Going private: Clinicians’ experience of working in UK Independent Sector Treatment Centres

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ABSTRACT

Objectives: With increased possibility that public healthcare services in the UK will be outsourced to the private sector, this study investigates how clinicians working in Independent Sector Treatment Centres perceive the differences between public and private sectors.

Methods: Qualitative interviews with 35 clinicians recruited from two ISTCs. All participants were transferred to the independent sector from the public National Health Service. Interview data were analysed to identify shared experience about the variable organisation and delivery of services.

Results: Clinicians perceived differences between public and independent sectors in the areas of ‘environment and facilities’, ‘management’, ‘work organisation and care delivery’, and ‘patient experience’. The independent sector was described as offering a positive alternative to public services in regard to service environment and patient experience, but there were concerns about management priorities and the reconfiguration of work.

Conclusions: Clinicians’ experience of moving between sectors reveals mixed experiences. Although some improvements might legitimise the growing role of the independent sector, there remain doubts about the commercialisation of services, the motives of managers and the impact of clinical roles and capabilities. With policies looking to expand the mixed economy of public healthcare services, the study suggests clinicians will not automatically embrace a move between sectors.

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1. Introduction

Over the last twenty years states with predominantly publicly funded and provided healthcare systems have looked to expand the mixed economy of care as a means of improving resource utilisation, patient choice and service quality [1,2]. This has involved, for instance, private investment in infrastructure renewal, the out-sourcing of services, and new commercial opportunities for private business [2]. The trend can be seen in the English National Health Services (NHS) where successive governments have fostered competition and choice in the delivery of public healthcare [3–5]. Following recent policy announcements, the diversification and pluralisation of the English NHS is set to continue with the state becoming a funder of care (via consortia of primary care commissioners) provided through an increasingly mixed economy of public, social enterprise and private organisations [5]. Policies highlight various benefits of this arrangement, which at a time of reduced public spending are particularly alluring. First, it is seen as placing the patient at the centre of care through enhancing choice and ensuring resources follow these choices. Second, it is seen as making care delivery more competitive and thereby efficient in the use of resources. And third, it offers new forms of investment and new ways of working that are essential to modernise service organisation and delivery.

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The extent to which social enterprises and private providers will enter into a healthcare market is uncertain. It may involve entirely new services that work alongside or in direct competition with existing public providers, or alternatively the out-sourcing or sharing of existing public services with the private or third sector [5]. Although policies suggest revolutionary change, there is a degree of continuity, even déjà vu, in reform. This can be seen, for example, with the return of commissioning responsibilities to General Practice. Similarly, the desire to expand the mixed economy of care provision echoes other recent policy initiatives, such as Independent Sector Treatment Centres (ISTCs) [6]. Drawing on European and North American programmes, these ‘one-stop’ diagnostic and treatment centres were introduced within the NHS to reduce waiting times, increase service capacity and expand patient choice [4,6]. Two features of their design make them particular relevant to current policy developments. First, they involve a separation of urgent and elective care, often within relatively discrete service units, that enable better planning of scarce resources. Second, they make it more feasible for the independent sector to take responsibility for managing these more routine and low risk patients, especially through the application of innovative business and management practices [6]. Although relatively independent from other NHS services, ISTCs are regulated by the Care Quality Commission to the same standard as all private healthcare providers, against slightly different criteria to their NHS counterparts [7]. Over the last five years the number of ISTCs has increased to 34 and in 2007/2008 ISTCs carried out approximately 6 million elective procedures, 1.8% of the NHS total, including around 7% of hip procedures and 9% of arthroscopies [8].

Throughout their short history ISTCs have garnered significant debate and controversy that is currently being echoed in relation to current healthcare reforms [9]. First, research shows the translation of policy into practice has been variable. For instance, ISTCs vary in scope and scale depending on the involvement of different strategic partners [10]. Second, ISTCs have been criticised in relation to their value for money, especially as many benefit from higher levels of funding than comparable NHS providers [11,12]. Third, commentators have suggested that the rationale of diverting high-volume, low-risk cases to ISTCs can have a negative financial and staffing impact on existing NHS services through leaving them to manage more complex and costly cases [12,13]. Fourth, despite some concerns about service quality [14–16], research shows ISTCs potentially provide improved levels of functional status, quality of life and patient experience, although such research also highlights that such variations may be a function of the reduced complexity of casemix and the improved aesthetics of patient experience [17,18].

A relatively under-researched aspect of ISTCs relates to the experiences of clinicians relocated from the NHS to the independent sector, where the ISTC involves a corresponding transfer of pre-existing NHS services. In other words, clinicians based within NHS hospitals have found the management and organisation of work moved to the private sector, albeit with protected terms and conditions. With a relatively finite clinical workforce, and with policies seeking to expand the mixed economy of care, this transfer arrangement is likely to become a more common feature of future health reforms in countries like the UK. As such, it is not only patients but also clinicians that are ‘going private’.

Although it can be expected that practically all forms of employment change involve some discontinuity, in most cases we think about these processes at the level of the individual and in terms of a shift between roles or organisations [19]. For health reforms like the ISTC programme however, we need to consider such changes as occurring at the level of the collective work group and at the level of the sector. Historically within the UK many clinical specialists have worked across the boundary between public and private sector, e.g. the private-practice of medical doctors, community-based therapists and private nursing facilities. However, for the vast majority of these healthcare professionals the public sector NHS has been the primary place of training, socialisation and employment, especially for nurses and allied health professions. According to NHS employment statistics approximately eight times as many qualified nurse work in the NHS as compared to the private sector [20]. It might be anticipated, therefore, that the relocation of clinical teams from the public to the private sector might be experienced, both individually and collectively, as a significant transition. In particular, research often characterises the public and private sectors as being different, not only in terms of their ownership and management but also culture and values [21–23]. Although recent healthcare reforms reveal a growing influence of private sector values and management practices, such as process re-engineering, there is equal evidence that such change is poorly aligned with the existing culture and values of the public sector NHS [24,25]. In the case of ISTCs, this logic of reform is reversed, whereby change no longer involves introducing private management practices into the public sector, but rather taking public sector workers out to the private practice.

Given that the movement of clinicians between UK health sectors is likely to increase; this study investigated how those transferred to the independent sector experience the differences between NHS and ISTC services. Although some attention has given to the changing employment relationship [26,27], this study aimed to understand how clinicians perceived the differences between sectors as a means of organising and delivering patient care, and what they saw as the benefits and draw backs of each sector. Unlike existing research in this area, we do not seek to quantify differences in clinical work or service quality; rather we look to employees’ subjective experiences of working in a relative new organisational and sectoral context. These are important because collective experiences of change often have an impact upon subsequent performance and attitudes to work [28] and may therefore have a bearing on the future success or otherwise of policies that seek to transfer public healthcare services to the mixed economy. This study contributes to current policy debates where similar processes are at work and where clinicians’ reactions to change will be integral to the successful implementation of policy.
2. Study design and method

With its interest in the ‘insider’ experiences of clinicians working within ISTCs, the study adopted a qualitative design. Qualitative health research is a broad umbrella for a variety of methods that aim, in general, to investigate and interpret the more subjective and situated experiences, attitudes and beliefs and interactions involved in the organisation and delivery of patient care [29]. This paper makes use of semi-structured qualitative interviews as a means of investigating the views and experiences of clinicians working within ISTCs, focusing in particular on the perceived differences with former NHS services. It is acknowledged that interviews do not necessarily produce an unproblematic, unbiased or necessarily ‘truthful’ account [30], yet they provide an effective means of eliciting, exploring and interpreting how individuals and social groups experience, make sense of and act upon the social world through re-counting these experiences through conversation. The role of the researcher in this case is not to establish a single ‘truth’ but rather to describe the shared perceptions of participants and relate these to the wider changes occurring in the social context and to determine the potential implications for policy implementation.

The research was undertaken in two ISTCs located in the English Midlands, both providing elective day surgery to NHS patients through contracts with local healthcare commissioners (Primary Care Trusts). In both sites the majority of staff (87–90%) were recruited through full or partial secondment from respective NHS hospitals in the locality, as a function of the contract for day surgery being moved from the NHS to the independent sector. For surgical and medical specialists this involved the partial relocation of selected lists and clinics, but where the NHS remained their workplace. For nurses, therapists and auxiliaries, however, the transfer of work was on a fulltime and permanent basis. Of this latter groups, 62 and 41 were transferred to the respective ISTCs involved in the study. Of these 35 participants were recruited according to the following purposive criteria. First, participants’ work had been relocated fulltime from an NHS to the ISTC service, i.e. they were not direct hires or transferred from other private services, on the basis that they could make some comparison between public and private sector. Second, participants had worked within the ISTCs for at least 6 months so that they had sufficient experience of their new work environment. This included 18 scrub nurses, 10 Operating Department Practitioners (ODPs), and 7 Health Care Assistants or Support Workers (HCAs). The significance of selecting representatives from these occupational groups is that they are largely unfamiliar with working across the private-public sector divide (unlike medical professionals) and therefore their experiences and views of this transition are particularly revealing in terms of how clinicians might experience similar policy developments in the future.

Data was collected through semi-structured interviews that followed a common thematic guide, including: career histories, perceptions of management, working in the ISTCs and patient care. The study was also attentive to emergent findings that were incorporated into subsequent interview guides. In line with research governance procedures, all participants gave written informed consent. Data analysis aimed to develop empirical categories through an iterative process of close reading and coding by both authors to identify, compare and explore links between empirical concepts. The initial phase focussed on common descriptions, views and events. These were routinely checked for their internal consistency and clustered into thematic categories related to the experiences of working within the ISTCs. These themes provide the basis of our empirical findings and illustrative extracts of data are provided. One overarching theme from the interviews, but not directly discussed in the findings relates to the transfer process itself and how clinicians were seconded from the NHS to the ISTCs. Practically all participants described the relocation of work to the ISTCs and, more broadly, the private sector as disconcerting, with many feeling anxious about how their work might change or the influence of new managers. An important reflection on the analysis of the data is participants’ interpretation of the differences between the NHS and ISTCs might in part be clouded by these initial feelings.

3. Findings

3.1. Environment and facilities

The most praised aspects of the ISTCs are related to the improved work environment and clinical facilities. All participants described how ISTCs were unlike previous NHS hospitals and, in many ways, were more like shopping centres or airports. From the perspective of clinicians’ work this related to the improved lighting, air quality or temperature, and better facilities for changing, washing and resting. Many also welcomed the provision of complimentary refreshments, fruit and news media, and improvements in public areas, such as coffee shops, car parking and reception areas. It was also described how both centres benefited from a more orderly layout that better reflected the contemporary flow of patient care. Specifically, the spatial configuration of work was seen as more sequential when compared to previous NHS facilities that were described as “irrational” (Sister) or “all over the place” (Nurse), often because they had been developed incrementally over a long period.

‘It’s a much better place to work. It’s light and airy. Things actually work. It doesn’t feel like the old place.” (Sister)

‘I think the building is quite nice and I think that improves staff morale working somewhere where you know the equipment works and you are not just dealing with other people’s leftovers, that is quite nice.’ (Nurse)

As well as environment, both ISTCs were perceived as having more up-to-date and higher quality equipment, as compared to former NHS services. This ranged from new IT systems for patient booking and ‘paper-less’ record keeping to devices and instrumentation for surgery, anaesthetics and patient monitoring.
There was always a problem with equipment over there and it always seemed to take ages for them to get stuff down. We had lots of old pieces of equipment and so I suppose really we have got better equipment' (Sister)

Clinicians therefore appeared to perceive the ISTCs as offering a more up-to-date and modern work environment that reflected contemporary working practices and care processes. Moreover these were viewed favourably by previous NHS services which were widely described as poorly planned. However, a common concern for clinicians related to the level of induction and training provided when moved to the new facilities. For example, staff claimed they were unfamiliar with the location of equipment or layout of rooms, suggesting a lack of foresight and preparation by the new service managers. Participants were also concerned about their lack of input in the design of services and their continued lack of influence on procurement decisions. This was exemplified by the choice of single-use devices, which staff had complained about in one of the former NHS services, but which was being used regardless of staff input within the ISTC.

'We had to go round labelling doors so people could identify which room was which and you will find that there are still labels on some of the doors' (Sister)

'We stopped using those bougies ages ago in the NHS, but they still use them here, which isn’t always good practice’ (Nurse)

Although it might also be expected that new infrastructure, whether public or private, might invoke the above reactions, an important point for consideration was the way these views played into clinician’s wider assumptions that private healthcare was often better funded than the NHS, but perhaps lacked knowledge of clinical and professional processes.

3.2. Management

The most controversial aspect of both ISTCs related to new service managers. Although a small number were recruited from the NHS, the majority of operational service level managers, as well as senior executive managers, were recruited from the private sector, including non-health related sectors such as manufacturing and retail. When reflecting upon these groups, participants articulated deep-seated concern about managerial ethos and values. Specifically, participants perceived managers as being driven to meeting the commercial aspirations of the parent company, and where patient care was seen as a means to ‘making a profit’. This was reinforced by managers’ demands for improved operational productivity and efficiency in the use of resources. Although such priorities are common to the NHS, within the ISTCs they were perceived as more obvious and driven, not by the desire to improve patient care, but instead to maximise financial return. As such, some clinicians interpreted management as not working in the best interests of patients or indeed patient safety, but rather shareholders or executives.

'They are different. They say similar things, but you know they are different and that they work for somebody who is about making money' (Nurse)

'We are told all the time that this is not the NHS, they expect us to do things differently, more efficiently, that’s how they make their money. It’s very different from what we are used to.' (ODP)

These concerns often centred on ISTC managers’ enthusiastic use of process reengineering methodologies that were more commonly associated with retail, manufacturing or aviation, such as Lean Thinking and Six Sigma. Although such methodologies are also common to healthcare services across the world and have extensive application within the NHS, in the ISTCs clinicians experienced them as different in character and ethos. It was suggested, for instance, that despite the rhetoric of patient safety and quality, they were primarily oriented towards cost-cutting. Equally, they were interpreted as ‘squeezing’ staff resources and reconfiguring clinical pathways, without necessarily recognising the experience and talent of staff. These views were exacerbated by what clinicians saw as ISTC managers lack of experience in delivering healthcare to NHS patients.

"[The manager] was interesting really, and he talked a lot about what they do in other places and how we could work like a car factory." (Nurse)

'We’re not a supermarket, so don’t try and turn us into [Supermarket name]. They might be really efficient and make lots of money but they are doing something different.' (Sister)

More generally, clinicians described managers as disengaged with clinicians, rarely participating in team meetings, and offering little support. Managers were described as communicating through memos, policies and key performance indicators and focussing more on the goals of senior service executives, rather than frontline clinicians. Although negative views of managerialism may be common within the NHS, in the ISTCs these were explicitly associated with the contractual foundations and profit requirements of the ISTC Company.

'Their day to day consists of meeting after meeting, you can never get them. I need to speak to one of them today and I have been down there four times and each time they have been in a meeting. You used to be able to knock on their door and have a chat, but they always seem to be in meetings with other senior staff and you don’t feel like you can go and intrude.' (Nurse)

3.3. Work configuration and care delivery

In line with managers’ use of process re-engineering methodologies, clinicians highlighted significant changes in the configuration of work and care pathways through techniques more commonly associated with retail or manufacturing. In particular, participants reported more explicit use of formal policies, protocols and Standard Operating Procedures (SOPs) within day-to-day clinical
practice, for example in relation to theatre checks, store area checks, handover and discharge. These were described as making clinical roles less ambiguous and patient care more standardised. Moreover, clinical teams were given explicit expectations for performance at the start of each day and clinical responsibilities were tightly defined in relation to meeting targets. Reflecting on their past experiences within the NHS, many clinicians described the ISTCs as more straightforward and certain, with fewer changes or disruptions, and therefore potential safer for patients.

‘I have a clearer idea of what I am supposed to be doing. There is far less change between jobs. . . you are assigned to a team, you get your list and you just get on with it.’  (ODP)

‘With the way of working it is a lot smoother, less chopping and changing between lists’ (Nurse)

As with other research studies [31] clinicians were concerned about the proliferation of such guidelines and templates. Some argued that they detracted from high quality, patient-centre care through forcing clinicians to work in ways that were primarily process-focussed and not patient-focussed. This was illustrate by the view that clinical work now involved more checklists and paperwork rather than attending to the needs of patients. More broadly, participants also saw work as pressurised with less time to focus on the needs of individual patients.

‘The jobs have been squeezed down and clearly there is a bigger workload for people to do’ (Sister)

‘It is more busy because there are more theatres and the wards are busier as well. . . we have more lists that we used to have before’ (Nurse)

‘It is harder to make decisions over here, because usually if you had problems you would go and find the appropriate person and check it with them but we can’t do that so easily anymore.’ (Nurse)

A further concern related to how standardised roles and responsibilities might undermine professional training and limit exposure to a wider range of clinical tasks and duties. Participants also claimed that the strict planning of work made it difficult for the service as a whole to respond flexibility to unanticipated changes or address risks as they unfolded in situ.

‘Things happen all the time that shouldn’t and we have to adjust and keep on going, but here [ISTC] it is more difficult to do that as everything is so tightly planned. I do worry that something is going to happen and nobody will know what to do because their isn’t a policy for it’ (Nurse)

Clinicians’ experiences of work configuration, together with their perceptions of management, highlight something of a contradiction. On the one hand, and in comparison to the NHS, the private sector is perceived as more ‘tightly’ managed, concerned with productivity and oriented to maximising financial return. For many clinicians this was seen as running counter to the values of a high-quality and patient-centre care. On the other hand, however, clinicians saw the ISTCs as being more stable, and less ambiguous than NHS services which in turn supported enhance clinical practice and safe working. This highlights something of a gap between clinicians’ assumption and experiences of service leaders and their day-to-day work experiences.

3.4. Patient experience

Although the study did not recruit patients, it examined clinicians’ perceptions on the changes in patient experience. In general, participants felt that the level of direct clinical care provided to patients was unaltered from past NHS service. It was usually explained that the “same people” with the “same skills” (Sister) were providing the service. Although the wider organisation of work was seen as more tightly controlled, the narrow technical aspects of clinical work, such as clinical assessment or aseptic practice, were largely prescribed by professional training.

“Well apart from the fact that we have got a new building and new equipment I would say that it really hasn’t changed an awful lot.” (Nurse)

“The actual surgery itself is not much different. Except for the layout of the theatre, which means the anaesthetist team and surgical team are closer as there is no separate room. But for the patient care we are mostly the same people actually doing it” (Nurse)

Nevertheless, participants did highlight two significant improvements in patient care. First, patients received an improved aesthetic service, with cleaner and more orderly waiting and reception areas. This was also evident in more private and clinical areas, where patients had private bays, individual televisions and were provided with high quality refreshments. Second, participants suggested patients experienced a more reliable, stable and speedy service with fewer delays, cancelations or return visits. Again this appeared to reflect the way service were organised within the ISTC. Participants often described patients as receiving a service more in common with private healthcare than the NHS.

One interesting aspect of clinicians’ views on patient experience was that there was little reflection on how patients overall encounter with the health service changed by using an ISTC. Views of patient experience related for the most part to their own area of clinical responsibility, rather than giving a reflection on overall waiting times, referrals or ease of navigating the healthcare system.

4. Discussion

Clinicians have both positive and negative experiences of being relocated from the NHS to the independent sector. On the one hand, ISTC leaders were seen as seeking to reshape and manage services in ways that might prioritise productivity and efficiency ahead of quality or safety. On the other, ISTCs were characterised by an improved and more stable work environment and patient experience that offered, in general terms, an alternative to,
what were portrayed as, old or out-dated NHS services. This mixed experience perhaps reflects some underlying prejudice on the part of clinician. It might be surmised that, for some clinicians at least, the private sector is perceived as being driven by profit, ahead of patient needs or safety. Although experience of working within these services seems to reinforce this view for some, clinicians also describe how their work might actually be more stable and less risky because of the way services are managed, and that patients receive an improved service. It might be concluded, therefore, that clinicians need time to overcome their initial apprehensions about the private sector. However, this mixed and contradictory experience remains an important finding and suggests that it can be difficult and time consuming for clinicians to come to terms with such change. In short, such contradictory experiences ultimately add further uncertainty to staff as they struggle to determine whether working in the private sector is better than previous NHS services. Reflecting on the findings, three cross-cutting issues appear to underpin the tensions experienced by clinicians as they move as a collective group between public and private sectors.

The first relates to what clinicians see as the commercialisation of public healthcare service. In various ways, ISTCs were described as being more business-orientated in how they were managed and with patients seen more explicitly as customers. On the one hand this was found in the emphasis given to financial viability and corporate profitability, and on the other through the proliferation of a more commercial and consumer-focused mindset. This is exemplified by the use of practices aimed at increasing productivity and enhancing customer experience through the delivery of a standardised, commercial service that aligned the aspirations of both patients (as consumers) and shareholders. Although issues of cost and choice have been common to recent UK health policies [4,5], for clinicians the growing role of the independent sector embodies a significant commercialisation of public services.

The second issue relates to new expressions of management within healthcare. In line with the above, ISTC management were perceived as embodying the values and ethos of private business. This included an explicit focus on service-level and clinical performance, which although arguably common to all healthcare systems, was directly linked to commercial success and customer service. Elaborating this further, ISTC managers were generally seen as ‘outward facing’, or being orientated to key performance indicators or shareholder priorities. In comparison, and thinking about those managers transferred from the NHS, clinicians were more accustomed to managers that were ‘inward facing’ and more involved in day-to-day decision-making. As such, ISTC managers were seen as relying more upon being formal protocol and pathways to order work, rather than their inter-personal skills or participation in day-to-day service management. This appeared to invoke apprehension about the widespread use of new policies and pathways, especially the view that they were designed to undermine professional judgement. While this proposition could be explicitly tested in future studies, perceptions of managerialism were tied in with clinicians (pre)conceptions on the values inherent within public and private sectors.

The final theme relates to implications for healthcare professionalism. Although clinicians saw merit in the use of more explicit guidelines, protocols and SOPs in making patient pathways more standardised and less ambiguous, there was also concern about the longer term impact on professional practice. In one regard, clinicians described new ways of working as extending managerial or corporate control over clinical practice. Clinical judgement and discretion, for instance, were seemingly substituted with formulaic guidelines and instruction. Taking this further, the apparent construction of professionalism within ISTCs related less to professional knowledge, skills and competence and more to meeting stipulated guidelines or performance indicators. As such clinicians revealed a new idea of professionalism within the independent sector that in some sense ran counter that often found in the public sector. Moreover, clinicians raised concerns about the declining reliance upon and role for professional competencies and the sense that the service was now less able to respond positively to periods of rapid change, uncertainty or risk.

This paper describes the experiences of NHS clinicians transferred to and working within ISTCs. It highlights a number of emergent issues that for these clinicians represent important changes and disjunctions in their work. Although important not to overstate or generalise excessively from this study, the study shows that clinicians perceive the ISTC programme and the wider healthcare reform agenda as a highly controversial and uncertain transition, about which they had little control. It might be expected therefore that a degree of scepticism and resentment permeates these views and that clinicians may look back with a degree of nostalgia about working within the NHS. As such there is scope for more research in these areas, for example to relate qualitative data to emerging evidence of clinical and performance outcomes.

5. Conclusions

Although the independent sector has the capacity to offer an improved work environment and more standardised and consumer-type patient experience, there remain doubts on the part of some clinicians about the motives of managers to provide public healthcare. Moreover, there are anxieties about the longer term implications for healthcare professionalism, and perhaps the need to restate professional standards in a context where commercial pressures shape service delivery. With policies looking to expand the mixed economy of public healthcare services, the study suggests clinicians will not automatically embrace a move between sectors. The extent to which these new services and their managers are able to transform institutionalised ways of working remains unclear and there is a risk of managers poorly engaging clinicians as they direct their attention to external or corporate priorities over those of care providers. Understanding the shared experiences and views of clinicians is important for policy-makers and service leaders seeking to introduce new ways of working because clinicians can represent significant barriers to
service modernisation if the desired change and change process is perceived or experienced in a negative way in light of prevailing cultural or professional norms and values. The experiences of clinicians within ISTCs therefore provide important lessons for future healthcare services, that like the NHS, seek to pluralise and diversify the market for healthcare through expanding the role of the independent sector.

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