follow-up patient. This is based on providing good patient care ethics and that the consultant may also be supervising and/or training junior doctors aspiring for the consultancy accreditation.

The CRD had facilities at both the hospitals with the CRD manager being responsible to the Directorate of Medicine & Elderly Care. The department has staff available 24/7 over the year as they have a remit to provide emergency and routine diagnostic testing services throughout the hospital. They also provided staff for the recently opened Catheter Laboratory. The CRD staff are qualified Cardiac Physiologists that complete four years of training, including a degree in Clinical Physiology, prior to practising in physiological measurement. The diagnostic tests that are applicable for OPD patients attending cardiology clinics are shown at Table 2.

The two OPD Appointments Offices are part of the Medical Records Department and are located at both hospitals. The office managers report to the OPD manager. The non-medical administration staffs are responsible for arranging clinic appointments and ensuring that the patient's medical records are available for the clinic they are attending. Each staff member is allocated a number of consultants and based on declared availability and job plan protocol, will arrange patients to attend the clinics. The staff do not have access to the CRD appointments system and, although they are in physical close proximity, they work in isolation of each other.

<b>Table 2 - CRD Diagnostic Tests Applicable to Cardiology OPD Patients</b>	
Electrocardiogram (ECG)	Checks heart rhythms are either normal or irregular
Echocardiogram (ECHO)	Accesses pumping ability of the heart function
Treadmill Stress Test	Serious of tests on a treadmill designed to put the heart under 'stress'
24hr ECG Tape	Attached to the patient to monitor heart rhythms over an extended period
Angiography	Performed in the Catheter Laboratory and is arranged outside the OPD clinic sessions. It is an invasive procedure that falls within the remit of the 18 WPP

Recently included within the appointments offices are CB staff who undertake call-centre responsibilities for the hospitals and arrange appointments using the new system. It was anticipated by the end of 2006 all OPD appointments would be made through the CB system. From interviewing clerical staff, it was clear that they attempt to manage the appointments system very tightly to ensure that the NHS targets were not breached. However, there prevailed a 'fear management' environment in respect that breaches were unacceptable and everything must be done to avoid them even if it meant inconveniencing the patient. Unexpected changes by consultants and hospital management also created an 'air of chaos' whilst appointments were rescheduled. At times, extra clinics have had to be arranged, known as 'Waiting List Initiative Clinics', to bring in patients to see a consultant in order that targets were not breached. These extra clinics are expensive to arrange, approximately several thousand pounds, and are funded directly by the hospital with the consultants paid 'overtime' as these clinics are outside their job plan. Additionally, if a clinic has to be held after normal working hours or at a weekend, the cost rises further as all the staffs involved are paid

overtime. Interestingly, the clerical staff said that the patients were more receptive to evening and weekend appointments as this made their travelling and time off work easier to arrange.

Both hospitals had adopted different procedures. The first hospital had two resident Cardiology Consultants who were contracted to conduct three OPD clinics a week, with obligatory continual professional training and holidays, this equates to clinics being held on 36 weeks of the year. Both consultants also undertook clinics at the second hospital along with some private work. The existing procedure for seeing new patients had been developed on the premise that the consultant would request a patient undertakes a number of diagnostic tests prior to their first encounter with the consultant. These tests were based on the evidence that was presented on the referral letter to the consultant and the test results allows for a more thorough understanding of the specified condition. Cancelled appointments by both the hospital and the patients were backfilled by another patient who was waiting for an appointment. However, with did-not-attend (DNA) patients, the assumption was that this appointment was not filled and thus reduced the effectiveness of that clinic.

This procedure works well for the consultants and allowed for investigations prior to a treatment plan prescribed by the consultant. It also allowed the consultants to 'weed-out' patients who were not ill enough to warrant an appointment with the consultant. However, there were weaknesses with this procedure in that the CRD Appointment Office and OPD Appointment Office were not co-ordinated and appointments were arranged in isolation of each other. Additionally, with the delay in arranging CRD diagnostic tests, and with no control by the OPD appointments office, new patients may not have been seen by a consultant prior to the 13 week target deadline. The appointments office initiated the patient booking by writing out to the patient requesting them to contact them for an appointment. Under the 18 WPP regime, the 'clock start' of the timelines had already started with the receipt of the GP

referral; consequently, 'clock' time is consumed waiting for the patient to respond to the office. With the CB system, the 'clock' does not start until the patient has activated their booking referral. The overall result is that a patient may make several visits to the CRD and the OPD to have diagnostic tests and follow-up appointments with the consultant to discuss the results before an indicative treatment plan is provided for the patient.

The second hospital had one resident cardiology consultant who was contracted to conduct two OPD clinics per week. The two cardiology consultants based at the first hospital also attended the second hospital to hold three clinics, giving a total of five clinics. The hospital based consultant elected to see patients prior to requesting CRD diagnostic tests whereas the visiting consultants continued with the policy they have adopted at their hospital. Consequently, there was a two-tier system operating at the second hospital with the impact that some patients were undertaking numerous appointments to fulfil test requests prior to seeing a consultant; whereas, other patients were having tests requested with follow-up appointments after seeing the consultant for the first time.

Cancellations of appointments by consultants were another of concern with the consequence of the OPD appointments office had to undertake a considerable amount of extra work in changing schedules and informing patients of the changes. From interviewing clerical staff in the OPD appointments office, it was made clear that approximately 40 per cent of their work was unnecessary rescheduling as a result of consultants changing clinic times or cancelling clinics. Table 3 highlights the reasons for cancelling appointments.

<b>Table 3 - Cardiology OPD – Reasons for Cancellations by Consultant</b>		
Audit/Meeting	Awaiting Tests/Results	Brought forward
By Secretary	Cancelled by Consultant	Cancelled by Nurse
Cancelled by Ward	Change time	Changed consultant
Clinic overbooked	Consultant on leave	Duplicate request
Error	No Doctor to cover	No longer required
No Registrar	Not given three weeks notice	On call
Other	SHO away	Study leave

It was observed that the cardiology OPD appointments office was endeavouring to align to 13 weeks for a patient to have their first appointment with a consultant. Diagnostic testing was fitted around this deadline date as these tests were currently ‘hidden’ from the 18 WPP; however, these hidden lists were due to be exposed and included in the 18 WPP. From interviewing the appointments staff, they were just about managing to meet the 13 week deadline for a first appointment and they had no plan in place to reduce the deadline to within six weeks. Clearly, the key was to have a plan in place as soon as possible in order that it could be piloted to allow for adjustments.

Research published by the DH had shown that patients want to be more involved in making decisions and choosing their healthcare; they view the experience as positive and valuable if they are offered a choice of hospital and an appointment that suits them. Since the summer of 2004, CB has been introduced throughout England and since 1 January 2006, all patients have the ability to choose where and when they are seen for their first and subsequent hospital appointments (DH, 2005a). Patients have a number of methods of arranging their first OPD appointment: directly with their GP or through a member of the practice team; by telephoning a central CB Appointments number; using the Internet; or telephoning the hospital

of their choice direct. Each patient referral is given a unique booking reference number (UBRN) and a password. The GP practice will populate the patient field on the CB system including generating a GP referral letter within 5 days. This field will remain dormant until activated by the patient. Once a patient has arranged a mutually agreed appointment with a hospital, the referral letter can then be opened and viewed by the specialist consultant who is due to see the patient.

CB is aligned with the 18 WPP and patients are expected to be able to have their first appointment within 13 weeks (reducing to six weeks by the end of 2008). Failure by a hospital to provide a suitable appointment will be a breach of the PSA target. However, a patient has the right to change an appointment should the need arise and, in doing so, the patient can then be excluded from the 18 WPP targets on the premise that they chose the alternative appointment. According to the Healthcare Commission, currently all of these hospitals are showing average waiting list times for outpatient appointments and the waiting times are regularly updated. Accordingly, a patient may use a number of factors when deciding which hospital to attend: how quickly they will be seen; ease of using public transport or parking (and cost) if using a car; the information on the quality of care; the reputation of the hospital and their clinicians; and, recommendations from family and friends who may have used that particular hospital. Consequently, as the NHS is now in a 'market mechanism' environment, the hospitals and in particular the OPDs would have to undertake active marketing of their services to attract a patient (customer) over and above another hospital or independent sector organisation. Additionally, as patients will be expecting a smooth and efficient experience with minimum inconvenience, the OPDs would also have to ensure that they had efficient patient pathways in place.

PbR is made up of financial tariffs evolved from a clinical coding exercise to identify the cost of materials and clinician time in treating patient conditions. The DH have averaged the tariff and introduced a Market Forces Factor (MFF) to increase/decrease the tariff based on the geographical location of the hospital. See Table 4 for the FY06/07 Cardiology OPD tariff.

Table 4 - FY06/07, the Cardiology OPD tariff	
New Adult Patient National Tariff	£151.00
MFF Applied (1.089135)	£164.46
Follow-up Adult Patient National Tariff	£80.00
MFF Applied (1.089135)	£87.13

However, these tariffs are not explicit as to what services are included or not. However, for now, it had been assumed that diagnostic testing were included in the tariff. The paradox here is that a provider may attempt to maximise their income from the tariff by minimising expenditure on the patient at every possible opportunity. This is especially so as the Hospital Board had expressed concerns that their forecast PbR income would not meet the fixed costs of operating the OPDs.

## Discussion

The project was centred on the significant changes that have been taking place in the NHS since 2000 when the DH published the '*NHS Plan: a plan for investment, a plan for reform*' (DH, 2000a). This modernisation plan was the most ambitious since the formation of the NHS in 1948 and it was clear that the numerous directives issued by the DH would have far-reaching consequences for NHS employees in the 'front-line'. The objective was to research and analyse the findings of a particular process to establish if there has been an identifiable

service improvement based on the guidelines issued through the modernisation plan. In order to focus on the subject area, a review was undertaken of an existing Cardiology OPD Clinic patient pathway. The project involved understanding the reasoning for the existing pathway with the intention to recommend a revised pathway that could be implemented to meet the protocol of the NHS 18 WPP. This protocol would be the baseline for any OPD clinic by the end of 2008. The project was completed and presented to the OPD Manager for deliberation by the Hospital Executive Board, specialist clinicians and administration staff involved with the cardiology clinics. It was clear from the project that a number of other DH initiatives were identified that required further research to understand their full implications with regard to the organisation of the Cardiology OPD clinics.

From the field research, it was quickly ascertained that the OPDs had endeavoured to implement some changes to their clinic procedures to meet targets that were already imposed by the DH. Despite the volume of change literature documents that were available through the NHS, change within this Department appeared to be based on emergent findings to suit the immediate priorities for staying within the targets. To clear waiting lists and to overcome breaching targets, additional expense had been incurred by the department through holding extra clinics under the remit of 'waiting list initiatives'. However, what was actually required was a new pathway to manage the protocol of the 18 WPP and the decreasing timeline for a first patient encounter with a consultant. Allied to this was a need for greater co-ordination with the CRD to ensure their resources were available for patient diagnostic tests and results in order the consultants could recommend a treatment plan. This was not the only problem that the OPD was facing. Change was also manifesting with the implementation of patient choice through the CB system, PbR and the implications of Practice Based Commissioning (PBC) within the PCT environment. All these areas would determine patient demand, income for the



department and whether or not the PCTs would be attempting to undertake greater patient responsibility with fewer referrals to the OPD.

Five key subject areas were identified from the literature review and compared with the findings conducted during the field research. Articulating and managing change in the NHS was never going to be an easy task as the NHS is now the largest employer in Europe with around 1.3 million employees in over 300 careers (Hyde *et al*, 2006). However, despite numerous publications providing guidance on change, the expectation remained from the ‘front-line’ that more assistance could be provided. Also OHM (2003) identified that change was not totally welcome with clinicians concerned over the level of new ‘power’ that was now afforded to managerial staff.

Concurrent to change in the hospital environment was the scaling down of the SHAs from 99 to nine (Binley, 2006); understandably, the SHAs would need to concentrate on devising and implementing their new structure and responsibilities whilst continuing to monitor the activities of the NHS trusts. Similarly, the PCTs were also faced with reconfiguration with proposals to downsize PCTs from 303 to 152. Public consultation and debate on the new boundary reconfigurations would need to be addressed at the same time of managing the PbR protocol and the implications of the DH impetus on employing PBC within their communities (King’s Fund, 2006). Hospitals needed to undertake reviews and, where appropriate, reconfigure their services to better manage their income, capacity and demand for handling patients within the new guidelines set by the DH. In particular, the subject hospitals were in the process of managing their reconfiguration ‘delivering quality and effectiveness in a patient-led NHS’ (NCH 2006b). A number of commentators have said that the pace of change was too fast and ambitious (OHM, 2003). Additionally, senior practitioners have expressed their lack of confidence in the reform methodology (Miller, 2006).

That said, patients now have a choice of where they can receive treatment and the implementation of 18 WPP will ensure that a patient receives not only consultation but also indicative treatment within strict timelines (DH, 2005b). With this in mind, the Author provided a recommendation for a revised patient pathway for the Cardiology OPD Clinic. What was not clear from the field research was the whether or not the OPDs would be able to satisfactorily manage the demand of patient referrals. However, as patient referrals means income (PbR) for running the department, a reduction in quantity of new patients would have implications on not only their future strategy but also the structure of the OPD to remain financially in balance. The introduction of PBC within the PCT community will also have an impact on the traditional activity of an OPD. However, what is apparent is that the NHS finances are moved around internally between organisations in a ‘shop-keeping’ fashion in an attempt to find savings and balance deficits with the real winners being the private healthcare providers (King’s Fund, 2005).

## **Conclusions and Recommendations**

By returning to the research questions that had been posed to guide the recommendations for an 18 WPP patient pathway for the Cardiology OPD Clinics, conclusions can be drawn and recommendations made.

In considering ‘*How is strategic planning considered at NHS Trust level and how is change being articulated to the workforce?*’ a former NHS CE, stated ‘modernisation of the NHS and delivery of the NHS plan....add up to the toughest management task’ (DH, 2002). The subject NHS Trust Executive Board was fully cognizant of the modernisation initiatives that were being cascaded down to them for implementation with the Deputy Director of Operations (responsible for hospital services and infrastructure) stated that accountability is a

good thing and to modernise they should aim higher than the actual requirement. Their direction appeared to be identifying the available capacity using the existing resources with plans to reconfigure these resources to make even better use of the capacity. As part of their modernisation programme, the Board had undertaken their own project to reconfigure the two hospitals in order to provide centres of excellence and remove duplication.

The Board were fully conscious that their hospitals will no longer choose the patient and, for example, a recently opened ISTC next to one of their own hospitals was now undertaking some of the orthopaedic services. Additionally, the true impact of PbR was taking time and effort to fully realise with numerous implications for the Trust if the proposed income fell short of the running costs for the two hospitals. To keep patient care in their region, the Trust had recently invested in a Cardiology Catheter Laboratory for day case investigation and surgery. The impact of Patient Choose and Book was in the process of unfolding with some of the hospital administration staff dual-trained to operate the system in tandem with the legacy booking system. To communicate the changes and hospital led initiatives, the Board published a monthly 'Team Briefing' document that was intended for managers to cascade down to their areas of responsibility. Additional copies were also available to read in the various staff canteens.

Understandably, the Board had the 'big picture' whilst the employees saw the 'small picture' and at times this has created antagonism between the workforce and senior management. For example, the reconfiguration project was interpreted as a stripping of assets from one hospital to close it to ensure the future of the other hospital. At no stage was this indicated in the project literature (NCH, 2006b). Other employees thought the Board saw targets as more important than patient care and that 'more output was expected for less'.

The Board were in an unenviable position: working to the direction of the DH and targets set by through the SHA whilst also encouraging their staff to move forward and accept change for the benefit of the hospital not just for the DH. The main difficulty faced was the cultural change in that clinicians were now expected to be more than just practitioners but also decision makers. Considering the rapid pace of change and ambitious plans set by the DH, the Board appeared to have articulated the change programme to their advantage and the employees agreed that change was necessary, but understandably change would not sit comfortably with everyone. In fact the balance of patient care against financial accountability will not sit easily in *any* NHS Trust.

The second question '*Who are the agents of real change and who are the actual agents of change?*' highlighted that service improvement is about changing business techniques not just for the good of the organisation but also to encourage new customers and retaining existing business (Ruffini *et al*, 2000). Change in the NHS has been a constant feature since the mid 1980s (Bamford and Daniel, 2005). From the extensive field of literature published by the DH, numerous policy documents have set out the strategic intent for the future of the NHS. A key document was published in 2000: 'The NHS Plan: A Plan for Investment, a Plan for Reform'. However, closely linked to the DH policies are the Modernisation Agency publications issued through the Service Delivery Organisation (SDO). Authors, for example, Iles and Sutherland (2001) and Iles and Cranfield (2004) provided extensive literature for administrators and clinicians alike to use as reference documents. Real change has been instigated by the DH but using guidance, tools and techniques from both the business world and the SDO.

Actual change could be expected to be augmented by the secondary care environment; however, change in this environment is based on the requirement of the

commissioners. The majority of the NHS budget (75 per cent) is held by the PCTs (Binley, 2006) who commission services that are not available within their environment. Traditionally, the main providers have been the NHS acute hospitals and other NHS specialist organisations; latterly, the inclusion of private healthcare facilities has also been made available. The DH is also encouraging PCTs to adopt PBC to invest in resources within the primary care environment and to educate the referrers to seek value for money when engaging providers (King's Fund, 2006). Therefore, as the providers are reacting to demands of the commissioners, who now also have an increased choice, the actual change agent is the PCT. With PbR, the prices may be fixed, but it is the PCT who will choose where they place their business and a provider must ensure that they are able to continue to provide the level of service to meet the expectations of the patient and the PCT.

Lastly, the third question '*How easy is it to change a process, for instance a patient pathway, and for whose benefit?*' drew on the factors that since the inception of the NHS Modernisation Programme in 2000, numerous changes have taken place through policies driven down from national level and implemented at regional and local level. Arguably, the difficulty in changing a process will be at the 'front-line' if there is not a perceived need to change (Dale, 2003). Lewin's 1958 Three Step Model can only work if the organisation and the individuals want to change and accept the consequences (Burnes, 2004). From the Author's direct observation during the field research, it was clear that change does take place as long as the right 'change agents' are encouraged to adopt the thinking as their own. In the majority of the cases, as long as the consultants could see the benefit of the new procedure, especially if they had an input, the change could go ahead with full approval. Administrators and accountants, seeing cost-reduction as part of change process, will endorse the change; however, to a clinician, cost is only a relatively new phenomenon, as in previous years cost

was never an issue. Iles and Sutherland (2001) identified that 'systems thinking' was a favoured process to plan change in the NHS, the Author assumes that as this is a scientific and explorative approach, it should suit the medical background of clinicians.

The modernisation programme within the NHS is very much a living subject with numerous changes undertaken and more to be achieved by 2010. With multiple negative media articles it is all too easy to be judgmental; however, this research shows a completely different rhetoric that is usually adopted. Yes, as with a major organisation there will be difficulties with opposing opinions; however, from interviewing clinicians it is clear that providing free healthcare and treatment remains a founding principle to all sections of the NHS community. Moreover, modernisation and appropriate change is accepted as necessary as long as efficiency is not impaired. The main recommendation from this research is that all practitioners need to remain aware of the balance between efficiency and effectiveness if the NHS is to survive in the 21<sup>st</sup> Century.

## References

- Appleby, J., Harrison, A., Devlin, N. (2003) 'What is the Real Cost of More Patient Choice?' London: King's Fund Publications
- Bamford, D., Daniel, S. (2005) 'A Case Study of Change Management Effectiveness within the NHS'. Journal of Change Management, Vol 5, No 4, pp 391-406.
- Binley. (2006) 'Binley's NHS Guide'. (Winter/Spring 2006 Edition), Basildon: Beechwood House Publishing Ltd. ISSN: 1743 – 7916.
- Bracker, J. (1980) 'The Historical Development of the Strategic Management Concept'. Academy of Management Review, Vol 5, No 2, pp 219-224.
- Burnes, B. (2004) 'Managing Change', 4<sup>th</sup> Edition. Essex: Pearson Education Limited.
- Chandler, A. D. (1962) 'Strategy and Structure: Chapters in the History of American Industrial Enterprise'. USA: MIT, Cambridge.

- Chatziaslan, E., Bamford, D. R. (2005) 'Matching Demand and Capacity of Patient Services within the UK National Health Service'. Presentation to EurOMA, June 2005.
- CM SHA. (2006) 'About the Cheshire and Merseyside Strategic Health Authority'. <http://www.cmha.nhs.uk/about.htm>.
- Dale, B. G. (2003) 'Managing Quality', 4<sup>th</sup> Edition. Oxford: Blackwell Publishing Limited.
- DH. (2000a) 'Department of Health – The NHS Plan: A Plan for Investment, A Plan for Reform'. Norwich: HMSO.
- DH. (2004a) 'Department of Health - The NHS Improvement Plan: putting people at the heart of public services'. London: Department of Health.
- DH. (2004b) 'Department of Health - National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08'. London: Department of Health.
- DH. (2005a) 'Department of Health - Commissioning an 18 week patient pathway – Proposed principles and definitions: A discussion document'. London: Department of Health.
- DH. (2005b) 'Department of Health - Creating a Patient-led NHS – Delivering the NHS Improvement Plan'. London: Department of Health.
- DH. (2006a) 'Department of Health - Practice Based Commissioning: early wins and top tips'. London: Department of Health.
- DH. (2006c) 'Department of Health - National Service Frameworks'. <http://www.dh.gov.uk/PolicyAndGuidance>.
- Elliot, K., and Lawrence, P. (1985) 'Introducing Management'. Harmondsworth: Penguin.
- Ghauri, P., and Gronhaug, K. (2002) 'Research Methods in Business Studies'. 2<sup>nd</sup> Edition, Harlow: Pearson Education Limited.
- Hambrick, D. C., and Fredrickson, J. W. (2005) 'Are you sure you have a Strategy?' Academy of Management Executive, Vol 19, No 4, pp 51-62.
- Hyde, P., Boaden, R., Cortvriend, P., Harris, C., Marchington, M., Pass, S., Sparrow, P., Sibbald, B. (2006) 'Improving Health through Human Resource Management: Mapping the Territory'. University of Manchester, ISBN 184398153X.
- Iles, V., Cranfield, S. (2004) 'Managing Change in the NHS: Developing Change Management Skills'. London: NCCSDO, London School of Hygiene and Tropical Medicine.
- Iles, V., Sutherland, K. (2001) 'Managing Change in the NHS: Organisational Change'.

London: NCCSDO, London School of Hygiene and Tropical Medicine.

Johnson, G., and Scholes, K. (1993) 'Exploring Corporate Strategy'. London: Prentice Hall.

King's Fund. (2005) 'An Independent Audit of the NHS under Labour (1997-2005).' London: King's Fund Publications.

King's Fund. (2006) 'Practice-based commissioning: what is practice-based commissioning?' King's Fund Briefing Paper.

Mannion, R., and Street, A. (2005) 'Payment by Results and Demand Management: learning from the South Yorkshire laboratory'. Centre for Health Economics, York: University of York Publications.

Miller. (2006) 'Paul Miller, Chairman of the BMA, speech to the Consultants Conference – 7 June 2006'. Accessible via [www.bma.org.uk](http://www.bma.org.uk).

Mintzberg, H., Quinn, J. B. (1991) 'The Strategy Process: concepts, contexts and cases'. London: Prentice Hall.

NCH. (2006b) 'Delivering Quality and Effectiveness in a patient-led NHS'. Report by NCHT Chief Executive, 16<sup>th</sup> January 2006.

OHM. (2003) 'Learning from the NHS in Change'. Office for Health Management, prepared by OPM, available through The King's Fund.

Porter, M. E. (1996) 'What is Strategy?' Harvard Business Review, Nov-Dec, pp 61-78.

RCP. (2005) 'Consultant Physicians Working with Patients', 3<sup>rd</sup> Edition. London: Royal College of Physicians Publication.

Remenyi, D., Williams, B., Money, A., and Swartz, E. (1998) 'Doing Research in Business and Management: An Introduction to Process and Method'. London: Sage Publications Limited.

Ruffini, F. A. J., Boer, H., Riemsdijk, H. (2000) 'Organisation Design in Operations Management'. International Journal of Operations and Production Management, Vol 20, No 7, pp 860-879.

Seddon, D., Dr. (2004) 'Choosing Health in Halton, Living Longer, Staying Well, Annual Public Health Report'. Halton PCT NHS Trust Publication.

Slack, N., Chambers, S., Johnston, R. (2004) 'Operations Management'. 4<sup>th</sup> Edition. Essex: Pearson Education Limited.

Warrington PCT. (2006) 'Warrington Patients to have a greater choice over hospital



appointments'. Warrington PCT News Release, 4 January 2006 available at <http://www.warrington-health.nhs.uk>.