Informed Choice or Informed Voice?

A consideration of the impact of proposed NHS service developments on divided communities.

By

Rebecca Laura Jane Parish

School of Social Sciences
Cardiff University

A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Health Studies of Cardiff University

November 2023

Summary

Scholars suggest that divergence in national policy across the United Kingdom post-devolution contests the use of the word 'National' in the National Health Service. However, 'big D' devolution is not the sole factor challenging the word 'National', as variation occurs at much smaller 'little d' devolved geographies. This thesis considers both healthcare policy divergence between administrations in England and Wales post-devolution and explores the dialogue between a health and care system and the people and communities it serves regarding the reconfiguration of specialist hospital services within a single English county. The analysis explores what informs people's voices and choices and whether this results in differential appetites for service change between two geographical areas. Le Grand's (2007) four models for good public services: trust, command & control (targets); voice; and choice & competition is the analytical framework used to undertake the secondary analysis and interpretation of qualitative data from three surveys and two citizens' juries' reports. The research identifies what influences the choices people make and the informed voices they use to express their preferences regarding IDEAS for change, POLICY to implement change and specific PROPOSALS for change to the location of specialist hospital services. The results are presented using claim, warrant, data chains with illustrative quotations selected from the data. The analysis reveals evidence of differential appetite for change but not as significant as expected. Influencing factors include accessibility of services and preference for the *status quo*. The impact of misinformation or misunderstanding about current services is an important finding. The data show that labelling one side of the county as more resistant to change than the other would be inaccurate. This research identifies learning for practice, policy and future research with respect to public services communications and working in partnership with people and communities.

Table of Contents

1 Introduction 1
1.1 Divided communities 1
1.2 Thesis Structure 3
1.3 Theoretical Framework 4
1.4 Literature Review 9
1.5 Decentralisation of healthcare policy development in the NHS 24
1.6 Dominant Theories influencing Public Policy from the 1980s onwards 31
1.7 ‘Big D’ Devolution (Macro): Opportunities for Policy Divergence 35
1.8 ‘Small d’ Devolution (Micro): Opportunities for Policy Divergence 41
1.9 Gloucestershire (Micro) 42
1.10 Involving People and Communities 50
1.11 Chapter Summary 55
2 Method 56
2.1 Chapter Structure 56
2.2 Researcher Familiarity 56
2.3 Data Selection for Secondary Framework Analysis 58
2.4 Introduction to Case Studies 60
2.5 Primary Analysis 68
2.6 Secondary Analysis 71
2.7 Chapter Summary 76
3 Results and Analysis 78
3.1 Chapter Structure 78
3.2 Priority Findings 79
3.3 Generalisability of the findings 81
3.4 Voice 82
3.5 Voice Priority Findings 105
3.6 Choice & Competition (Choice) 107
3.7 Choice Priority Finding 122
3.8 Trust 124
3.9 Trust Priority Finding 130
3.10 Command & Control (Targets) 132
3.11 Targets Priority Findings 141
3.12 Chapter Summary 142
4 Discussion 144
4.1 Chapter Structure 144
4.2 Priority Findings 145
4.1 Limitations and Strengths 152
4.2 Emerging themes 160
5 Conclusion 172
5.1 Divided communities 172
5.2 Divided individual 173

5.3 Contribution statement 173
6 References 175
6.1 Case Studies 175
6.2 Academic References 175
7 Appendices 189
7.1 Case Studies References 189
7.2 Appendix 2: Consolidated Criteria for Reporting Qualitative Studies (COREQ) – 32-item checklist 190
7.3 Appendix 3: Trust Full Results and Analysis 195
7.4 Appendix 4: Command & Control (Targets) Full Results and Analysis 216
7.5 Targets Findings 230
7.6 Appendix 5: Impact of COVID-19 on this research 233

Table of Figures

Fig. 1 Trust: Elements and Attributes developed from Le Grand (2007) 6
Fig. 2 Targets: Elements and Attributes developed from Le Grand (2007) 7
Fig. 3 Voice: Elements and Attributes 7
Fig. 4 Choice: Elements and Attributes 8
Fig. 5 Voices and roles associated with Le Grand models 15
Fig. 6 Bed usage by speciality across CGH and GRH 2010 43
Fig. 7 Summary of the Gunning Principles first applied during a court case by Mr Stephen Sedley QC adopted by Mr Justice Hodgson in R v Brent London Borough Council, *ex parte* Gunning, 1985 52
Fig. 8 Evolution of the FFtF Programme 59
Fig. 9 The most important thing to you when you need to see a specialist 62
Fig. 10 NHSG Information Bus 67
Fig. 11 Survey participation across NHSG (2016-2021) 68
Fig. 12 Extract from FFtF 'Output of Consultation' Report 69
Fig. 13 Quantitative data showing % level of support/opposition in the east and west to the three FFtF consultation change proposals and preference for site for Planned Lower GI Surgery 70
Fig. 14 Nine-point Framework Analysis Process 72
Fig, 15 Coding Framework using Le Grand's four models (2007) 74
Fig. 16 Four-step Data Selection Process 74
Fig. 17 Example Claim, Warrant, Data Chain, Cross-case Analysis Process 76
Fig. 18 Voice (1) Chain: IDEAS 1 83
Fig. 19 Voice (2) Chain: IDEAS 1 85
Fig. 20 Voice (1) Chain: POLICY 2 88
Fig. 21 Voice (2) Chain: POLICY 2 90
Fig. 22 Voice Chain: POLICY 2 Citizens' Jury 94
Fig. 23 Voice Chain: Proposal – Acute Medicine at GRH 95
Fig. 24 Voice Chain: Proposal – Planned Lower GI Surgery at either GRH or CGH 95
Fig. 25 Voice Chain: Proposal – Planned Day Surgery Upper and Lower GI at CGH 95
Fig. 26 Jurors' Confidence in the FFtF Consultation Process 101
Fig. 27 Voice Chain: Proposal – Citizens' Panel 102
Fig. 28 Choice Chain: IDEAS 1 108
Fig. 29 Choice Chain: POLICY 111
Fig. 30 Choice Chain: POLICY Citizens' Jury 114
Fig. 31 Choice Chain: Proposal – Acute Medicine at GRH 115
Fig. 32 Choice Chain: Proposal - Planned Day Surgery Upper and Lower GI at CGH 116
Fig. 33 Choice Chain: Proposal Planned Lower GI Surgery at CGH or GRH 116
Fig. 34 Trust Chain: POLICY 125
Fig. 34 Trust Chain: Proposal – Acute Medicine at GRH 127
Fig. 35 Trust Chain: Proposal – Planned Lower GI Surgery at GRH or CGH 128
Fig. 36 Trust Chain: Proposal – Planned Day Case Upper and Lower GI (colorectal) surgery at CGH 128
Fig. 37 Targets (2) Chain: IDEAS 133
Fig. 38 Targets (2): POLICY 134
Fig. 39 Targets Chain: Proposal – Acute Medicine to GRH 138
Fig. 40 Targets Chain: Proposal – Planned Lower GI Surgery at either CGH or GRH 138
Fig. 41 Targets Chain: Proposal – Planned Day Case Surgery Upper and Lower GI at CGH 138
Fig. 42 Learning points associated with the trust model (Le Grand, 2007) and associated priority finding 149
Fig. 43 Learning points associated with the command & control (targets) model (Le Grand, 2007) and associated priority finding 150
Fig. 44 Learning points associated with the voice model (Le Grand, 2007) and associated priority findings 150
Fig. 45 Learning points associated with the choice model (Le Grand, 2007) and associated priority finding 151

Acronyms

A4OC	Action 4 Our Care
A&E	Accident and Emergency
AM	Assembly Member (in Wales)
CCG	Clinical Commissioning Group
CGH	Cheltenham General Hospital
CoE	Centres of Excellence (Policy)
DH	Department of Health (in England)
DNA	Did not attend (for an appointment)
ED	Emergency Department
EEIA	Engagement and Equality Impact Assessment
FFtF	Fit for the Future (Programme)
FT	Foundation Trust
GCC	Gloucestershire County Council
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
GI	Gastro-intestinal
GRH	Gloucestershire Royal Hospital
HOSC	Health Overview and Scrutiny Committee
ICB	Integrated Care Board
ICS	Integrated Care System
IIA	Integrated Impact Assessment
MIIU	Minor Injuries (and Illness) Unit
MP	Member of Parliament (in England)
NHS	National Health Service
NHSE	NHS England
NHSG	NHS Gloucestershire
NHSW	NHS Wales
NPM	New Public Management
NPP	New Public Philosophy
PCT	Primary Care Trust
PPI	Patient and Public Involvement
PPE	Patient and Public Engagement
RCT	Rational Choice Theory
REACH	Restore Emergency at Cheltenham general Hospital
TCI	The Consultation Institute
UK	United Kingdom

Acknowledgement

I would like to thank my employer, NHS Gloucestershire, for the financial and management support given to undertake this research. Acknowledgement also is due for authorisation for the use of primary data collected in my professional role for the secondary analysis presented in this thesis. I would also like to thank two NHS colleagues: Caroline Smith and Micky Griffith for providing their technical support and friendship.

I have benefitted from the advice and guidance of several thesis supervisors over the last 8 years. I must pay credit here to their expertise and persistence. I am particularly grateful to Professor James Lewis, University of Cardiff; Professor G J Melendez-Torres, University of Exeter and Professor Graham Moore, University of Cardiff, my independent reviewer, who guided me, and this thesis, through to the end.

Finally, I would like to acknowledge the individuals and communities across Gloucestershire, and beyond its borders, who continue to make the ‘choice’ to use their ‘voice’ to share their experiences and express their views about their NHS.

Dedication

For George, Jenny, Jim, Kate and Simon.

I hope I’ve done enough to deserve this for both of us.

1 Introduction

1.1 Divided communities

This thesis is about divided communities. Its focus is the informed, and sometimes misinformed, voices and choices of people and communities that influence the development policy, service development and change in healthcare.

This thesis addresses two research questions:

1. What influences the choices people make and what informs the voices they use to express their preferences regarding IDEAS for change, development of POLICY to implement change and specific PROPOSALS for change?
2. What do the expressed attitudes towards proposed reconfiguration of specialist hospital services of two geographically divided communities tell us about differential appetites for change?

The analysis of three case studies from Gloucestershire and the discussion in response to these questions supports the identification of factors healthcare professionals and policy makers and other should consider when involving people and communities in developing IDEAS, POLICY and PROPOSALS for change and identifies future potential areas for research.

1.1.1 *Why I think the choices I have made and the voice I have used in this thesis are important*

How this thesis is structured I describe in a linear way below (see1.2). However, I think it is important first to express from the start why I consider this research to be important.

The presentation of this thesis represents the academic culmination of a hypothesis I have been developing over many years about differential responses to potential healthcare service change. I have finally been able to test this through the secondary and cross-case analysis of the case studies' data presented in this research.

Over several decades, governments across Europe have promoted decentralization of the accountability for healthcare policy development and service delivery (Adolph et al, 2012; Costa-Font and Greer, 2016). Devolution in the UK brought opportunities for healthcare policy divergence at a national level. However, I have observed another aspect of divergence at a micro-level within England, where I have worked for more than 30 years, in the form of delegated development of local policies and

programmes to local health and care systems in England. In that time I have observed the relative support for development and change amongst resident populations; in this instance, the people living in the east and the west of Gloucestershire. I was interested to confirm whether my premise regarding geographically differential appetites for change would stand up to the academic rigour of a professional doctorate research thesis. To test this, I wanted to consider local policy evolution of IDEAS and POLICY, and the discourse used to present the case for PROPOSALS to reconfigure some specialist hospital services in Gloucestershire through the 'centres of excellence' (CoE) policy, and the delivery mechanism, the 'Fit for the Future' (FFtF) programme.

The literature review I present focusses on the manifestation of choice and voice in relation to potential changes in healthcare services and citizens' appetite for patient choice. The scholarly views I have selected suggest that, despite the shift in public policy towards greater patient choice, those choices offered are not necessarily those that people and communities would choose for themselves.

The case studies represent the voices informing this thesis. They allow me to consider the research questions and test my hypothesis through analysis of data collected by me from people who have interacted with me in my professional role and who are also members of the community in which I live.

I chose to provide some context for the thesis through a brief history of the evolution of the rise of marketisation and decentralisation in the NHS and dominant theories influencing those public policies. The focus is decentralisation of healthcare policy development in the UK; which I refer to in this thesis as national big 'D' Devolution and local little 'd' devolution. This context is important because it is the backdrop to my NHS career over the past 34 years. I carefully consider my familiarity with the subject of this thesis. Effectively I am a 'divided individual'. I have my professional role, my role as a citizen and my role as a researcher. It was important to notice this shift from the prerequisite of neutrality in my professional practice to a position where I can add my interpretation of the data (see 2.2).

The organising theoretical framework for the analysis and interpretation I chose for this thesis is Le Grand's (2007) four models for organising good public services: trust; command & control; voice; and choice & competition (see 1.3.3). Commencing studies for my MSc in Healthcare Policy and Management during the 2000s, I became aware of Le Grand's work influencing contemporary policy makers. An

advisor to the Blair Labour Government; which passed the legislation for big 'D' devolution; Le Grand's work promotes patient choice within decentralised public services.

Le Grand's promotion of patient choice in public services signals the opportunities of delegation for freedom within local NHS systems in England to be responsive to both national policies and resident patient consumer needs and demands. The analysis of the content of two political speeches, identifies a demonstrable appetite for change and policy divergence between the two nations at a big 'D' devolved level (see 1.7). These findings provide context for the analysis of the case studies; which present the differential response to proposals to reconfigure some specialist hospital services in Gloucestershire; illustrating similarities and differences within the public appetite for change in the east and the west of a county at a small 'd' devolved level (see 1.8).

The method chosen to analyse and interpret the case study data is described in detail (see 2.6). The method used is a secondary framework analysis using Le Grand's four models (Le Grand, 2007). The method selected is important because it allowed me as the researcher to build on my professional role in conducting the engagement and consultation activities described and factually reporting on the output of engagement and consultation. In the primary analysis of the three case studies the focus must be on 'what' people said with no opportunity for interpretation. Whereas in this research I aspire to achieving a deeper level of understanding of 'why' individuals respond in the way they do to new IDEAS, POLICY and PROPOSALS for changes to the healthcare services used by themselves and their communities. This understanding has enabled me to identify learning for fellow and future practitioners and areas for future research (see 4).

The purpose of this thesis is the production of knowledge and understanding rather than serving one political or policy cause over another (Hammersley, 2005). It also seeks to test whether the application of Le Grand's four models for organising public services: trust; command & control; voice; and choice & competition (Le Grand, 2007) is a valid framework for a secondary analysis of qualitative data with respect to patient choice and voice.

1.2 Thesis Structure

The 'introduction' chapter sets the scene by providing a general overview of approaches influencing health care policy development and divergence across the NHS, over a forty-year period (pre- and post-devolution) in the United Kingdom (UK).

The chapter introduces: relevant literature; the theoretical framework used; a brief history of the evolution of the NHS; and dominant theories influencing public policy development. This includes two examples of healthcare policy divergence between the administrations in Wales and England.

A series of theoretical policy concepts is presented: the 'invisible hand' (Smith, 1776); the 'other invisible hand' (Le Grand, 2006, 2007); rational choice theory (RCT) (Heath and Heath, 1976); and 'new public philosophy' (Marquand, 2004). The four models for organising public services described by Le Grand (2007) provide the analytical framework used to consider evidence of the appetite for choice and voice amongst the population in response to proposals to reconfigure specialist hospital services in Gloucestershire as described in the case studies.

The chapter goes on to describe relevant structural and legislative milestones within the NHS during the period, including the introduction of statutory duties with respect to involving the public. The last part of the introduction presents Gloucestershire: its geography; people; and healthcare landscape. Finally the three case studies are presented.

Chapter Two, the 'methods' chapter, describes the approach taken to collect and analyse the data from three case studies.

Chapter Three, the 'results and analysis' chapter, presents a secondary analysis of the qualitative data from three case studies and two citizens' juries. The data were originally collected to inform local NHS policy development and service change in Gloucestershire.

Chapter Four, the 'discussion and conclusion' chapter, presents the interpretation of the findings and synthesises the outcomes of the research, its limitations and identifies learning for practice, policy and future research.

1.3 Theoretical Framework

1.3.1 *The Invisible Hand*

In a 21st century discussion about the perception of a relative shift towards consumerism in public services, one might not expect to find a reference to a 240-year-old concept.

> As every individual endeavours so to direct his industry that its produce may be of the greatest value; every individual necessarily labours to render the annual revenue of the society as great as he can. He generally, indeed, neither intends to promote the public interest, nor

> knows how much he is promoting it, he intends only his own gain; and he is in this, as in many other cases, led by an invisible hand to promote an end which was no part of his intention. (Smith, 1776, p. 400)

However, in his book Le Grand (2007) adopts Smith's 1776 metaphor of the 'invisible hand', which conceives that the choices made by self-interested individuals can have an unintended positive impact on wider society.

Using Le Grand's models (2007) to segment the data to be analysed, I coded the data using each of the models systematically. Then I undertook secondary coding using the attributes of each of the models before finally segregating the data into responses from residents from the east or west of the county of Gloucestershire. This process enabled me to identify, present and interpret contrasts more clearly between divided communities thematically, as well as identify similarities revealed in the data.

Le Grand's ideological standpoint is one of 'new public management' (NPM), grounded in neoliberalism (Gruening 2001; Hood, 1991, 1995); neoliberalism being the dominant global paradigm in public sector policy development from the second half of the twentieth century (Osborne and Gaebler, 1992). Neoliberalism seeks to integrate business-like practices of the private sector into the public realm for the purpose of efficiency and productivity gains (see 1.6.1).

However, Smith's analogy of the invisible hand guiding individual self-interest, oblivious to its effect on society, seems wholly relevant to a discussion about the implications of the neoliberal application of consumerist principles in parts; in England; of the NHS through NPM approach; and wider citizen satisfaction through collective ownership (Collins et al, 2019) or welfarist approach in Wales at the end of the 20th and beginning of the 21st centuries in the UK. The four models described by Le Grand (2007) are used as the analytical framework, to support the analysis in this thesis.

1.3.2 *The Other Invisible Hand*

Le Grand presents an alternative 21st century version of 'the invisible hand' in his book "The other invisible hand…", describing four models (means) for organising public services – trust, command & control (targets), voice and choice & competition (Le Grand, 2007). The four models are defined in economic terminology by 'ends' and 'means'; another way to describe them would be 'mechanisms' and 'outcomes'. For the purposes of this thesis, the desired outcome is delivering a good local

service, and the mechanisms to achieve this are Le Grand's models (see 0.) The elements and attributes, or components and characteristics, of the four models; which I have extrapolated from Le Grand's description of the characteristics of the four models; are used to inform the coding of the data, to support the secondary framework analysis (see 2.3 for details of the coding process). Le Grand notes that a combination of all four models is beneficial. However, he concludes that choice & competition is the most advantageous, as providers of public services are incentivised to deliver what their potential service users want, and all individuals are offered a choice, resulting in an equitable model. There are several critiques of Le Grand's preferred model, one of which is whether all individuals have sufficient information or equitable opportunities to make informed choices (Greener and Powell, 2009). The criticisms are explored below.

1.3.3 *The Four Models*

1.3.3.1 Trust

Trust is the simplest model. It describes a situation where an administration allocates money to professionals, trusted to know how best to spend it. The trust model relies upon the assumption that public sector staff members are 'altruistic knights' as opposed to the 'self-interested knaves' of the private sector (Le Grand, 1997).

Fig. 1 Trust: Elements and Attributes developed from Le Grand (2007)

Le Grand Model: TRUST
MEANS: What matters – how can you get a good service?
Elements: Collaborative working/network; Motivation (selfless/self-interest); Perceptions; Paternalism; Patient autonomy (or lack of it); and Potential for lack of innovation
ENDS: Why it matters – what makes a good service?
Attributes: Quality and Excellence
Elements: Inputs – Number/type of staff; Skills; Size and condition of facilities; Process – Patient experience and waiting times; Outputs – number of interventions; Outcome – improvement in health

1.3.3.2 Command & Control (Targets) developed from Le Grand (2007)

The next model is the opposite of trust; it is the method of organising services through the imposition of targets and performance management. This model has been referred to as a 'regime of targets and terror' (Bevan and Hood, 2006 (a), p. 257). In this thesis I will refer to it as the 'targets' model.

Fig. 2 Targets: Elements and Attributes developed from Le Grand (2007)

Le Grand Model: Command &Control (Targets)
MEANS: What matters – how can you get a good service?
Elements: Effectiveness; Targets/results; Priority; Bureaucracy; and Political influence
ENDS: Why it matters – what makes a good service?
Attributes: Efficiency
Elements: Cost/resources; Opportunity costs; and Consideration of taxpayer

1.3.3.3 Voice

Voice is a bottom-up service model relying upon the involvement of users of services to influence changes in the organisation of services, having more say in decisions about their treatment and care. The concept of 'voice', from the 1990s onwards is associated with public engagement and patient empowerment, often combined with the concept of patient choice and appetite for choice (Coulter, 2010) (see 1.4.1.2).

Fig. 3 Voice: Elements and Attributes

Le Grand Model: VOICE
MEANS: What matters – how can you get a good service?
Elements: Dissatisfaction/satisfaction; Perception; Participation; Voting; Equality; Articulate (subjective) and Legal
ENDS: Why it matters – what makes a good service?
Attributes: Responsive, Accountable
Elements: Consideration of service user and taxpayer

1.3.3.4 Choice & Competition

This model differs from the trust and targets models in the levels of activation of the service user; where the patient is passive, as all decision making is made by professionals. This model, like voice, fulfils the principle of autonomy and promotes responsiveness to users' needs and wants. It produces incentives for providers to supply higher quality, efficient services, and Le Grand argues, is likely to be more equitable than other models as choice is available universally.

Fig. 4 Choice: Elements and Attributes

Le Grand Model: CHOICE
MEANS: What matters – how can you get a good service?
Elements: Who/Where/When/What/How; Individual choice; Collective choice; Autonomy/respect; Responsive; Incentives; Equitable; and Potential for innovation
ENDS: Why it matters – what makes a good service?
Attributes: Equitable
Elements: Access; Geography; Transport infrastructure/costs; Individuals' resources; Individuals' characteristics; Communities' characteristics

1.4 Literature Review

This review situates the thesis within relevant literature providing an overview of scholarly works that focus on the core areas explored in this thesis: divided communities, choice and voice. It considers how scholars view the manifestation of choice and voice amongst people within communities in relation to the reconfiguration of specialist NHS healthcare services. This literature review also considers scholars' responses to the appetite for patient choice resulting from relative national 'macro' level promotion of healthcare consumerist policies.

The purpose of this literature review is to build my argument through familiarisation, authenticating my understanding of relevant published research associated with my thesis and the framework used to analyse and interpret the data (Le Grand 2007). In this section, I summarise earlier theories and commentaries, identifying areas of difference and divergence, as well as any gaps that exist in the literature. Literature Searches.

Literature searches show there is a growing body of literature: academic, statistical and grey, to inform an exploration of patient choice policy development and the public response specialist service reconfiguration in the UK.

The first type of literature reviewed is a selection of published academic research which considers the impact of consumerism in healthcare and thereby the application of Le Grand's preferred model: choice & competition. Also in this section there is a review of literature which considers change in healthcare services, in particular service reconfiguration and the cases for and against concentrating specialist healthcare services in central locations.

Finally there is consideration of literature which considers public involvement in, and appetite for, health care reconfiguration and thereby the application of another of Le Grand's four models: voice.

1.4.1 *Choice*

1.4.1.1 The Other Invisible Hand

The version of choice presented in this paper assumes secondary benefits for wider society delivered by an 'invisible hand', as an unintended consequence of primary individual actions (Harding, 2021; Le Grand, 2007; Smith, 1776). 'The Other Invisible Hand', the text which provides the theoretical framework for the secondary analysis in this thesis (Le Grand, 2007), incorporates two invited critiques as Afterwords.

The first, Endhoven's American view, is that public frustration with the performance of public services is common both in the USA and the UK. The antidote is the social controls, or 'models or means', described by Le Grand (Endhoven, 2007, quoted in Le Grand, 2007, p. 170). Endhoven is persuaded by Le Grand's argument that non-choice models favour more affluent groups, noting that choice must be real i.e. there must be more than one provider offering a service. He proposes a mitigation such as access to low-cost transport for lower-income groups to enable them to choose from the available alternatives.

The second 'sceptics' Afterword from Lipsey, agrees with Le Grand that a combination of the four models is necessary, whilst remaining less convinced about the dominance of choice & competition as promoted by Le Grand (Lipsey, 2007, in Le Grand 2007). Le Grand is an advocate for choice to be more prevalent than the other models in social policy development, suggesting it maximises public interest better than the other three models (Greener and Powell, 2009). Lipsey's sceptical view is that choice is expensive for the individual in terms of time spent researching choices and can be a disappointment if individuals conclude they made a wrong choice. Referring to choice as being intrinsically good, Lipsey notes that a justification for choice in public services is that it is also instrumentally good as an incentive for improvement and innovation. Lipsey remains suspicious of the use of private sector methods in the public sector; in particular, constraints which exist in the private sector, notably individuals' budget limits, which do not exist in the public sector where individuals are free to demand more at the same time as opposing tax increases. Also I would add that the private sector provider can exclude costly or challenging customers, while a universally accessible public sector service cannot. Consequently, Lipsey argues that marketisation cannot directly apply to public services, concluding that the 'invisible hand' works differently in the two sectors, and is not a 'panacea' (Lipsey, 2007, quoted in Le Grand, 2007, p. 179) for the challenges of delivering good public services.

Unsurprisingly, there is no consensus amongst scholars with respect to the components of the value in choice they observe in consumers of, or providers of, services subject to choice. It is suggested that there is intrinsic value in choice; that it is a good thing (Dowding and John, 2009; Le Grand, 2010). However, one study into parental choice of school shows that choice is desired only to minimise negative outcomes, rather than being intrinsically good (Bhattacharya, 2020). Another study

shows that citizens gain satisfaction from the quality and quantity of choices available to them. This is noticeable in the consideration of collective democratic benefits of quantities of choice, such as equity of access and reduction in health inequalities (Collins et al., 2019). I think this runs counter to the origins of the purely consumerist version of choice; whereby personal gain is the motivating factor and any societal benefits are unconsciously achieved (Smith 1776).

One study suggests that medical consumerism is unpopular amongst the medical profession, potentially harming patient/clinician relationships, reducing patient compliance with recommended treatments, and resulting in poorer clinical outcomes (Iliffe and Manthorpe, 2021; Zeckhauser and Sommers., 2013). Other scholars observe that clinicians are more supportive of personalisation than consumerism in healthcare (Gusmano et al., 2019). Some argue that patient choice erodes trust between doctors and patients, constrains professional judgement (Iliffe and Manthorpe, 2021). This view aligns with the findings of the Bristol Royal Infirmary (BRI) inquiry, which identify a 'club culture' within the BRI, a supra-regional specialist service centre providing paediatric cardiac surgery. This culture is said to have prevented any challenge to clinical leaders by their patients or professional colleagues (Department of Health, 2001(a)).

I have felt for a long while, that the findings of the BRI Inquiry (Department of Health, 2001(a)); which I was professionally associated with as Head of Communications within the Inquiry management; prepared NHS staff and patients for less medicalised, more person-centred ways of working aspired to twenty years later (Iliffe and Manthorpe, 2021). I think that those findings inspired the growth in patient involvement, shifting individuals' agency from simple choices about the preferred hospital provider towards active participation on codesigning healthcare services and having a say in how they are organised.

1.4.1.2 Appetite for Choice

"To do nothing is within the power of all now" (Johnson 1751 in Samuelson and Zeckhauser, 1988:7). Actively choosing or accepting the *status quo* is an option for patients and, for some in the case studies considered in this thesis, it is a preferred option (see 3):

A scoping exercise has found that the willingness and ability of patients to make choices about healthcare providers is dependent on patients' characteristics, the

characteristics of the healthcare providers, and the weight patients given to the provider characteristics (Victoor et al., 2012). The scoping review notes that there is no such thing as the 'typical patient' (Victoor et al., 2012:13) and a wide range of characteristics beyond health outcome influence patients' choice.

Whether patients actively choose their healthcare providers is of relevance to this thesis. One study from the USA found that 65% of patients say they would want choice of hospital if they had cancer, but only 12% of patients with cancer say they would exercise choice (Schwartz, 2004). Three studies from the UK (Fotaki et al., 2008; Magee et al., 2003; Robertson and Burge, 2011) found that few patients do choose their healthcare provider; which suggests that the policy objective of creating consumer choice to create competition between providers to improve efficiency and thereby reduce waiting lists will not be successful. Two studies from the UK found that a high percentage of patients felt that choice of healthcare provider was unimportant (Fotaki et al., 2008; Magee et al., 2003). One study from the USA found that only 10% of patients consider an alternative to choosing their local hospital (Schwartz et al., 2005). Two studies from the UK found that some groups (young people, those with more academic qualifications, and higher-income groups) make choices in healthcare more actively (Burge et al 2004; Exworthy and Peckham, 2006). However, one of these studies found that patients are still more likely to choose to go to their nearest hospital (Exworthy and Peckham, 2006). These observations are relevant to the results and analysis of the case studies (see 3).

A later study focussing on patient choice in England (Fotaki, 2014) addresses the statement 'what market-based patient choice can't do for the NHS'. It compares the policy makers' assumptions that implementing patient choice & competition lead to improved quality and greater efficiency in healthcare, and what choices are important to patients.

Fotaki (2014) considers the reasons why the scale (of the impact of patient choice in healthcare as a method of provider influence in relation to efficiency and quality) may vary from policy makers' expectations. Fotaki draws four main conclusions. Firstly, the demonstrable impact of patient choice policy implementation on improving efficiency and quality of NHS services is very limited. It is suggested that choice in healthcare may increase inequities; because the ability to make choices is inequitable for a number of reasons. It is shown that differential access to, or comprehension of, information may disadvantage older patients and those less well

educated (Fotaki, 2014). Others have noted that it is a complex task comparing health care providers due to poor information and the level of trust individuals might have in a hospital based on factors other than waiting times or other quality markers such as where individuals live in relation to the providers offering services, their personal circumstances, knowledge and resources as well as age, gender and ethnicity (Costa-Font and Greer 2016; Exworthy and Peckham 2006; Harding 2021).

Secondly, instead of patients making technically rational choices, cultural and social contextual factors guided patients' choices, and the processes they used to make choices. Also, the choices offered by patient choice policy in England are not necessarily the choices patients want, such as choosing a named Hospital consultant rather than a Hospital Trust, as well as shared decision making in partnership with trusted clinicians, is preferred by many to the role of informed customer in a marketplace (Coulter, 2010; Fotaki, 2014).

Thirdly, many patients are willing to reject the freedom to choose in favour of supporting the retention of universal public services provided locally by trusted, good quality NHS providers (Fotaki, 2014). Hospital location in the context of the third Gloucestershire case study is a very important factor influencing individual and collective public choices.

Choosing healthcare is not a simple process and the implications for patients of making the wrong choice can be profound (Fotaki, 2014). Individuals require accessible information to support them to make informed choices (Harding 2021); patients' choice selection must be supported if choice policy is to be affective in achieving its objective of improving services and making them more equitable (Fotaki, 2014).

The scoping review concludes that technical assumptions made by policy makers, that patient choice of provider is wanted by patients and can be used to affect the delivery of healthcare, may be misplaced, with the reality of patient choice in action being quite different (Victoor et al., 2012).

For more than 20 years, patient choice has been a policy mechanism promoted to improve the quality, efficiency and equity of access to secondary hospital care in England. It is noted by academics that there has been little involvement of patients in the development of choice policies; rather, the type and range of choices available has been determined by policy makers (Peckham et al., 2012). As it is assumed by

the public today that choice in healthcare is ubiquitous, particularly so in England where it is enshrined in the NHS Constitution (Department of Health, 2009), there is little appetite amongst policy makers to alter the policy direction (Bhattacharya, 2020; Greener and Powell, 2009; Harding, 2021). The aims of patient choice policies referred to above include quality improvement and greater efficiency. These are cited in the case studies in this thesis as rationales for reconfiguring some specialist hospital services in Gloucestershire.

1.4.1.3 Choice in Different Contexts and Roles

If patients in the collective role as consumers are to affect provider behaviour and outcomes, there must be acknowledgement of the different relationships people and communities have with the NHS (Simmons and Powell, 2009). Individuals play many roles in the public space (Jung, 2010). At any one time individuals may be patients, carers, potential future users of services, citizens, voters, residents of a particular area, part of an underserved community, or a community with higher health inequalities than another community in another area. They may be consciously ethical consumers, who achieve utility and satisfaction through collective goods, considering the wider population (Collins et al, 2019; Greener and Powell, 2009; Jung, 2010) rather than self-interested maximisers of utility who accidentally create public benefit through actions guided by the 'invisible hand' (Smith, 1776). All these differences, and their combinations, must affect the voices of those individuals.

As well as different contexts, individuals will have different values, and there will also be value pluralism within individuals and groups (Simmons and Powell, 2009). There is no one type of individual, patient, citizen or consumer. A distinction is offered between the latter two: "the citizen is embodied in public identifications and practises. By contrast the consumer is a figure motivated by personal desires, pursuing their own interests through anonymous transactions" (Clarke et al, 2008, p. 2). Frequently the role of the individual in relation to the discourse around patient choice is defined as the 'chooser'. However, scholars argue that the role changes depending on the multiple cross-sectional contexts and the value pluralism of the individual (Simmons and Powell, 2009). Individuals are referred to in the context of patient choice policy as 'differentiated consumers' (Beresford, 2009; Laing et al., 2005).

In this thesis it can be argued that individuals, as the recipients of the service produced by each of Le Grand's four models for organising public services, could

have any one of four roles or voices, and more than one at any one time where the models are combined to achieve the best outcomes (see Fig. 5).

Fig. 5 Voices and roles associated with Le Grand models

Model	Voice	Role
Trust	Believer	Quiet client with passive confidence in the healthcare professionals providing the service
Command & Control	Statistic	Marginal piece of data, again with no agency or power
Voice	Individual or Collective	Assert power through speaking up to achieve its ends
Choice & Competition	Chooser	Potential to choose to exit from the service and go elsewhere; or stay if the quality or the quantity of the service is satisfying to the individual (Collins et al, 2019); thereby incentivising providers towards excellence (Hirschman, 1970).

Few people who use public services see themselves in any of these roles, more often identifying themselves as patients, service users, or members of communities (Simmons and Birchall, 2009). This is seen in the data across the three case studies, where frequently individual respondents refer to personal experiences of current services or comment in the context of the community or area within which they live, representing a collective voice.

Choice is also aligned to ethics (Needham, 2008). Choice is not only seen as a disciplinary mechanism for providers, but also an emancipatory power for patients, freeing them from the dominance of monopoly providers (Thatcher, 1987). In New Labour’s second and third terms, choice fulfils this role of ‘moral compass’ as well as an ‘organisational tool’ (Needham, 2008, p. 181). It is suggested that the New Labour offer of choice relates only to ‘sanctioned’ choices, requiring consumers to value opportunity to choose and embrace the responsibility of choosing wisely (Clarke, 2005; Clarke et al., 2008, cited in Powell, 2008; Vidler and Clarke, 2005). New Labour would argue that, as well as providing equity of opportunity to all by forcing providers to pay attention to diversity to attract patients (Blair, 2002), by

unifying the wider general population more around it, patient choice policy is deployed to reduce the potential for increasing privatisation of healthcare, by persuading the middle classes to stick with the NHS because it was now more responsive to their consumerist tendencies, making the private sector option less attractive and thereby protecting the NHS (Blair, 2002; Peckham et al, 2012; Iliffe and Manthorpe, 2020). Le Grand also expects medical consumerism to shift the power relationship away from clinicians towards their patients, opening the NHS to: "new ways of working"; scholars suggest any expectation of real challenge to professional power and medicalisation of illness and health has not been achieved yet (Iliffe and Manthorpe, 2020, p. 185). Needham (2008) suggests that with choice comes responsibility, an expectation that individuals will make the right choices, or the state might not bear the consequences, although RCT expects choices to be perfect in terms of optimising the outcome for the individual. However, as shown below there is inequity in opportunities between different characteristic groups to make choices about their healthcare (Costa-Font and Greer 2016; Exworthy and Peckham 2006; Fotaki, 2014; Harding 2021).

Therefore, balancing collective and individual values, norms, beliefs, and attitudes is important (Simmons and Powell, 2009). For instance, some people value their individual freedoms to have a voice and make choices which will impact only themselves (Smith, 1776), whereas others, referred to as citizenly consumers, see choice and voice as: a civic engagement (Greener and Powell, 2009); valuing unison with the community, or multiple communities of interest (Durkheim, 2014); and seeking to make ethical and responsible choices (Malpass et al., 2007).

Bhattacharya (2020b) considers the instrumental and intrinsic value or disvalue of choice in public services, noting that instrumental values are frequently contested by social scientists but intrinsic values are under-researched; although it is noted elsewhere that: the offer of choice seems to have intrinsic value to patients, even if they do not intend to switch providers. Choice is valued by all patients even if their preference is for their local hospital. This is particularly observed amongst older people, people with lower educational attainment and members of non-white ethnic communities (Coulter, 2010; Fotaki, 2014).

1.4.1.4 The Cases For and Against Centralisation of Specialist Healthcare

Reconfiguration of specialist services into centralised units, to attract high volumes of patients to achieve better clinical outcomes and greater efficiency, is a common

feature of NHS planning (Bühn et al., 2020; Hunter, 2018; Hunter et al., 2013; Vaughan et al., 2023). Most studies identified here relate to specialist emergency care units. Some scholars raise concerns about the impact of greater centralisation, resulting in restrictions to patients' choices of hospitals. This affects a key aim of patient choice policy, which is to improve quality and increase efficiency through provider competition (Victoor et al., 2014). Others argue that to address the underlying factors affecting the provision of emergency services – an ageing population, recovery from the COVID-19 pandemic, and recruitment challenges – efforts should be focused on using the current smaller hospitals to support the larger specialist centres, rather than policies promoting hospital closures or reconfiguration (Vaughan, 2023).

Whether people are prepared to travel further to access centralised specialist healthcare services is the focus of several studies (Bhattarai et al., 2019; Bühn et al., 2020; Hunter, 2018; Hunter et al., 2013;). The expressed public preference is for hospitals nearer to where people live, with shorter travel times (Victoor et al., 2014). However, findings show that extended travel time, up to two hours, and longer waiting times, are identified by many as being acceptable trade-offs for higher-quality services (Bhattarai et al., 2019; Bühn et al., 2020).

Other studies reveal that centralisation of healthcare services is unpopular amongst populations in terms of expectation of poorer access, increased travel times, and associated costs; safety issues linked to increased distance to travel; proximity to family and friends; and continuity of care. There is an observable overall preference for service provision to be smaller and locally based (Barrett, 2012; Farrington-Douglas, 2007; Black, 2013; Costa-Font and Greer, 2016; Finlayson, 1999; Fulop et al., 2010; IRP, 2010; Kelly et al., 2016; Landau et al., 2013; 2016; Roberts et al., 2014; Turnbull et al., 2008) (see 2.3.1.2 and 2.3.1.3).

Although the studies above note safety as a reason for centralising services, in order to maximise the benefit of clinical skills and equipment located in one place, thereby improving patient outcomes (Hunter, 2018; Hunter et al., 2013; NHS England, 2013; Vaughan et al., 2023), one study notes that older people and people with lower educational attainment prefer to access potentially poorer-quality services in a local general hospital rather than travelling further for a specialist service. Distance to travel is more important to them than clinical outcome (Bühn et al., 2020). This demographic is also less likely to access information to support them in choosing a

hospital for specialist treatment (Victoor et al., 2014). One study suggests that non-traditional, informal forms of information (such as newspapers), or local knowledge about accessibility of car parks, are more likely to influence older people's choices (Harding, 2021; Harding et al., 2014).

1.4.2 *Voice*

1.4.2.1 Involving People and Communities: Voice

Scholars suggest that there is a lack of consensus nationally in the UK about what successful PPI looks like (Greer et al., 2021). Understanding what involving the public in shaping health services entails, in particular through the development of strategic plans, local policies, and service change proposals, is not well defined; it varies within and between organisations in health and care systems (Coultas et al., 2019; Dalton et al., 2016). It is reported that the understanding within organisations ranges from PPI being about venturing out into communities to talk about change that is happening, to PPI is about co-producing with service users. This contestation is seen because of contradictions between (on the one hand) the national rhetoric that a benefit of partnership working between system partners and the public is the freedom to develop local policy and delivery mechanisms, and (on the other hand) top-down policy implementation (Coultas et al., 2019; Jones and Exworthy., 2015; Stewart, 2016).

For this reason it is suggested that social science approaches (to studying healthcare service change) are important, because rather than just being considered as a technical exercise, policy change of this kind affects the social realities of individuals and multiple communities (Fraser et al., 2019; Madden and Speed, 2017; Means and Evans, 2012; Stewart, 2019). However, the approaches to obtaining public views are contentious amongst commissioners of those services. Scholars propose that developing effective engagement strategies and involving stakeholders (including the public) throughout the process of policy and change proposal development, can assist NHS organisations in addressing communities' concerns (Foley et al., 2017).

One study identifies three frames to involve the public successfully in service reconfiguration (Greer et al., 2021). These frames can coexist within public bodies. The first frame is described as adversarial; conflict is caused by scarcity of resources, and the frame is defined as 'change against the public'. The second frame or approach is communicative; problems are resolved by educating the public

about the benefits of change, and the frame is defined as ‘change for the public’. Finally, the frame defined as ‘change with the public’ is described as a collaborative approach, integrating public engagement as early as possible and throughout change discussions (Greer et al., 2021, p. 12).

1.4.2.2 Public Opposition to changes to configuration of Specialist Healthcare

Reconfiguration of healthcare services is difficult (Best et al., 2012; Ferlie, 2022). Success is defined by management scholars as the achievement of defined goals (McConnel, 2010); whereas participation scholars ascribe success to the ability of public voice to challenge, shape, and influence service change (Carter and Martin, 2018; Martin et al., 2018).

Academics have observed that one reason making changes to healthcare services is difficult is that in publicly funded services, policy is often not guided by science or technocratic evidence, but by political ideology, which is an ‘ever swinging pendulum’ (Ferlie, 2022, p. 2). Studies cite examples of swings affecting the NHS in the UK over the past fifty years, beginning with the shift from traditional vertically integrated and administered NHS systems to the quasi markets and New Public Management (NPM) (Dopson, 1997; Griffiths, 1983). These are followed by New Labour’s relatively short-lived increased investment in the NHS, and subsequent partial return to consumerism with the extension of patient choice and the creation of NHS provider Foundation Trusts in England in the 2000s (Harding et al., 2021; Le Grand, 2007). The aspiration was that controlled consumerism with reasonable personal choices available would encourage responsible moral choices amongst the citizenry (Clarke, 2005). There then followed a period of austerity, starting in the 2010s under the coalition and subsequent Conservative governments (Ferlie, 2022) (see 1.5.5).

Scholars have identified three relevant constant features in England: NHS services provided by NHS Foundation Trusts; patient choice policy (Black, 2013; Ferlie, 2022; Independent Review Panel, 2010); and the statutory requirement for public sector organisations to undertake PPI (patient and public involvement). This is because contentious service change is ever-present in an environment where new ways of providing services are consistently promoted through national policy (Crisp et al., 2016; Ham, 2006).

Understanding public views about the nature and location of healthcare services is a crucial influence on national and local policy (Bühn et al., 2020). Each of these three elements is relevant to this thesis: the NHS provider of the services described in the

case studies is an NHS Foundation Trust; patient choice is the key policy explored and the Independent Review Panel could; had the FFtF consultation been referred to the Secretary of State for Health and Social Care, been asked to review the consultation process on behalf of the Department of Health. However, no referral was made.

As at January 2024, there are imminent new regulations amending the UK legislation with respect to NHS significant service change relating to local government scrutiny; new call-in powers for the Secretary of State and finally a new notification duty for NHS commissioning organisations: Integrated Care Boards. The government has committed to removing local authorities' long-held powers to refer proposals for substantial service changes to the Secretary of State for review. The Secretary of State will have the power to 'call in' any proposals for major service change and make recommendations. ICBs will be required to notify the Secretary of State of any plans to deliver major service change in their system.

Scholars observe vociferous popular opposition to proposals to centralise local healthcare services (Daniels et al., 2018; Ferlie, 2022; Fraser et al., 2017; Fulop et al, 2012; Jones, 2015; Jones and Exworthy, 2015). It is reported that communities feel their concerns are frequently ignored by decision makers, despite local NHS systems often providing extensive information and completing extensive engagement activities (Barratt et al., 2015). Commentators note that individuals consider information presented to them to be too complex for lay readers, commenting that managerial or technical terminology is often used. This type of information is referred to as 'credentialed knowledge' (Stewart et al., 2022, p. 111). An example of a credentialed term, frequently used by NHS partners, is 'reconfiguration'; this is often translated by the public to mean 'local hospital closure' (Fraser et al., 2019; Pettigrew et al., 1992).

The validity of the motivation for undertaking PPI is questioned by the public, and it is evident that policy makers are frustrated by public devotion to local hospitals, and resistance to change from the status quo (Samuelson and Zeckhauser, 1988; Stewart et al., 2022). Studies show that public service managers may be inclined to ignore citizens' assessments, such as satisfaction with a current service, in favour of technical professional measures such as efficiency (Collins et al., 2019; Kelly, 2005)

The ability to achieve large-scale change in health service delivery, without establishing credibility and trust between the NHS and the public it serves, is noted,

and it is also recognised that trust can be easily lost and difficult to regain (Barratt et al., 2015; Fulop et al., 2012; Wynne, 1996). It is suggested that mistrust is focused rarely on clinicians, but more often on unelected bureaucrats such as NHS managers. One study suggests that anti-hospital-closure campaigners seek to politicise decisions, highlighting the democratic deficit within the NHS since its establishment 75 years ago in 1948 (Stewart et al., 2022). Some campaigns emphasis the fact that the public ownership of some local hospitals is only part of their history (Gosling, 2017). In the case of CGH this is very true, having opened, funded in part by public subscription, in 1848, precisely 100 years before the creation of the NHS (see 1.9.4.). Therefore ownership of, and by association changes to, such facilities is seen as a legitimate subject for debate (Collins et al., 2019; Davidson et al., 2019). Other scholars note how campaigns sometimes shift focus between preserving the NHS institutional values on the one hand, whilst criticising the local NHS on the other, in the form of the faceless bureaucrats inflicting change on local services, considered by many local residents to be good (or good enough) (Crane, 2019; Stewart et al., 2022).

Methods to sustain trust include allowing sufficient time for public engagement, and focusing on factors that are important to the public (Dalton et al., 2016). It is noted that such factors may not easily be measured, such as public feelings of ownership of public services (Fraser et al., 2019); and differences in appreciation or acceptance of risk exist between the public and NHS commissioners and providers (Barratt, 2015). Good communications materials, which include options to oppose proposals in official literature, and reassurances that multiple public views will be considered, are also considered to be valuable resources to support credible PPI (Barratt et al., 2015; Dalton et al., 2016; Stewart, 2019).

So that multiple points of view or voices can be heard, this is why engagement and consultation, about potential service change across populations and targeted groups, is so important. People choose to participate; some people will be more active than others at choosing or voicing their opinions; many choose, for legitimate reasons, or through lack of awareness of the opportunities, not to get involved. It is therefore impossible to achieve consensus. This is why engagements and consultations are not referendums; and it is why the data received must be 'conscientiously considered' (see 1.10.).

1.4.3 *Context*

1.4.3.1 Grey Literature

Grey literature, such as policy documents produced by administrations in England and Wales and speeches given by elected representatives provide context. This grey literature provides insight into policy development and the alignment and divergence between England and Wales post devolution.

Key sources of policy grey literature include Making the Connections (Welsh Assembly Government, 2004), which describes an approach to delivering better services for Wales and the NHS Constitution (2009), which sets out the Rights and Responsibilities of patients and staff in relation to the NHS in England. Two key policy documents which influence the development of the three case studies considered in this thesis are the NHS Five Year Forward View (NHS England, 2014) and the NHS Long Term Plan (2019).

Current examples of national patient and public engagement statutory guidance documents are: Working in partnership with people and communities (NHS England, 2022) and Guidance for engagement and consultation on changes to health services (Welsh Assembly Government, 2022).

1.4.3.2 Decentralisation

Decentralisation has been defined as "a change in the allocation of authority in which powers shift to smaller territorial units of government." (Costa-Font and Greer, 2016: 4). Over the last 30 years, the policy to decentralise health services is not unique to the UK (Saltman and Vrangboek., 2007; Connell et al, 2022). Devolution has been defined as the action of transferring a range of public policy responsibilities away from central control, within a democratic state which expects public services to be funded through taxation. Public policy responsibilities for services may relate to one or a combination of the following: levying and collection of taxes; planning; designing; commissioning/decommissioning; providing; monitoring; and evaluation (Adams and Robinson, 2002). Another term like decentralisation and devolution is delegation; this applies particularly whereby the central administration delegates accountability to smaller geographical systems such as in Wales a Health Board or in England a county such as Gloucestershire, for commissioning NHS funded services.

The motivation for decentralisation might be to produce better policies and improved health outcomes. However, it is also likely that the desire for devolution is politically

motivated (Costa-Font and Greer, 2016; Greer and Jarman, 2007). Academics point to decentralisation as being an antidote to the privatisation of public services, by increasing complexity for private providers to navigate (Tanzi, 2008). This view echoes the hypothesis that the purpose of devolution in the UK was to maintain unity, supressing calls for national independence (Stepan, 2005).

Studies confirm that many western industrialised countries have decentralised control over public policy and service delivery to smaller national or regional units over the past 30 years. It is suggested that geographically devolved systems can develop policies which reflect the homogeneity of their populations (Connell et al., 2022; Costa-Font and Greer, 2016; Hooghe, 2010), legitimising local administrations to pursue innovative and responsive ways of organising services (Greer, 2012). However, there is a warning that politicians might need to be careful about what they wish for. It has been noted that NHS England, itself created by Coalition politicians in 2013 as a semi-independent non-departmental function, can use this devolved at one remove from Westminster status to be the NHS' negotiating voice with the government" (Ham et al, 2015).

Scholars have noted that, after their creation in 2012, clinical commissioning groups (CCG) in England found it difficult to deliver redesign of local services. There are some examples of new models of care being implemented by intrepid clinical leaders, but no evidence that competition between providers, or patient choice, had a noticeable impact on innovation (Storey et al., 2019). CCGs were abolished in 2022, and the current iteration of decentralised health and care infrastructure in England is Integrated Care Systems (ICS). Some scholars see these as potential threats to the future of public services, as ICS do not fully integrate the NHS and social care within the new systems (Roderick and Pollock, 2022). It is worth noting here that health and social care organisations have been fully integrated, defined by geographical health boards, in Wales since devolution in 1999.

1.4.3.3 Devolution

Academic studies have identified devolution as being 'one of the UK's most significant programmes of constitutional change' (Brown, 2023, p. 468). The UK is formed of nation states, which simultaneously display allegiance through unity and difference through national autonomy (Colley, 2014). Devolution and Policy Divergence

During the first year after devolution, a UK-wide review notes that policy differences would take time to emerge, and there is no decline in commitment to the NHS founding principles in any nation (Jervis and Plowden, 2000). It is suggested that policy makers and advisors, such as Le Grand, in the 2000s in England focus more on the means or models of service delivery for individual consumers (Greer and Rowland, 2007), whilst the Welsh administration focuses more on the ends or outcomes for the many, through population-scale public health policies (see 1.6) (NHS Wales, 2001). Interestingly a year after the publication of the Five Year Forward View (NHS England, 2014), which launched the case studies considered later (see 2.3.1), Le Grand moves on to concentrating on whether nations should guide citizens' lifestyle choices as opposed to hospital choices; concluding that although such direction might encroach on individual autonomy, the health and wellbeing outcomes might justify the state intervention. This feels like Le Grand is rebalancing his preference away from the choice model and more towards the models most strongly adopted in Wales shortly after devolution - trust and voice (Le Grand and New, 2015).

As explored elsewhere, patient choice is identified as a significant health policy difference between the devolved nations, emerging several years after devolution. However, scholars observe that the actual experiences of patients each side of the border, when selecting specialist hospital services, are less distinct than might be expected, suggesting policy divergence is likely to be more 'rhetorical than actual' in practice (Peckham et al., 2012, p. 26).

1.5 Decentralisation of healthcare policy development in the NHS

1.5.1 *Do we still have a 'national' NHS in the UK?*

Does the 'national' in the 'NHS' imply the same service everywhere? A clear observation to make is that the 'national' in the NHS must apply to more than one nation post-devolution in 1999 in the UK, when health policy became the responsibility of devolved nations (Hughes and Vincent Jones, 2008). Some scholars have suggested that divergence in policy, across the four home nations of the UK, challenges the continued use of the word 'National' in the NHS (Branigan and Carvel, 2008, cited in Needham, 2008; Maslin-Prothero et al., 2008). 'Big D' devolution provides an opportunity to view the development and divergence of health policy between the four nations of the UK. In this thesis, due to the geographical

proximity of my research area, Gloucestershire, to the Welsh border, I pay particular attention to difference between England and Wales.

However, there is also delegation of responsibility, or ‘small d’ devolution, for shaping and delivering public services within England, as increasing levels of autonomy pass from the central bureaucracies of the UK government through the Department of Health and NHS England to NHS commissioners in local areas (Greer in Costa-Font and Greer (Eds), 2016); Klein, 1989; Paton, 1993). This is frequently referred to as the ‘postcode lottery’, whereby decisions can be made by healthcare systems, often delineated along county boundaries (Russell and Greenhalgh, 2014). Therefore, any proposition that devolution in the UK is the sole factor that takes the ‘National’ out of the phrase NHS is arguable; it is a factor, but not the only factor. As shown in this thesis, local variation frequently occurs at much smaller geographies, such as NHS England regions, and between individual healthcare systems. Service variation can also occur within systems such as Gloucestershire. As an example, in Gloucestershire, there is a decades long view amongst local NHS commissioners and providers that strong divergence exists between the reactions of people and communities living in two halves of the county, east and west, regarding specialist hospital reconfiguration, with members of the perception of residents from one side of the county being that the other half of the county is receiving a better ‘tier’ of services over time. This perception is linked to the experience of service reconfigurations and associated patient and public engagements since 2005.

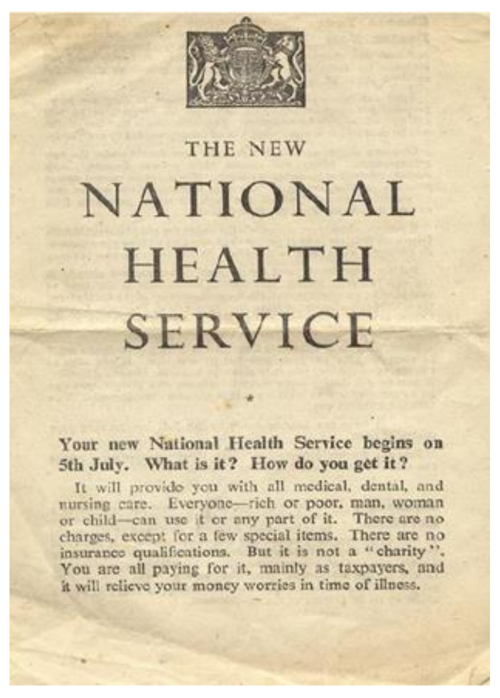
In Gloucestershire, the organisational structures have changed several times during the research period, to reflect new national policies such as: the purchaser provider split; the creation of provider foundation trusts; purchaser or commissioner primary care groups; primary care trusts; clinical commissioning groups; and the current iteration of NHS commissioning in Gloucestershire – the NHS Gloucestershire Integrated Care Board (ICB) (see 1.9.4). Each reorganisation has seen increased delegation of responsibility or ‘devolution’ from a centralised national body, either the Department of Health or NHS England, to local NHS commissioners of services.

1.5.2 *1948: Introduction of a Publicly Funded Health Service in the UK*

Prior to the establishment of the NHS in 1948 all patients were medical consumers, funding their access to services directly to the clinician or hospital providing the service or through mechanisms such as friendly societies or mutuals (Iliffe and Manthorpe, 2021). Some current NHS establishments pre-date the creation of the

NHS (Gosling, 2017). Cheltenham General Hospital is a relevant example. It opened in 1848, its relationship with the local community commencing exactly 100 years before the birth of the NHS.

The National Health Service Act (1946) provided the legal platform from which to launch the first publicly funded NHS in the world, on 5 July 1948 in the UK (Roderick and Pollock, 2022). The pamphlet below was distributed to all households in the United Kingdom on 24 February 1948. It introduces the new National Health Service and invites them to make their first patient choice – their own GP.



THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

1.5.2.1 NHS Founding Principles

The founding principles of the NHS are - meeting the needs of everyone; free at the point of delivery; and access to services based on clinical need, not ability to pay (Drakeford and Campling 2000; Klein, 2010; Powell, 1996). The results of the 2015 British Social Attitudes (National Centre for Social Research, 2015) Survey demonstrate that, across UK society, 89% of respondents support the principles of a healthcare service which is free at the point of delivery, is comprehensive, and is accessible to all based on need rather than ability to pay (Gerschlick et al., 2015). In 2017, a Health Foundation survey based on the BSA in that year found similar results regarding the support for the NHS principles (Health Foundation, 2017).

In the latest iteration of the BSA, in 2021, there is an overall 24% drop in satisfaction with the NHS since before the COVID-19 pandemic, with more people stating they

are dissatisfied with the NHS than those who are satisfied. This is the first time relative satisfaction has flipped since 2002. However, despite the recent fall in satisfaction there remains widespread support for the NHS principles, although levels of support are lower than they were in 2015 overall, and particularly lower amongst those who are dissatisfied, compared with those who are satisfied with the way the NHS is run. A substantial majority of respondents to the survey (76%) believe the NHS should 'definitely' be free of charge when needed, and 67% think it should 'definitely' be available to everyone. A smaller majority (54%) think the NHS should 'definitely' primarily be funded through public taxation (National Centre for Social Research, 2021).

Administrations in both England and Wales have remained committed to the founding principles of the NHS. However, ever since the Labour government's decision to establish an NHS across, it has been seen in the Labour movement as a victory for Aneurin Bevan's version of 'red-blooded universal socialism' over the 'pale pink pusillanimity' of Morrison's local model, managed by trusted clinicians and influenced by local democracy (Marquand, 2004). Yet, post-devolution, differences have emerged (see 1.7).

1.5.3 *1980s and early 1990s*

The first period of particular interest in this thesis is the 1980s and 1990s, the pre-devolution period in which the dominant paradigm in Western industrialised nations was neoliberalism (Archer and Tritter, 2000) (see 1.6.1). 'Neo' implies 'newness' and of course neoliberalism finds its roots in the liberalism which emerged in the 18th and 19th centuries. From the social-liberal tradition, through the development and delivery of policies created at national and local levels, liberalism focuses on reducing the inequalities which affect individuals' freedoms, such as disease, poverty, and education.

In the UK this approach has been encapsulated in the welfare state, introduced in response to the publication of the landmark report 'Social Insurance and Allied Services' (a.k.a. the Beveridge Report illustrated opposite) in 1942. The function of the welfare state in the UK is to provide services which support everyone equally. In the case of the NHS this means: 'from cradle to grave', free at the point of need and delivery, funded through general taxation (Beveridge, 1942) (see: 1.5.2).

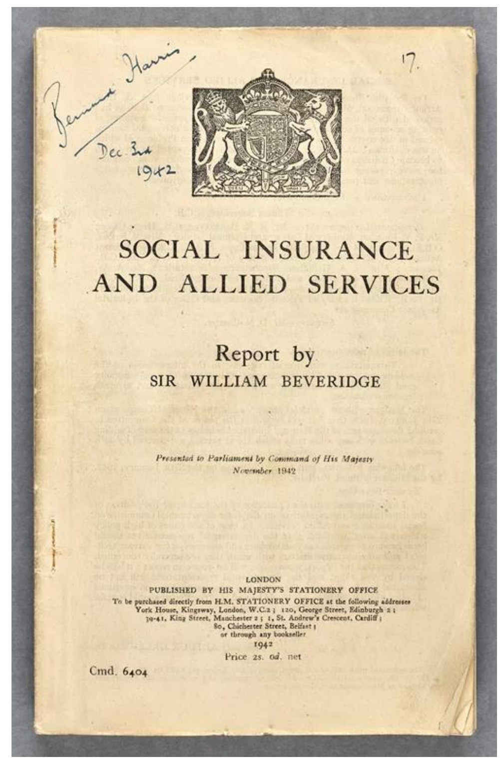
Neoliberalism promotes competition and consumer choice within free markets. Originally the preserve of the private realm, it is now a feature of public services. It

posits that human progress is achieved through lasting economic growth, through freedoms to act independently as a benefit of reduced central control.

This thesis acknowledges Smith's 'invisible hand' – that is, effectively, the state giving freedom to individuals to make choices to maximise their personal benefit (see 1.3.1). Le Grand (2007) describes the work of another invisible hand, which whilst maximising personal benefit, at the same time impacts positively on wider society (see 1.3.2). This is the inspiration for the 'choice & competition' model for organising good public services (Le Grand 2007).

In the UK, Conservative neoliberal policies dominated from 1980 to 1997. An internal market was introduced into the NHS in the early 1990s, creating a split between providers and purchasers of healthcare; and patients or 'agents' were promoted as active consumers using their agency to make rational choices (1.6.2) in order to maximise personal health outcomes (Smee, 2005). The governments led by Margaret Thatcher and John Major were the 'epitome' of NPM and centralisation both territorial and political (Costa-Font and Greer, 2016; Ferlie, 2022). New Labour maintained a neoliberal approach from 1997 to 2010.

In 1990 the NHS and Community Care Act (Department of Health, 1990) introduces an internal market to create a distinction between purchasers or commissioners, who buy healthcare services on behalf of local populations, and providers of services such as hospitals.



SOCIAL INSURANCE
AND ALLIED SERVICES

Report by
SIR WILLIAM BEVERIDGE

Presented to Parliament by Command of His Majesty
November 1942

LONDON
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses
York House, Kingsway, London, W.C.2; 120, George Street, Edinburgh 2;
39-41, King Street, Manchester 2; 1, St. Andrew's Crescent, Cardiff;
80, Chichester Street, Belfast;
or through any bookseller
1942
Price 2s. 0d. net

Cmd. 6404

Public services users were evolving from grateful recipients into demanding consumers, or choosers (Gabriel and Lang, 2006), whilst healthcare providers were moving away from unchallenged institutional status towards being competitors in a market. An alternative to the consumerist approach, New Public Philosophy, is presented below (Marquand 2004).

1.5.4 *Late 1990s to 2012*

The second period of interest is the administrations of the three New Labour governments of the pre and post-millennium period, late 1990s and 2000s, during which time health policy making powers were devolved to the four nations of the UK. At which time, the Assembly Government in Wales, now Senedd, chose to move away from the neoliberal approach of New Labour and return to a grounded 'structured' approach (Greer, 2005, 2016).

Having temporarily abandoned Conservative marketisation (choice & competition) between1997 and 2002 (Jervis and Plowden, 2000), New Labour in England recognised that by only focusing on targets and increased funding, hospital waiting list were not reducing as much as planned for (Stevens, 2004). Revitalising a quasi-market in the NHS was the New Labour solution to the problem described in the example of Ms Skeet. Earlier in 2002, the case of Mavis Skeet, whose early death was attributed (by her daughter, as reported in the national media) to long waiting times due to cancelled operations, galvanised the New Labour 'fight back on health' (Hinsliff and Ahmed, 2002; cited in Ball and Exley, 2010). Hinsliff and Ahmed observed that a well-functioning NHS is the point of New Labour's existence as a party, with different priorities to the previous Conservative administrations.

The NHS is presented as a barometer of the success of New Labour; it is a key performance indicator of the New Labour project. Therefore, during the second and third New Labour governments, a reinvigorated NHS internal market, and patient choice policy, was promoted in England, enabling patients to choose a preferred secondary care provider from 2005 (Department of Health, 2003; Klein, 2010; Millburn, 2002 (a), (b), (c), 2003). Giving patients choice of service provider was seen as a mechanism for improving efficiency and quality amongst those competing service providers paid through a process called 'Payment by Results' (Greener and Mannion, 2009).

As noted above, both administrations shared the same fundamental respect for the founding principles of the NHS (Jervis and Plowden, 2000), but in Wales, the

devolved Assembly wanted to show difference quickly post-devolution (Peckham et al, 2012; Rawlings 2022). Rhodri Morgan, Welsh Labour's First Minister in the first Welsh Assembly Government, stated: that he wanted to put 'clear red water' between Wales and England; that he wanted to promote 'made in Wales' policies; and that he wanted the devolved nations to be 'laboratories for the formulation of new [policy] ideas to be subsequently shared and learnt from across the union' (Adams and Robinson, 2002; Costa-Font and Greer, 2016; Moon, 2012; Morgan, 2002, 2010) (see 1.7.2.1). New Labour's Secretary of State for Health, Alan Milburn, wanted to promote patient choice by creating more autonomous provider NHS Foundation Trusts (see 1.7.2.2).

By 2009, New Labour is diminishing politically and moving back towards fostering positive clinical engagement; trusting, when the energy to keep promoting choice & competition is too challenging to maintain. In Wales, the focus on public health is not delivering results as quickly as hoped as the wider determinants of health (Whitehead and Dhalgren, 1991), such as housing, employment and education are outside the responsibility of the health ministry in the Assembly (Greer in Costa-Font and Greer Eds., 2016).

In 2010, the UK general election results in a change of UK government from New Labour to a Conservative/Liberal Democrat coalition. Therefore, there are no longer two Labour administrations taking responsibility for health policy development in England and Wales. From 2010 onwards the dominant 'difference' discourse diminishes in the Welsh Labour Assembly but develops in the English administration. There, the implied negative impact on patient experience of Labour's divergent anti-choice and anti-competition policies in Wales are used as a point of contrast by English elected representatives and policy makers.

In England the Coalition Government maintains Patient Choice as a policy, extending it to include choice of consultant team and treatment (Department of Health, 2010); thereby shifting the balance of power, and responsibility, further towards the patient and away from the clinical professional (Harding, 2021).

1.5.5 *2012 - 2023*

In 2012 the Health and Social care Act replaces Primary Care Trusts with GP led Clinical Commissioning Groups in England (Department of Health, 2012). The creation of Clinical Commissioning Groups (see 1.8.1); the local organisational decision making structures in place during the research period in this thesis; is

considered a far reaching example of devolution of responsibility for tackling difficult problems facing integrated health and care systems to the clinicians, notably GP representatives on CCG Governing Bodies, in the front line of service delivery (Storey et al., 2019).

In 2023, CCGs are replaced by Integrated Care Boards (ICB) through primary legislation1. ICB responsibilities mirror those of PCTs but with the addition of a greater number of providers, GPs and Foundation Trusts, within a defined Integrated Care System having a seat at the local decision-making Board table.

During the 2020s there is no observable intention to reverse the promotion of patient choice as a mechanism for health service improvement and equity in England (Bhattacharya, 2020; Greener and Powell, 2009; Harding, 2021). Choice of an out of area secondary care provider within Wales is introduced on an individual case-by-case basis through a Prior Approval Policy (NHS Wales, 2018).

1.6 Dominant Theories influencing Public Policy from the 1980s onwards

1.6.1 *Rise of Neoliberalism and New Public Management*

Neoliberalism is the dominant political paradigm in western industrialised countries from the 1980s onwards (Archer and Tritter, 2000). An incarnation of the shift away from the Weberian organised society of public administration (Lewis, 1975), which had dominated NHS organisations since 1948, is the adoption into the NHS of NPM, a term described first in 1991 (Hood, 1991; Hood and Jackson, 1991). Policy makers and NHS managers seek to integrate business-like practices from the private sector into the public realm, to promote free-market capitalism; the objective being to achieve greater efficiency and productivity in public services through the restructuring of the organisation and governance of those services, reducing the distance between the public and private sectors (Le Grand, 2006, 2007; O'Donnell et al., 2011). Accountability is focused on technically measurable quantitative targets rather than qualitative measures (Dalingwater, 2014; Le Grand, 2007; NHS Management Inquiry and Griffiths, 1983). The patient is rebranded as consumer, and patient choice finds its place at the centre of health policy development (Hall, 2003; Marquand, 2004; Needham, 2003, 2007, 2008, 2009; Smee, 2005).

[1] Health and Care Act https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

The policies of the first New Labour government see the internal market briefly recede, with a shift towards collaboration rather than competition between providers. However, the increased investment in the NHS by New Labour from 1997, alongside the collaborative approach and targets, does not deliver the desired reduction in waiting lists, and therefore the choice & competition model is reintroduced into a quasi-internal market and NHS Foundation Trusts are created in England. Le Grand is a New Labour policy advisor during this period.

NPM's dominant premise is that only by restructuring the governance and organisation of public services (by minimising the difference between private and public sectors) can efficient and effective public services be delivered (O'Donnell et al., 2011).

In the UK, prior to devolution, and maintained in England post-devolution, consumerisation of public services is accompanied by the adoption of private sector performance management models, described as the 'command & control' or 'targets' models by Le Grand (2007) (see 1.3.3.2 and 1.3.3.4); these focus accountability on the achievement of prescribed results rather than the quality of the systems designed to achieve them (Bach and Bordogna, 2011; Bach and Kolins Givan, 2011). The dominant theory influencing NPM is RCT (Lewis, 1975; Oullier et al., 2010).

1.6.2 *Rational Choice Theory*

Building on Smith's self-interested individual, RCT is a product of standard economic technical theory, which applies itself to *'homo œconomicus'*, a utilitarian, selfish individual whose optimal decision making is informed by rational intelligence and logic, unlimited knowledge, willpower, and self-control, and whose instrumental rationality is impenetrable to the influence of personal emotions or surrounding societal influences (Archer and Tritter, 2000; Oullier et al., 2010). Specifically, RCT states that individuals make choices based on the desire to achieve the maximum benefit for themselves because of the choices they make (Green and Fox, 2007; Green and Shapiro, 1996; Heath and Heath, 1976). Put simply, people are expected to select their preferred choice, the top ranked by them, from a range of options (Samuelson and Zeckhauser, 1988).

As applied to healthcare policy development in the UK, RCT is particularly linked to policies relating to choice & competition.

Davis (1990) suggests that Smith's (1776) 'invisible hand', which guides self-interested individuals' unwitting behaviour towards selfless wider social impacts, is the force behind the means, and the 'interests and progress of society' are the ends; 'individuals are tricked by a sleight of hand into a pursuit of trinkets to further that end' (Davis, 1990, p. 350).

Can these individuals' choices be considered 'rational' in that context? Archer and Tritter (2000) argue that rational choice does not address the key sociological debate that is the problem of the relationship between societal structure and individual agency. This is a chicken and egg conundrum; individuals form and transform society but are shaped and then reshaped by the society in which they live. So, what is the interplay between them given their interdependence?

In relation to the case of patient choice in healthcare, the policy objective is for rational patients' aggregate decisions to influence the efficiency and quality of services by ultimately rejecting *en masse* the least desirable providers, and thereby forcing them to leave the market in favour of providers who can attract customers (Archer and Tritter, 2000; Timmins, 2005). For instance, a patient makes a short list of potential hospitals in the market to provide cardiac surgery. The patient selects one hospital over another because the waiting times are shorter, and the published surgical outcome statistics for the surgical team suggest that the patient will obtain maximum relief from their medical condition. This more popular hospital, having met the patient's selection criteria, will thrive at the expense of another, thus improving services for other patients who choose that hospital in future. By default, the alternative hospital has left the market having not demonstrated the quality of its services sufficiently.

RCT is criticised for its 'lack of realism' in the way human beings calculate the implications of a range of choices before making their selection (Hechter and Kanazawa, 1997). Research suggests that people make decisions in many ways, e.g. impulse, instinct, and tradition (Victoor et al., 2012). In the case of patients, previous experience of hospital services or recommendations of friends and family maybe bigger factors influencing choice. As will be seen when the case study results data is examined (see 3), accessibility and travel times influence choice, with people preferring hospitals closer to where they live (Bühn et al, 2020). It is suggested that some sociologists have misunderstood the intended application of RCT (Archer and Tritter, 2000; Hechter and Kanazawa, 1997). It is suggested that RCT does not seek

to describe what a rational individual will do, as this would be explored using decision theory (Hechter and Kanazawa, 1997). Rather, RCT is concerned not with individual but with social outcomes. It is suggested that social scientists' unease about RCT is due to their observations that individuals do not act in homogeneous ways. Is the aggregate of individual rational choice desirable or rational? Not always. Overgrazing of the common meadowland is an example of the other side of Adam Smith's 'invisible hand' (Hechter and Kanazawa, 1997). In a healthcare context, increasing demand at one popular hospital more than its capacity to deliver services to the quality advertised and expected, could, if one follows the RCT argument, result in the hospital becoming unpopular amongst consumers of healthcare and suffering the market consequences. Le Grand's 'choice & competition' model is clearly influenced by RCT, but the attributes described by Le Grand (2007) amplify the common good of equality (see 1.3.3.4).

1.6.3 *New Public Philosophy*

In terms of scholars' appetite for choice in public services, it is polarised. There is difference in opinion about whether choice increases or reduces equity and about choice in terms of a mechanism improving service provider responsiveness and quality (Clarke, 2009). Focusing on the discourse that choice is a good thing, the policy of patient choice has been referred to by scholars as a reform which enables quality, mobility and equity across the system (Fotaki et al 2005; Le Grand 2007; Clarke et al 2008; Peckham et al 2012).

To become the dominant paradigm, NPM has to dismantle the ideological barriers which protects the public domain using neoliberal rhetoric. Satisfied citizens served by universal public services must become consumers, dissatisfied with what universal services can offer them. Citizens must evolve into customers, only choosing the services they want, having compared the options. Marquand suggests that the English promotion of consumer choice is a disaster for the public domain, and the purpose of the welfare state. Marquand identifies an alternative approach: New Public Philosophy (NPP). NPP offers something different to the neoliberal pursuit of 'consumer entrenched orthodoxies' (Marquand, 2004, p. 134). Marquand (2004) describes the 'kulturkampf' (culture-fight) which has dominated political and social life since the 1980s, seeing in his view the widespread triumph of neoliberal ideology espoused by commentators such as Le Grand. In Marquand's view NPM seeks to narrow the public domain by offering the choice to 'exit' and undermine

public services and the confidence of public servants by suggesting that they legitimise the public services monopoly through knavish behaviours (Le Grand, 2003) to exploit the consumer.

As stated above, the NPM market approach prevails as the guiding policy development approach in England, whereas it can be argued that NPP is more closely aligned to the approach of the socially democratic public administration in Wales, post-devolution.

NPP reinvents the public domain, promoting a vigorous and extensive public domain, with primacy of public over private interest and of citizen's rights over market power. It promotes 'trust' (in Le Grand's terminology) (see 1.3.3.1), protection of public services from market incursion; and eschews market-inspired performance indicators (in Le Grand's terminology, 'targets'). Therefore, in contrast to NPM neoliberal consumers (or 'queens') of the public services being organised by 'knaves' who are tyrannised by performance targets (Bevan and Hood, 2006 (a) and (b)), NPP professionals (or 'knights') are trusted to act in the best interest of individuals (or 'pawns'), under the scrutiny of elected representatives and the communities they serve; in Le Grand's terminology, 'voice'. Marquand also suggests that the NPP allows for experimentation at a local level (Costa-Font and Greer, 2016), one of the potential benefits of devolution: the laboratories of innovation identified by Morgan (2002) (see1.7.2.1).

I suggest NPP; which aligns most closely to Le Grand's 'trust' and 'voice' models (see 0), informs the development of post-devolution health service policy development in Wales. Drakeford and Campling (2000) argue that there have been ongoing attempts to shift the balance of power between the private and the public, both at an individual agency level and at a structural level. However, Drakeford and Campling (2000) note that some commentators suggest that the widespread support for the NHS as an institution (which is publicly funded, as evidenced above) protects it from the excesses of neoliberalism (see 1.6.1).

1.7 'Big D' Devolution (Macro): Opportunities for Policy Divergence

In 1999 administrations in England, Northern Ireland, Scotland and Wales achieved autonomous oversight of the funding and policy development for their nations' healthcare from the UK government (Hughes and Vincent-Jones, 2008) providing opportunity for policy divergence (Greer and Trench, 2010). The UK nations of interest to this thesis are England and Wales.

1.7.1 *Divergences between Old Labour in Wales and New Labour in England*

Administrations compete against each other for political acclaim (Costa-Font and Greer 2016) and devolution brings, through multi-level politics, the possibility to showcase policy divergence between the countries of the UK (Adams and Robinson, 2002; Costa-Font and Greer, 2016). The English and Welsh healthcare systems are presented here as two polarities created through the political reorientation of the Labour Party in the UK in the 1990s: Old Labour in Wales – socially democratic, reliant upon public administration; and New Labour in England – neoliberal, market-oriented. The reality is by no means as extreme, but as a device to differentiate between the two nations it is helpful, and not unprecedented, as can be demonstrated below.

The English and Welsh administrations post-devolution prioritised two extreme policy model (Le Grand, 2007) combinations for organising health services. In Wales it was 'trust' and 'voice' – pay staff well, respect their public sector ethos, and trust their professionalism, and involve citizens, encouraging them to take responsibility for shaping of local services by promoting engagement with patients, communities and elected representatives, with the aspiration of delivering universality, social justice and equality. Wales: "tried to de-emphasize healthcare services" (Greer in Costa-Font and Greer Eds., 2013:90) shifting focus to public health interventions.

In England, it was 'targets', 'choice' and 'competition' – give orders, reward success, and punish failure, allowing market forces to drive efficiency and improve patients' experiences (Bevan and Hood, 2006 (a) and (b); Fotaki et al, 2008; Greer in Costa-Font and Greer Eds. 2016; Knight and Harper, 2013; Le Grand, 2006, 2007).

1.7.2 *National Political Discourses of Difference*

Devolution as well as bringing opportunities for policy divergence (Adams and Robinson, 2002), it also enabled the possibility of promoting national distinctiveness (Peckham et al, 2012). Of relevance to this thesis is the fact that patient choice of provider as a policy is not initially[2] promoted in the Welsh system post-devolution; instead, patients are referred to the secondary healthcare providers located in the

[2] In 2004 a second non-local hospital choice policy was introduced temporarily in Wales, in response to public concerns and increasing waiting times for inpatient treatment (Audit Commission in Wales, 2004; Hutt, 2004). Today, although choice of hospital for secondary care hospital remains enshrined in the NHS Constitution in England (Department of Health, 2009), in Wales access is still restricted to within the Health Board area where the patient is a resident.

Local Health Board area where they live with patients being able to choose the consultant, location, date and time of treatment. Therefore, Wales is not against all patient choices, just against consumerist choice of competing service provider which is seen to disadvantage some people (Peckham et al, 2012).

The following two political speeches, delivered on the same day in 2002, promote the different approaches to policy development taken either side of the border.

1.7.2.1 Rhodri Morgan AM, Welsh First Minister: 'Clear Red Water'

On 11 December 2002, First Minister for Wales Rhodri Morgan, delivered what has become known as the 'Clear Red Water' speech (Morgan, 2002). Morgan reflects on policies developed in Wales following devolution. His discourse differentiates the traditional welfarist approach taken in Wales from the New Labour consumerist approach pursued in England (Moon, 2012; Vidler and Clarke, 2005; Peckham et al, 2012). The main discourse this speech amplifies is 'difference from England and divergence from English New Labour public policy'.

A Different Version of Labour Ideology

In 'Clear Red Water' Morgan refers to himself as being a 'socialist of the Welsh stripe', suggesting difference from the English version of socialism demonstrated in England by New Labour. This is reinforced in other terms used in the speech such as the 'Welsh Way', and in how he differentiates the Welsh version from an English version of socialist ideology, drawing attention to ideological fault lines between the two Labour Administrations in power in Wales and England at the time.

Morgan refers to a specific example of a difference between health policy in England and Wales – free prescriptions for all. He states that 'free services bind a society together and make everyone feel they are stakeholders in it' (Morgan, 2022). In 1952 prescription charges were introduced across the whole of the UK but abolished for all patients in Wales quickly following devolution (Morgan, 2002). However, while 40% of the population in England are liable to pay for prescriptions, due to the nature of disease prevalence amongst those in groups exempted from payment for prescriptions (e.g. those over 65), 90.6% of prescriptions are dispensed free in England (Barker, 2014). Given this, perhaps it is understandable that such policy differences of this kind are referred to as "trivial" (Greer in Costa-Font and Greer Eds., 2016:91).

Morgan refers to ‘the glue of social solidarity’ and ‘permeable public services’ in the Welsh context. However, as shown in the case of the divergence of prescription charge policy on either side of the border, the ‘glue’ is given its co-operative property by political rhetoric (that services are only universally free on the Welsh side of the border), rather than the reality that prescriptions are also mostly free on the English side of the border.

Morgan sets out clear ideological differences (‘universalism versus means testing’ and ‘equity versus consumer choice’), rejecting key policy platforms in England. He rejects the New Labour version of the NHS internal market, including elements such as devolution of funding and decision making to local NHS commissioning organisations and a few newly established NHS Foundation Trusts. He rejects the promotion of patient choice as a quality improvement mechanism. He also rejects the setting of national targets, for example waiting times and performance measures. However, it is worth noting here that waiting times targets for hospital treatment are introduced by later Welsh Assemblies, to reduce hospital waiting lists.

Ambition and Innovation in Wales

Morgan’s speech is full of ambitious claims for the positive impact of devolution for Wales. He describes Wales as a ‘living laboratory’, and talks about ‘experimentation’, the ability to ‘innovate’, be ‘imaginative’, and be a ‘test bed’; and importantly, in terms of the hierarchy of innovation supporting ‘cross-fertilisation’. The ambition for this cross-fertilization applies to influence over the border into England or ‘policy transfer’ (Peckham et al, 2012). In ‘Clear Red Water’, Morgan makes much of the opportunities stemming from Wales being a small country. Morgan states the advantage of small scale is the ability to ‘make big decisions more easily’. Presaging this assessment by Morgan in a report one year post Devolution, Wales is referred to as a ‘policy village’ able to achieve quicker agreements over policy development (Jervis and Plowden, 2000:9; Costa-Font and Greer, 2016). Morgan uses the diminutive scale of Wales compared to England to explain why consumerist health policies such as patient choice and the associated establishment of Foundation Trust Hospitals are not relevant in Wales. He says there is no appetite or necessity for choice within a welfarist state, where universalism is the guiding ideology of Welsh Labour and values of the citizenry (Collins et al 2019). However, the exact opposite position is taken in England, promoting the benefit of local NHS commissioning as being the potential – at a smaller healthcare system level – to identify and respond to

the opportunities and challenges facing a county-size population, such as Gloucestershire.

Differentiated Welsh Voices

Picking up a divergence from English health policy, in 'Clear Red Water' Morgan refers explicitly to 'citizens' rather than 'consumers'. He refers to a 'shared social agenda' and the 'strengthening' of 'the collective voice of the citizen'. He sets out a different approach to the transactional relationship between patient customer and service being promoted in England, with the individual citizen, as part of a collective Welsh society, having a 'voice' in shaping policy and service delivery.

I suggest Morgan's words overall are chosen to show that the Welsh have a common purpose, are close with each other; the comparisons he prefers to make are between England and Wales rather than between communities in Wales (Peckham et al 2012). Comparisons between communities within a smaller geography are the focus of the secondary analysis (see 3).

1.7.2.2 Alan Milburn MP, Secretary of State for Health: New NHS Resources

On 11 December 2002, just a few hours before Morgan gives his 'Clear Red Water' speech, Alan Milburn, Secretary of State for Health, sets out the NHS reforms to be delivered through devolution to local areas within England, in a speech entitled 'New NHS Resources' (Milburn, 2002b). A key mechanism for this is the creation of NHS Foundation Trust hospitals; accountable to and owned by local people through the election of public governors, and wide resident memberships. Unlike Morgan's speech, no reference is made to the devolved nations in the speech; it is clear example of the lack of interest shown in the devolved nations by English politicians at this time (Greer in Costa-Font and Greer, 2016). However, as in Morgan's speech, a recurring theme is still devolution, but 'small d' delegation of power away from Westminster to local areas. Comparisons are instead drawn by Milburn between New Labour and Conservative administrations in England, as opposed to Old and New Labour by Morgan.

Milburn (2002b) reinforces the discourse of 'small d' devolution, giving greater freedoms to frontline NHS organisations, NHS staff, and local people through the removal of top-down controls, which stifle local innovation. This potentially feels more like a version of 'trust' than the version described in Wales. However, as shown below, delegation of power comes at the price of prescribed reform in England.

In ‘New NHS Resources’ Milburn reinforces the impact of performance targets and standards, citing improved results such as: reduced waiting times for hospital treatment; better emergency care; and improvements in cancer, heart, mental health, children’s and older peoples’ services. Interestingly, in relation to the discourse around performance and standards, Milburn (2002b) links back to the earlier freedom discourse, referring to ‘improved performance through devolution of power and responsibility’, stating that ‘standards are national, control is local’. In my view this aligns with Le Grand’s 'trust’ model, and the discourse regarding local engagement and co-operation sounds like Le Grand’s ‘voice’ model. Milburn’s 2002 approach seems to be attempting to combine all four of Le Grand’s models into a New Labour ‘best of all worlds’ resource and reform package. As stated previously, Le Grand also favours a combined model, with choice & competition dominating.

Milburn confirms that capacity will be expanded where waiting times are longest. However, to secure increased funding for the NHS, the NHS in England must agree to accept New Labour policies of patient choice, and increased capacity created by opening NHS funded service provision to the market. This is something the NHS in Wales is not asked to consider by its Old Labour Welsh politicians (Hinsliff and Ahmed, 2002; cited in Ball and Exley, 2010).

A few months before delivering ‘New NHS Resources’, Milburn addresses the National Social Services Conference in, of all places, Cardiff. Milburn rehearses the discourses he will present in Westminster later in the year (Milburn 2002c). Milburn’s key framework for the speech is to locate the New Labour reform offer within the current consumer age, where an informed and inquiring society expects choice and demands quality; and, devolution of decision making to the front line, away from central government, whilst working within a centrally regulated and performance-monitored system.

Respecting the skills and attributes of the audience for the October 2002 speech in Cardiff, Milburn notes that the NHS can learn from social care about sharing ‘more power’ with service users and ‘more choice’ for service users. Milburn differentiates choice from consulting people about what they want; it is more about expanding what it is available, and their awareness of their choices, giving them the freedom to tailor services to fit their needs. In ‘New NHS Resources’, Milburn frequently uses phrases such as ‘staff feel involved’, ‘communities are better engaged’. In addition to these general statements he describes some of the mechanisms which will support

involvement and engagement: ‘elected hospital governors’ and ‘local communities [which will] control and [legally] own their local Foundation Trust’.

An interesting relationship arises with the ‘Welsh Way’ discourse from Morgan’s ‘Clear Red Water’ speech (Morgan, 2002), which talks about the values of the ‘Welsh Co-operative movement’; Milburn states that Foundation Trusts are modelled on co-operative societies and mutual organisations which pre-dated the NHS (Iliffe and Manthorpe, 2021). One can speculate that this reference to the ‘not for profit’ model for Foundation Trusts in this statement, made in Westminster, on the same day as Morgan’s speech is delivered in Swansea, is calculated to undermine Morgan’s attack on the Foundation Trust policy in England, as being contrary to the NHS founding principles, and a potential threat to the public ownership and public provision of health services in England.

1.8 ‘Small d’ Devolution (Micro): Opportunities for Policy Divergence

1.8.1 *NHS Gloucestershire (NHSG)*

The NHSG commissioning area is located at the northernmost point of the NHS England South-West region, bordering onto the NHS England Midlands region to the north, NHS England South-East region to the east, and the Aneurin Bevan Health Board to the west in Wales. An important factor for NHS commissioners in Gloucestershire to consider, when commissioning and developing services, is cross-border patient flow between counties and countries, to access services either inward-coming or outward-going.

NHSG manages NHS-funded contracts with organisations to provide services for the resident population of Gloucestershire. This includes people who live within the county boundary but who may access services inside and outside of the county. Examples of this are people who live in the east of the county whose closest specialist hospital might be located in Wiltshire or Oxfordshire; or individuals who are resident in Gloucestershire who are registered with Welsh GP practices in Monmouthshire, Wales and who may choose to access services in either country. The issues identified regarding inequity between England and Wales, for instance in relation to waiting times for operations, do not apply across borders to the north and south of Gloucestershire, as waiting times standards are England-wide. However, difference in service provision and quality, and public expectations and preferences, are observed at county and district level. It is worth noting that waiting times for

inpatient services across all areas of England and Wales deteriorated significantly following the COVID-19 pandemic, whilst the NHS implements recovery plans.

1.9 Gloucestershire (Micro)

1.9.1 *NHSG Geography*

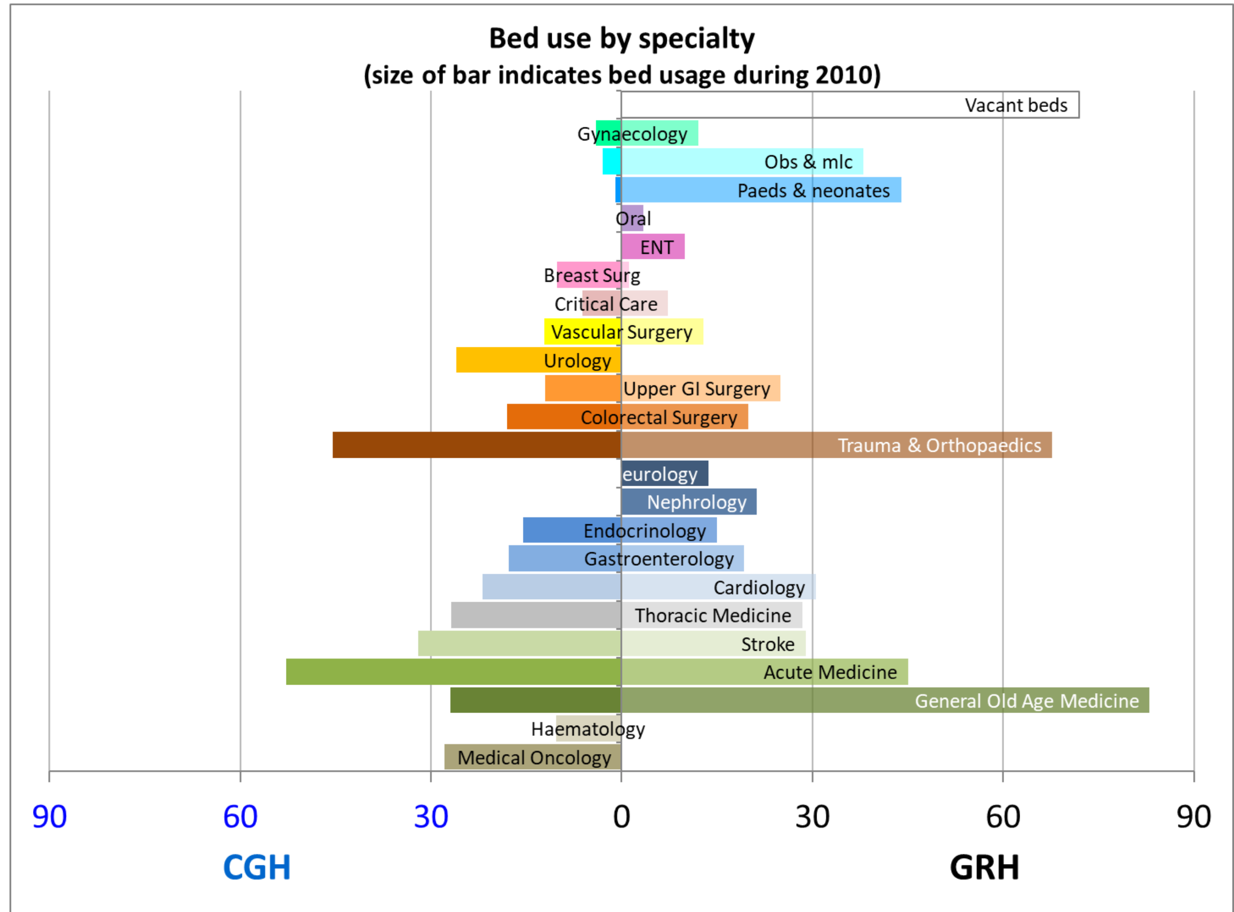
Gloucestershire is a semi-urban/rural county located in Southwest England. It has a land border with several other counties in England to the north, south, and east, and with Monmouthshire in South Wales to the west.

NHSG is coterminous with the top-tier local authority county border and includes the city of Gloucester and the main towns of Cheltenham, Cirencester, Coleford, Stroud, and Tewkesbury[3]. There are six boroughs or districts –Cheltenham, Cotswold, Forest of Dean (which borders Wales), Gloucester, Stroud, and Tewkesbury. One Gloucestershire as a health and care system is relatively unusual in that the partners within it are all located within the county boundaries. Challenges experienced by other systems with multiple counties boundaries, particularly in relation to involving the public in strategic service redesign conversations, have not been a feature of the Gloucestershire experience (Coultas et al, 2019).

There is a single acute-service provider, Gloucestershire Hospitals NHS Foundation Trust, which provides specialist hospital services from two acute hospitals, one in Gloucester and the other in Cheltenham, located less than 10 miles apart. Today both hospitals provide a range of specialist services. However, over a twenty-year period individual specialist services have gradually consolidated onto one or other hospital site. Below (see Fig. 6) is a snapshot from the 2010s showing the speciality bed distribution between the two hospitals.

[3] There are other towns in Gloucestershire, including (in the east) Bourton-on-the-Water, Moreton-in-Marsh, and Winchcombe, and (in the west) Cinderford, Dursley, and Lydney.

Fig. 6 Bed usage by speciality across CGH and GRH 2010



1.9.2 *Reconfiguration of specialist hospital services in Gloucestershire*

Reconfiguration in healthcare is defined as a deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital … in a locality … or healthcare administrative area (Fulop et al, 2012). Changes to the way healthcare is experienced at any scale effects the social realities for numerous communities of interest (Means and Evans, 2012) such as patients, residents and consumers. Therefore, it is important that social science approaches are used to study service change in healthcare (Fraser et al, 2019).

Today each hospital is designated as a CoE. GRH is the CoE for emergency care, obstetrics and paediatrics; the latter specialty centralised following the closure of the children's ward at CGH; a parliamentary election issue in Cheltenham in 2005. CGH is the location for the county's Linear Accelerators for radiotherapy treatment. Their installation physically required several tons of concrete, thereby cementing the location of a specialist oncology service at the hospital in the east. Therefore, CoE for oncology/cancer care as well as planned care.

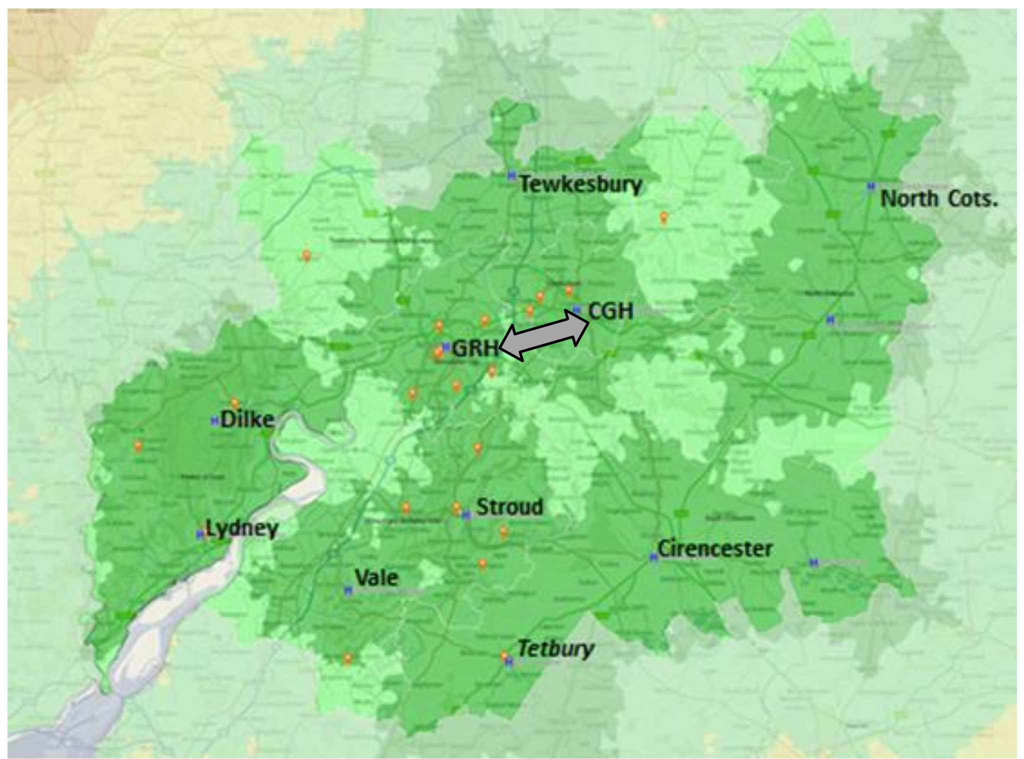
Two CoEs in Gloucestershire

GRH: CoE for Emergency Care, Paediatrics, and Obstetrics

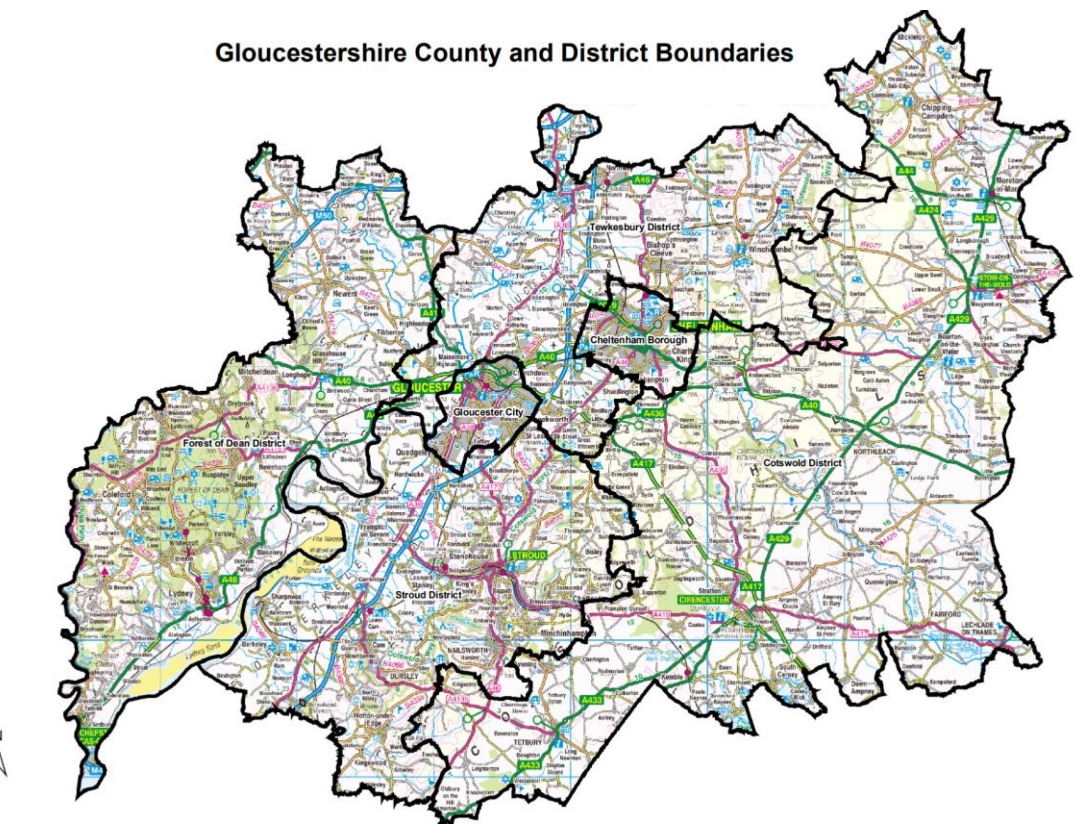
CGH: CoE for Planned Care and Oncology/Cancer

The M5 Motorway bisects them, and the A40, known locally as the Golden Valley Bypass; this is the most direct route between Cheltenham and Gloucester. As an homage to the 'Clear Red Water' metaphor used by Morgan to differentiate policies in Wales from those in England post-devolution (Morgan, 2002), it could be said that the two acute hospitals are separated by less than 10 miles of 'Hard Grey Tarmac'. As many of the public responses to the FFtF programme discussed later illustrate, 10 miles' distance to travel to access specialist services may as well be 110 miles for some and considered to be not very far for others. This 'hard grey tarmac' is also commonly referred to locally as a 'Long Corridor' joining the two acute hospitals in NHSG public communications (see Map 1). An interesting observation made by the NHS Foundation Trust Medical Director, Dr Sean Elyan, in public consultation events in 2019 and 2020, was that the time taken to drive between the two acute hospitals in Gloucestershire is approximately the same as the time it takes to walk from one end of the Queen Elizabeth Hospital in Birmingham to the other: roughly 20 minutes.

Map 1: Showing Location of 2 x Acute: CGH and GRH, separated by the *'Hard Grey Tarmac',* and 7 x Community Hospitals in Gloucestershire: Tewkesbury, North Cotswolds, Cirencester, The Vale in Dursley, Lydney and The Dilke in the Forest of Dean. Tetbury Hospital Trust Ltd is a charity established in the 1990s, and independent provider to the NHS.

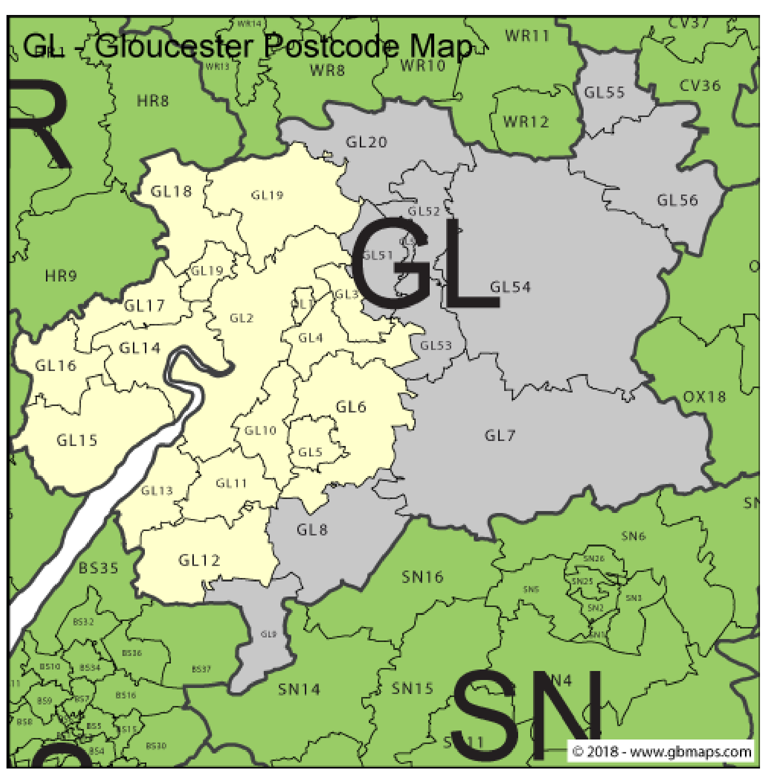


Map 2: Gloucestershire County and District Boundaries



The east/west division I have used in this thesis does not consistently follow district/borough council boundaries (see Maps 2 and 3). The first reason for this is found in the history of the configuration of NHS organisations in the county in the last 30 years. Tewkesbury has traditionally been linked with Cheltenham and the east, since it was part of East Gloucestershire NHS Trust in the 1990s, and Cheltenham and Tewkesbury Primary Care Trust in the first half of the 2000s. The second reason for this is the unusual shape of Tewkesbury Borough Council's geographical administrative area. The postcodes it covers are GL20 and the eastern parts of GL19, GL7, and GL4 creating a geographical administrative separation between Gloucester City Council and Cheltenham Borough Council areas. In this instance, the separation between east and west is a bureaucratic strip of 'red tape' instead of 'hard grey tarmac'. For the purposes of this research, the Tewkesbury GL20 postcode is identified as being the 'east', whilst the rest of the Tewkesbury Borough postcodes are identified as being in the 'west' of the county (see Map 3).

Map 3: Gloucestershire Postcode Map showing delineation of east and west as referred to in this thesis. Adapted from: https://www.gbmaps.com/4-digit-postcode-maps/gl-gloucester-postcode-map.html



East: Cheltenham: GL50, GL51, GL52, GL53; Cotswold: GL54, GL55, GL56, GL7, GL8, GL9; Tewkesbury: GL20

West: Forest of Dean: GL14, GL15 (borders Wales), GL16 (borders Wales), GL17, GL18, GL19; Gloucester City: GL1, GL2, GL3, GL4; Stroud: GL5, GL6, GL10, GL11, GL12, GL13

1.9.3 *The Population of Gloucestershire*

Gloucestershire's population is approximately 640,000, and is predicted to rise to 675,000 by 2030, with the proportion aged 75-84 increasing by 20% between 2016 and 2021. Those aged over 65, with a long-term health condition, will increase from 47,500 to 77,000 by 2030. Gloucestershire has a high proportion of people aged 65+ and a net movement of more than 400 people aged 18-30 leaving the county each year.

NHSG uses population data, including the Indices of Deprivation[4], to understand the health needs of local people, and works to improve long-term health and wellbeing. There are 39 indices, such as low income, unemployment, and poor access to education and health services.

In 2019, the mid-point of the research period, there are 12 areas in the county which are in the most deprived 10% nationally, for the overall Index of Multiple Deprivation. Ten of the 12 are in the west of the county, in the Gloucester District Council area, and two are in the east of the county, in Cheltenham. Seventeen out of the twenty CORE20PLUS5 areas in the county[5], where people experience greater health inequalities, are in the west.

1.9.4 *The History of the NHS in Gloucestershire: 1990s - Present*

CGH and GRH are both managed by Gloucestershire Hospitals NHS Foundation Trust. This has not always been the case. In the 10 years prior to the creation of the single acute hospitals NHS Foundation Trust in Gloucestershire, there had been competiton between two hospital NHS Trusts: Gloucestershire Royal Hospital NHS Trust; which mostly served the populations of the west; and East Gloucestershire NHS Trust; which mostly served the populations of the east. Competition between the Foundation Trusts was encouraged by the neoliberal policy of patient choice (see 1.7.2.2 and 1.6.1).

In Gloucestershire, by all national performance measures (or targets) for NHS Trusts, EGNHST was consistently rated as higher performing than GRHNHST. Two examples of early 2000s iterations of the promotion of competion between NHS

---

[4] Inform Gloucestershire https://inform.gloucestershire.gov.uk/deprivation/overview/

[5] CORE20PLUS5 https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

secondary care providers were the Charter Mark and National Star Ratings. EGNHST was amongst the first trusts in England to be awarded a Charter Mark, a quality measure relating to patient experience as set out in the national NHS Patients' Charter (Department of Health, 1991). National Star Ratings ranked all NHS secondary care trusts from 1 to 3 stars. NHS trusts were measured against a set of criteria which largely focused on financial probity, and patients' access to services, defined by waiting times targets. EGNHST was consistently ranked at the top end of the Star Ratings for England, even on one occasion taking the top spot nationally, whilst GRHNHST was consistently at the lower end of the national rankings. In 2004, following the merger of the two trusts, the combined Gloucestershire Hospital Foundation Trust received a three-star rating (BBC, 2004).

The 2004 Star Rating result reinforces the discourse which said that the arrangements in the east were better than in the west and that the east brought the standards in the west up as a result of the merger of the two trusts. The former disparity lives long in the collective memory of parts of the local population, and their elected representatives; as well as some current clinical and managerial staff. This is observed in several comments highlighted in the analysis of the FFtF 2020/21 consultation response data, some 20 years later.

1.9.5 *Evolution of IDEAS, POLICY and PROPOSALS: STP, CoE Policy and FFtF*

Healthcare for some conditions is becoming more specialist, increasingly adopting technological advances, the use of expensive equipment, and the employment of highly trained staff. This must be considered by clinicians and professional managers when planning service developments. As well as technical and operational considerations, the voices of service users and citizens should also be considered by accountable bodies (Collins et al 2019). In 2016/17 the mandate was delegated by NHS England to local geographical system partners to collaborate on developing Sustainability and Transformation Plans (STPs) to address the challenges and opportunities facing health and care (Storey et al 2019). When specialist hospital care is needed, the STP engagement results show that expertise is the most important factor when seeing a specialist (59%) and distance to travel is the third factor (8%). The aim of the CoE policy is to deliver specialist services efficiently and sustainably through the FFtF programme. Economies of scale (Costa-Font and Greer,2016) translate into centralising services in one specialist hospital location in

the county from a choice of two, where staff skills can be consolidated, with the equipment needed to provide the very best care. The Bristol Royal Infirmary Inquiry[6] Report (Department of Health, 2001(a)) and clinical studies have shown that outcomes are better at hospitals with higher volume activity; a result of which is centralisation of specialist services in supra-regional centres across areas larger than one healthcare system (Buhn et al, 2020; Finlayson et al, 1999; Landau et al, 2013). The CoE vision for acute specialist hospital services in Gloucestershire is:

> [a] single, ground-breaking specialist hospital for Gloucestershire, operating out of two campuses, one in Cheltenham and one in Gloucester. All the specialist care and expertise you need will be right on hand: whether you are coming to us for planned surgery, or in an emergency. (Gloucestershire County Council, 2020) (see Appendix 1).

The operational rationale for the CoE policy is that centralised specialist services at a single location translate into more attractive working conditions, thereby retaining and enticing skilled staff to work in Gloucestershire maintaining an in-county choice for patients who otherwise would need to travel out of county to access services. The policy is also more efficient in terms of other resources, such as dedicated specialist wards and equipment. The FFtF programme is clear that saving money is not a policy objective.

The rhetoric is that specialist hospital services are more likely to be retained within the county through centralisation, but the consequence of such a reconfiguration of services is that choice of location to access those services within the county is eliminated. Effectively the choice is a service in one location in Gloucestershire or having to access a service in another county. The CoE vision, which stresses 'excellence' on both hospital sites, plural, seeks to eradicate competition within the county by creating two equally interdependent parts of the same whole. This discourse has been controversial amongst some communities, notably residents and elected representatives from the east of the county, who express concerns about the 'downgrading' of CGH to the benefit of GRH. Several years prior to the STP and FFtF engagements and the FFtF consultation, due to Emergency Medicine consultant and junior doctor recruitment challenges, restrictions were placed on CGH A&E, with its 24/7/365 service operating from that point on as a nurse-led unit from 8pm to 8am, 7 days a week. This was a particularly controversial change, and

[6] http://www.bristol-inquiry.org.uk/

reaction to it in the east of the county remains high, as is seen in the results from the three case studies, with frequent calls for the A&E at CGH to be reinstated or protected, depending upon the respondent's understanding of the current status of the department.

Political resistance to reconfiguration of services away from Cheltenham and towards Gloucester has remained constant and consistent during the research period and will be a factor in Chapter Four.

In 2019, the CoE discourse is new in Gloucestershire. However, the practical reconfiguration of specialist hospital services is not. Since the early 2000s, several other specialist services are already provided in one acute site in the county, following reconfigurations planned, engaged, consulted upon, and implemented.

FFtF focuses on the medium- to long-term future of specialist hospital services provided at CGH and GRH. The FFtF programme is the plan to change how and where some specialist hospital services are provided in the county in future. Its purpose it to make the most of staff skills, resources, and advances in medicine and technology, and to secure best use of the two acute sites in the county.

Underpinning the FFtF programme is a strong commitment to listen to what matters to people, and to join up data and information to understand how to meet local needs in the best way.

1.10 Involving People and Communities

Individuals, either as individualistic consumers of public services as described in the Choice model or collective owners of public services as described in the Voice model (Le Grand, 2007) can all be engaged to inform decisions about the "provision of community assets" (Collins et al, 2019); such as hospitals.

1.10.1 *Statutory Duties Regarding Involving People and Communities*

Various Acts of Parliament have set out statutory duties for NHS organisations in England with respect to patient experience and involving patients and the wider public in the development of services. An early symbolic statement of intent by politicians with respect to introducing both voice and choice in healthcare was the introduction of the Patients' Charter in 1991. The Patient's Charter attempted to develop the patient as an individual consumer rather than part of the collective community (Mold, 2015).

The requirements in the most recent 2022 Act that are specifically associated with engagement, and are updated from the 2012 and 2006 Acts, are Sections 14Z36 and 45. The 2022 statutory update states that local NHS commissioners must involve and consult patients and the public:

> in their planning of commissioning arrangements; in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which services are delivered to the individuals or the range of health services available to them; and in decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

However, of relevance to the two engagements and the consultation activities which provide the case studies in this thesis are sections s14z2 of the 2012 Act, and s14z36 and 45 of the 2022 Act. Also relevant is the Equality Act 2010, which sets out duties with respect to nine protected characteristics and applies equally to administrations in England and Wales (as well as Scotland, and to a lesser degree in Northern Ireland). NHS England also provides guidance during the period to support engagement and consultation associated with strategic service change (NHS England, 2015). Worthy of note is the scholarly comment that the preferences of individuals, however they are described, should be considered important by decision makers, but that they are neither subordinate nor superordinate to the preferences of other key constituencies such as staff, wider citizenry, voluntary and community sector stakeholders (Needham, 2008 (a)).

Throughout the research period, NHSG has had strategies to meet the statutory requirements at the time. For example, there is an Equality and Diversity strategy, including guidance regarding the undertaking of Engagement and Equality Impact Analysis (EEIA) (NHS Gloucestershire, 2023), to support local NHS commissioning activities including engagement and consultation. The EEIA extends beyond the nine defined protected characteristic groups above, incorporating for instance ‘rurality’ and ‘out of county’ as characteristics requiring due regard in planning engagement and consultation activity, and impact assessment. Rurality is linked to distance to travel to access specialist hospital services and to visit patients; this, along with relative access to public transport, is a factor highlighted in the case studies, data findings, and analysis relating to equality presented in this thesis. Good practice in engaging the public in service reconfiguration describes three stages: sharing

information; public engagement/consultation; informed decision making (Barratt et al, 2015; Farrington-Douglas, 2007). The case studies presented in this thesis underpin these three stages.

1.10.2 *The NHS Constitution in England*

The NHS Constitution was established in law in section 1 of the Health Act in 2009 and came into force in January 2010 (Department of Health, 2009). The NHS Constitution places statutory duties on NHS bodies and sets out several patient rights, which are a legal entitlement protected by law; of specific relevance to this thesis are the rights relating to 'choice' of hospital and rights applicable to public engagement or 'voice'.

1.10.3 *The Gunning Principles*

The Gunning Principles encourage public sector organisations to aspire to proportionate and fit-for-purpose involvement activities. There are four Gunning Principles, which if applied should ensure informed choice and voice. These are summarised in Fig. 7 below.

Fig. 7 Summary of the Gunning Principles first applied during a court case by Mr Stephen Sedley QC adopted by Mr Justice Hodgson in R v Brent London Borough Council, *ex parte* Gunning, 1985

Number	Gunning Principle
1	consultation must take place when the proposal is still at a formative stage
2	sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response
3	adequate time must be given for consideration and response
4	the product of the consultation must be conscientiously considered

1.10.4 *CoE and FFtF Engagement and Consultation activities*

By completing two engagements and one consultation, NHSG can demonstrate it pays due regard to its statutory duties, the NHS Constitution (Department of Health, 2009), and the Gunning Principles in planning all public involvement and consultation activities. The Gunning Principles are important to this research because they are referred to by the second Citizens' Jury in 2021 (see 1.10.4.1) in considering their

confidence in the FFtF consultation process. The Consultation Institute (TCI), which quality assured the FFtF consultation, uses the Gunning Principles to test the efficacy of consultation plans. A TCI advisor worked with me, acting as a critical friend through each stage of planning and activity for the FFtF Consultation, including design survey. This included planning for consultation during a pandemic. In March 2020 I was pleased to receive confirmation that the exercise met 'good practice' requirements. It should be noted and was indeed noted by the second Citizens Jury, that an options paper was taken to the county council Health Overview and Scrutiny Committee (HOSC), to consider the pros and cons of conducting the consultation at that time (Gloucestershire County Council, 2020). Elected members were assured by the measures proposed to carry out a socially distanced consultation and identified no reasons to delay. It was agreed that, because it was impossible to know the timescale for the evolution of the pandemic, the consultation should go ahead so that the conversation about realisation of potential benefits, identified in the FFtF programme changes, should not be delayed indefinitely.

1.10.4.1 Citizens' Juries

The Gloucestershire health and care system commissioned an independent provider to run two Citizens' Juries, in January 2020 and February 2021, as part of the FFtF engagement and consultation activities. The rationale for this decision, to involve a Citizens' Jury, is to achieve a representative sample of participants. By increasing the knowledge and understanding of jurors, decision makers can benefit from receiving more reasoned feedback than the data gathered through self-selecting open public involvement (Whitty et al., 2014). Citizens' Juries were first developed in the 1970s, at the Jefferson Centre in the USA (Veasey and Nethercut, 2004). Jurors are selected randomly, to be representative of the population, using polling techniques. They are provided with impartial information from expert witnesses, who are also selected to ensure a range of opinions and interpretations are shared with jurors. Jurors have opportunities to question the witnesses. Sufficient time is given for jurors to deliberate together to ensure that all jurors' points of view are reflected in the jurors' report, which includes recommendations for decision makers.

The jury process enables jurors to build their knowledge and expertise on a subject which they may have previously given little thought to (Bennett and Smith, 2007). It has been shown that jurors are able to remember more aspects of the information shared with them through the jury process, such as the FFtF consultation

information, than the wider public who do not have the benefit of participating in collective deliberation (Menon and Stafinski, 2009).

Whitty et al. (2014) note that the wider public may complete surveys, offering their views even if they do not have much personal knowledge of the topic. This phenomenon is seen in the three case studies' data, in relation to some public views, specifically about the status of the Accident and Emergency (A&E) Department at Cheltenham General Hospital (CGH), and the suggestion regarding establishing a shuttle bus service between the two hospital sites in Gloucestershire, when such a service has been in operation for more than a decade. Based on their own knowledge, which may be based on misinformation or misunderstanding, of their experiences, the wider public may hold self-interested views. As noted below in Chapter Two, Le Grand, in referring to Adam Smith, suggests that there is an 'invisible hand' which guides individuals to make choices which benefit themselves over others. The concept of the 'altruistic knight' and the 'self-interested knave' (Le Grand, 2003) applies here. This is borne out in the analysis of the data across the three case studies.

Scuffham et al. (2014) suggest that jurors' initial views and opinions are representative of the general population, but that participating in the jury process can produce a change in jurors' individual positions (Tully et al., 2018). Using Le Grand's description, they can transform from self-interested 'knaves' to altruistic 'knights' or from 'pawns' to 'queens' (Le Grand, 2003). Evidence further shows that during the process consensus can be reached amongst a diverse group of individuals (Scuffham et al., 2014). Through the act of collective deliberation, jurors are facilitated by the jury process to consider complex information, thereby increasing comprehension of the topic, resulting in knowledgeable recommendations being made for the consideration of decision makers (Gooberman-Hill et al, 2008; Veasey and Nethercut, 2004). Jurors, having taken part in this approach, are able to present an impactful collective voice together, instead of disparate individual voices (Tully et al., 2018).

1.10.4.2 Involvement and Diversity

In addition to general population engagement, the views of groups identified through an Integrated Impact Assessment (IIA) are sought by NHSG. In case studies 2 and 3 groups identified within the IIA were relatively evenly distributed between the two halves of the county, with generally a larger proportion of people in older age groups

living in the east, but a greater proportion of people living in areas with greater health inequality living in the west of the county. Protected characteristics are defined by UK Law (see 1.10.4.2). The nine characteristics defined within the Act do not include financial status or rurality. However, these characteristics are considered by NHSG when completing impact assessments as these are recognised locally as having an impact on individuals experience of local services.

1.11 Chapter Summary

This chapter set the scene for this thesis. It has laid out the structure of the thesis to follow and has introduced the research questions and suggested why they are important. The theoretical framework (Le Grand, 2007) used to support the analysis and interpretation presented in this thesis is clearly explained, identifying elements of the four models and their attributes which are used in the coding and secondary analysis of the qualitative data from the three Gloucestershire case studies. In this chapter, there has been a review of literature relevant to this research. The focus has been on scholarly works concerned with patient choice and voice in relation to healthcare service reconfiguration and in particular the appetite for patient choice. To provide context for the thesis, the second half of this chapter has focussed on big ‘D’ and little ‘d’ devolution and the decentralisation of health care policy development in the UK. Theories dominating public policy: rational choice which influences the neoliberal new public management approach to public service policy development and delivery and an alternative to this, new public philosophy promoting a welfarist approach have been presented. These different approaches were observed in the rhetoric showcased in the consideration of two big ‘D’ political speeches given in Wales and England in 2001 post national Devolution.

Next the chapter provided a guide to Gloucestershire, its geography, population and the history of little ‘d’ healthcare service reconfiguration within the county. It briefly introduced the CoE policy and the FFtF programme, which are the focus of two of the research case studies.

Finally, because of the connection between the secondary analysis of the data in this thesis and the primary purpose for its collection this chapter concluded with information about involving people and communities in healthcare.

2 Method

2.1 Chapter Structure

The chapter first considers the question of researcher familiarity with the subject of the research.

It goes on to describe the process of data selection, introducing the three case studies, including how the data were collected. It briefly describes the procedure used to undertake the primary analysis of the data, before describing in detail the progression of the secondary analysis process. To support the method and reporting in this research I completed the Consolidated Criteria for Reporting Qualitative Studies (COREQ) 32-item checklist (Tong et al, 2007) (see 7.2).

2.2 Researcher Familiarity

My analysis of the data, as well as being affected by the tools used to support the analysis (see 2.4.5), is also affected by my familiarity with the research period, the location, and the content of the data. Consideration of the connections between the researcher and the research is not unique to this research. It is a well-recorded topic for debate, often associated with the concepts of 'insiders' and 'outsiders' (Arber, 2006; Mannay, 2010; Merton,1972). The implication is that an insider's analysis and conclusions lack the scrupulousness of objective criticism, as it can be 'overshadowed by the enclosed, self-contained world of common understanding' (Mannay, 2010, p. 91).

Coffey (1999) and Delamont and Atkinson (1995) consider the 'insider' problem. Coffey (1999) selects a quote from Becker (1971), who reflects with frustration on interactions with educational researchers – 'it is like pulling teeth to get them to see or write anything beyond what "everyone" knows' (Becker, 1971, p. 10). Becker's observation suggests that some researchers do not look outside their comfort zone, thereby missing opportunities to extend their own appreciation of their professional area of experience and expertise, or wider understanding (Delamont and Atkinson, 1995).

2.2.1 *Positionality: Who am I and What is my Position in Relation to this Research?*

Positionality refers both to the social and political standpoint from which the researcher undertakes the research, and their own personal view of how the world works (Rowe, 2014; Savin-Baden and Major, 2013). I am conscious of the influence

of the lenses; the influence my perspectives and beliefs, through which I see the world, have on all aspects of this research (Holmes, 2020).

I am an NHS senior manager with more than 30 years' experience working for the NHS. I am based in Gloucestershire in England, with day-to-day organisational responsibility for system compliance with statutory duties, in relation to involving the public in NHS service development and change. As mentioned above, I have personal experience of working outside of Gloucestershire as Head of Communications for the Bristol Royal Infirmary Inquiry. This independent public enquiry examined concerns about the outcomes of specialist paediatric cardiac surgical services in Bristol, serving children and their families living in the South West of England, and south Wales, in the 1980s and 1990s; concluding, of particular relevance to this thesis, that high volume specialist centres improve patient outcomes (Department of Health, 2001(a)) and; informing my professional career ever since; shifting my focus from simply communicating information towards listening to the voices of people who have experience of services alongside those of clinicians providing and managers operationally managing those services.

I have never worked in the NHS in Wales, making me an 'outsider' in Wales.

Taking a reflexive approach, I acknowledge that my professional experience makes me an 'insider' in England (Holmes, 2020). I undertook the primary analysis of three case studies' data. However, an important distinction is that the primary analysis focuses on 'what' people say, whereas the secondary analysis considers 'why' individuals might have responded in the way they did. Therefore, I also acknowledge that objectivity in carrying out the research and presenting results is impossible (Ormston et al., 2014).

I have considered the potential impact of researcher familiarity or bias in this research and recognise that my involvement as an 'insider' in both the primary and secondary qualitative analysis of the results could have resulted in a partial perspective, thereby potentially reducing the generalisability of the results. However, as stated below, I took a pragmatic approach to ensure subjectivity in the observations I make and objectivity in the secondary analysis of the case studies data (Shannon-Baker, 2015).

In my position in relation to the primary research, my professional role requires me to design methods which do not 'lead' participants to respond in a particular way; for

example, using Likert scales in surveys, and providing free-text boxes for comments. My professional approach to reporting results (primary analysis) is to present quantitative results in full, and to summarise the qualitative results into themes and provide illustrative quotations. In addition to this, all free-text comments received are published in full, having only been redacted for personally identifiable information e.g. first part of postcode. In the secondary analysis, the collective respondents' stated postcodes (first four digits) are a relevant consideration to answer the research question. Despite this, a regular criticism from public, and some elected, participants, is that survey questions are 'leading', and that there is a bias in the presentation of the results – by some parties or 'voices' the process and presentation of results is not 'trusted'. This is a theme explored in the secondary analysis.

Familiarity with the data is not the only relationship between me and the research. I must acknowledge that all research is influenced by a host of factors influencing the decisions made by the researcher, and that no knowledge can therefore be completely objective or neutral (Ormston et al., 2014).

To conclude this consideration of researcher bias and positionality, both bias and positionality are inherent to the research process; and my awareness and acknowledgement of the imbalance with respect to the research methods selected, analysis, and discussion is necessary (Holmes, 2020).

2.3 Data Selection for Secondary Framework Analysis

To track the public response to the evolution of the CoE policy and the FFtF programme, this thesis uses Le Grand's four models for organising good public services as the framework (2007) to structure the secondary analysis of existing data collected from three case studies: three self-selecting open public surveys and two independently sampled Citizens' Jurors' reports.

The selection of the three case studies was a pragmatic decision. My original research plan had been to investigate the ideologies informing policy divergence post devolution in the UK; their consequences, intended and unintended. The data I had planned to analyse and interpret to consider healthcare policy development in England and Wales was to have been gathered through a series of structured interviews with key individuals from the Action 4 Our Care Group and representatives of the NHS Cross-border Network (see 7.6). However, due to COVID 19 pandemic restrictions and my associated temporary redeployment; with support of my Supervisory team, I shifted focus towards micro-level 'small d' devolution at

local system level within England. I had, through my professional practice, already been responsible for collecting a large amount of data over several years. The data was collected through three surveys supporting three public engagement activities in Gloucestershire spanning five years 2016-2021,

The findings from the analysis and interpretation of the data presented in the three case studies represents the public responses to three phases of public engagement and consultation associated with the evolution of the Centres of Excellence Policy and the Fit for the Future Programme.

To make it easier for the reader to follow the progression of the data and the analysis, from this point on the graphics illustrating the three case studies have been colour-coded IDEAS: **green**, POLICY: **purple,** and PROPOSALS: **blue** (see Fig. 8).

Fig. 8 Evolution of the FFtF Programme

1. Engagement: Development of our Sustainability and Transformation Plan (2016/17)
Challenges, opportunities and priorities. Identification of IDEAS

2. *Fit for the Future* Engagement
(September-December 2019)
Citizens Jury 1 (January 2020)
Development of
'centres of excellence'
POLICY

3. *Fit for the Future* Consultation (October - December 2020)
Citizens Jury 2 (January 2021)
Consultation on
PROPOSALS

Details of each case study can be found at Appendix 1 and at: https://www.nhsglos.nhs.uk/have-your-say/working-with-you/you-said-we-listened-we-acted/

I have considered the decision to choose to undertake secondary analysis of an existing data set rather than collecting new data.

The reason for choosing to use data from multiple case studies is to increase generalisability (Miles and Huberman, 1994). The premise is that the results and analysis of one case might be unique, but that across several cases there is more likelihood of variation, allowing the analysis to focus on whether local conditions affect the results. This allows for more complex and meaningful discussion and findings. The secondary analysis in this paper uses Le Grand's framework (2007) (see 1.3) to structure the examination of this premise using qualitative data collected

through three public surveys linked to the three case studies above. The cases; which are separated by time; explore the evolution from developing policy to potential service change, i.e. the shift from a hypothetical abstract conversation about the potential benefits and trade-offs associated with developing specialist clinical teams in a single location (a CoE), to a conversation about proposed actual centralisation to a single location of some identified specialist hospital services.

Miles and Huberman (1994) advise against relying on purely quantitative surveying, which could lead to 'smoothed-down generalisations' which could adequately be applied to all circumstances, but which might risk the loss of making interesting connections in the local qualitative data.

2.4 Introduction to Case Studies

Each of the three case studies described below represents one of three consecutive conversations about local healthcare services between local NHS organisations and the Gloucestershire population over a period of five years. I was involved in the planning and delivery of each of the case studies in my professional role as Associated Director for Engagement and Experience at NHSG.

Each conversation, referred to in case studies 1 and 2 as an 'engagement' and in case study 3 as a 'consultation', is supported by an information booklet including a FREEPOST survey (also available online) as well as comprehensives schedules of planned involvement activities. The intention of these involvement opportunities and activities being to maintain and increase awareness amongst the local population. The three surveys provide a mechanism for local people to comment on the IDEAS, POLICY and PROPOSALS presented in the case studies and for their views to be recorded securely and systematically.

In my professional role I undertook the primary analysis of the data collected for all three case studies presented in this thesis. I have undertaken the secondary framework analysis of the qualitative data from all three surveys and two Citizens' Jury reports. The primary analysis of the three case studies' surveys response data consists of quantitative analysis of numerical survey data and analysis of free text qualitative data. For the primary analysis I sorted and organised the data into themes and from the attributes I identified in the survey free text responses using the constant comparative method (Vaismoradi, et al, 2016). I use the same raw data for the secondary framework analysis in this thesis. In the secondary analysis I apply the theoretical framework I have selected, Le Grand's models for organising good

public services (2007 (see 1.3) to code the qualitative data, looking for attributes from the analytical framework in the data. Finally, in order to undertake a cross-case analysis to look for any divergence between the two geographically divided communities' responses to the three conversations, I bisect the data into two sets: responses selected from the east and responses from the west of the county,

In the third case study, FFtF consultation, in addition to the NHSG consultation survey, the campaigning organisation REACH - Restore Emergency at Cheltenham general Hospital, produced and presented the results of an alternative survey (REACH, 2020 and 2021). The headline results from the REACH survey show support for proposals for services to remain at, or be centralised at, CGH and rejection of proposals for services to move to, or be centralised at, GRH. I decided that the results from this survey would not be considered in detail in this thesis as no demographic information about survey respondents was published by REACH to allow for cross-case analysis.

2.4.1 *Case Study 1: STP Engagement, 2016 (The IDEAS)*

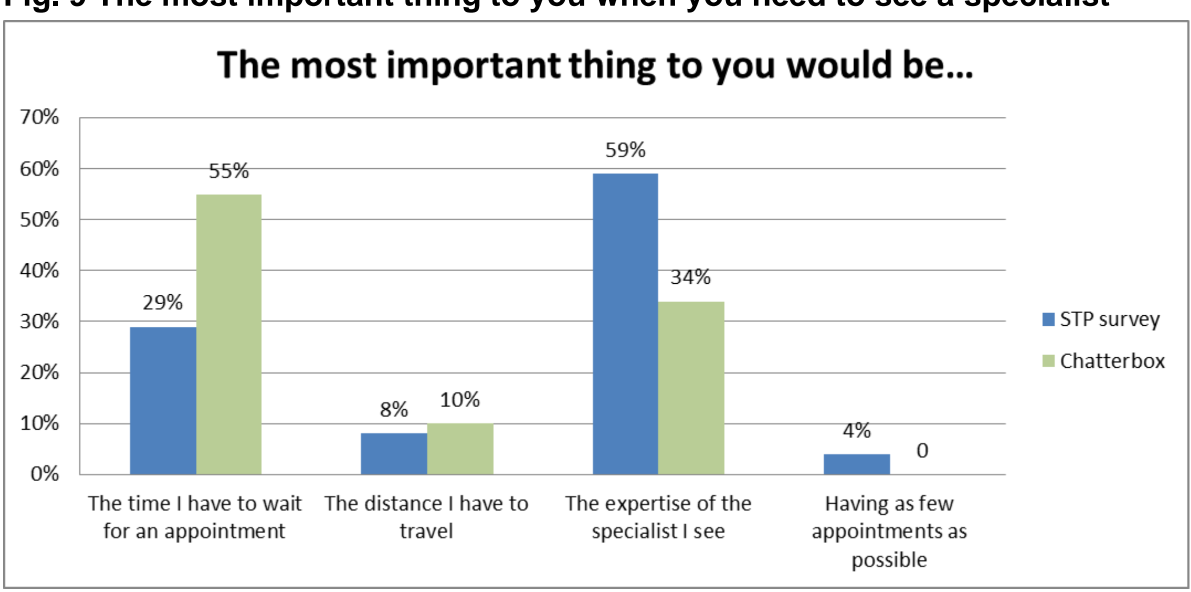
In response to the NHS England Five Year Forward View which saw a future with: 'far more care delivered locally but with some services in specialist centres where that clearly produces better results' (Bhattarai et al, 2019; NHS England, 2014:8), the STP sets out the health and wellbeing challenges facing the county, and the opportunities to ensure that 'people and communities could access high quality, sustainable and safe, physical and mental health care into the future'. The STP vision is:

> To improve health and wellbeing, we believe that by all working better together - in a more joined up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people.

Ideas in the STP include reducing clinical variation and duplication; promoting personal responsibility and improved independence for health; and reorganising care pathways and delivery systems to deliver the right care, in the right place, at the right time. This discourse is a reference to a 2013 engagement, which proposed a reconfiguration of: emergency and urgent medical care; the medical specialties gastroenterology, cardiology, and respiratory (thoracic) medicine; and paediatric day cases.

A comprehensive public engagement was undertaken in 2016 to test the STP ideas and an Output of Engagement Report was produced. Of relevance to this these is the public response to a question asked about the most important thing when you need to see a specialist (see Fig. 9).

Fig. 9 The most important thing to you when you need to see a specialist



For more detailed information about the STP Engagement see Appendix 1.

2.4.2 *Case Study 2: FFtF Engagement, 2019 (The POLICY)*

Building on the results of the STP engagement (Case Study 1) two years earlier, the FFtF engagement in 2019 is an opportunity to talk about ways NHS services could be provided in the future in Cheltenham and Gloucester. One of the models for service delivery described in the 5 Year Forward View is centralisation of specialist hospital services (Bhattarai et al, 2019; NHS England 2014). The FFtF engagement, supported by a comprehensive communications and engagement plan designed and delivered by NHSG, concentrates on urgent care and specialist hospital services. The focus of this thesis is the specialist hospital service element and the proposal to implement the CoE vision, a:

> …single, ground-breaking specialist hospital for Gloucestershire, operating out of two campuses, one in Cheltenham and one in Gloucester. All the specialist care and expertise you need will be right on hand: whether you are coming to us for planned surgery, or in an emergency.

The policy set out in the FFtF Engagement is to create a CoE for Emergency care at GRH. This would ensure that, if someone has a life or limb or sight threatening emergency, the right facilities and staff would always be available to give them the best possible chance of survival and recovery.

A second CoE for Planned care would be created at CGH. This would reduce the number of operations cancelled when beds or operating theatres are needed for the most unwell patients who arrive in the Emergency Department (A&E) and need urgent operations or treatment displacing and delaying elective patients.

The FFtF Engagement booklet reminds participants about what local people had previously said during the STP engagement about the most important things when needing to see a hospital specialist being the skills of the clinical team (see 2.4.1). The FFtF Programme acknowledges that the overall CoE vision could take up to ten years to achieve, being dependent upon a number of factors, such as having the right buildings, equipment, technology, staff and money in place. The purpose of the FFtF Engagement survey is first to hear people's views on potential solutions for general surgery and image-guided interventional surgery.

For more detail about the FFtF Engagement see Appendix 1.

2.4.3 *Case Study 3: FFtF Consultation, 2020 (The PROPOSALS)*

The FFtF consultation in 2020 is an opportunity to seek views on the future provision of five specialist hospital services in Gloucestershire. Once again, the consultation was supported by a comprehensive communications and consultation plan designed and delivered by NHSG. For the analysis I purposefully picked proposals from three of the services for the purpose of maximising the range of views within the data. I selected one proposal to centralise a service at CGH, one at GRH and one where the CoE could be at either hospital. The first proposal is to centralise a service in the west of the county at GRH – a CoE for Acute Medicine (it should be mentioned at this point that FFtF uses the term 'Acute Medical Take'; what this means is the co-ordination of initial medical care for patients referred to the Acute Medical Team by a GP or the Emergency Departments, and where decisions are made as to whether patients need a hospital stay). The second proposal is to centralise a service in the east of the county at CGH – a CoE for planned day case upper and lower gastrointestinal (GI) surgery. The third proposal offers a choice between the two hospital sites – a CoE for planned lower GI (colorectal) general surgery at CGH or at GRH, with no preference expressed by the local health and care system partners. It is worth noting that planned upper GI (colorectal) surgery was centralised in Gloucester several years prior to the establishment of FFtF, in response to an NHS England national directive.

The consultation took place during the height of the COVID-19 pandemic, with many activities having to be modified to support a social-distanced consultation with greater use of digital methods such as online discussions.

Some of the medium-to long-term changes proposed by FFtF relate to some of the same clinical services where temporary emergency changes were made in response to the COVID-19 incident, including temporary changes to the CGH A&E department. These arrangements led to confusion and scepticism amongst some sections of the public and staff, regarding the fairness of the consultation. Strong declarations are made to confirm that FFtF is not about the COVID-19 temporary changes made in 2020. Despite it being clearly stated that the FFtF consultation is not about the services provided at CGH A&E, the proposal to centralise emergency general surgery at GRH is one of the specialties included in the consultation (not one of the proposals selected for review in this thesis) created misunderstanding for some people. However, during the consultation it is clearly stated in all consultation materials and in public commitments that the status of the A&E Department in Cheltenham would not change; it would remain open 24 hours a day, 7 days a week, 365 days a year (nurse-led between 8pm and 8am). Despite this reassurance, many of the responses to the consultation do not trust these assurances, and frequently refer to the future of the A&E department in Cheltenham. This is discussed further in the Results and Discussion chapters.

2.4.3.1 The FFtF Consultation Outcome

The FFtF Output of consultation report was presented to the governing bodies of GHNHSFT and NHSG in January 2021 (NHS Gloucestershire 2021). A Decision Making Business Case (see Appendix 1) was requested and subsequently the recommendations of two resolutions within it with respect to the three proposals considered in this thesis were approved. Resolution #6: the recommendation to centralise Acute Medicine at GRH; and Resolution #7: the recommendation that work should continue to develop the option that would deliver Planned High-Risk Upper Gastrointestinal (GI) and Lower Gastrointestinal (Colorectal) surgery at GRH and Planned complex and routine inpatient and day case surgery in both Upper and Lower GI (Colorectal) at CGH.

2.4.4 *The Data*

The outputs of the engagement and consultation reports were authored by me. The first is publicly available on the One Gloucestershire Integrated Care System website

https://www.nhsglos.nhs.uk/have-your-say/working-with-you/you-said-we-listened-we-acted/ , and the second and third are available on the online participation platform Get Involved in Gloucestershire (GIG) https://getinvolved.glos.nhs.uk

GIG was developed by me and my system colleagues towards the end of the research period, as an online space to host Gloucestershire's engagement and consultation activities. This online function supported the opportunity for socially distanced approaches to ongoing involvement of people and communities (https://getinvolved.glos.nhs.uk/fit-for-the-future), in particular during the COVID-19 restrictions in 2020. A dedicated project page was developed to support the FFtF programme, where all marketing materials, the online survey, and the engagement and consultation reports were published.

The jurors' reports were authored by members of two Citizens' Juries, following the FFtF engagement and FFtF consultation. The reports were commissioned from independent facilitators Citizens' Juries c.i.c. and the Jefferson Centre and published by NHSG. The jurors' reports are also available at https://getinvolved.glos.nhs.uk/fit-for-the-future.

It is important to acknowledge the difference between the primary and secondary analyses. The primary analysis focuses on 'what' people say, whereas the secondary analysis uses a theoretical framework (Le Grand 2007) to consider 'why' individuals might have given the responses they did. To support the secondary analysis, and to reduce repetition in the presentation of results, I selected data associated with three out of five specialist hospital services subject to public consultation at the PROPOSALS stage. I selected three out of eleven services for two reasons. Firstly, a practical reason was to ensure the amount of data was manageable for analysis. Secondly, having completed the primary analysis, I was already aware that there is considerable duplication in the data between proposals. Therefore I selected one proposal to represent potential centralisation at CGH; one at GRH; and one where no preference was expressed by the system. The selection and use of the public responses to these three surveys, to inform this thesis, was approved by my employer and research funder, NHSG.

2.4.5 *Survey Development, Marketing and Data Collection*

The original fieldwork was conducted using surveys to gather patient and public insight, on three occasions, in response to the IDEAS, POLICY, and PROPOSALS previously described, which (if implemented) would change the access points for

some specialist inpatient services in Gloucestershire. The surveys were developed by me and NHSG staff at my direction under license using SMART survey software; its functionality is compliant with data protection requirements set out in the General Data Protection Regulations (Data Protection Act, 2018). The survey questions used to collect the data for this research were designed by me. I have undergone training with The Consultation Institute with respect to survey design and, for case studies such as the three considered in this thesis, Associates from The Consultation Institute review the survey design and questions. In developing survey questions we test the draft survey questionnaires by asking ourselves questions such as: How long are the survey questions? Are there technical terms in the questions which require explanation? Are the questions leading? (Bryman, 2016).

The primary quantitative reporting was produced using SMART functionality. The surveys were promoted using print marketing information, on the NHSG online participation platform and NHSG websites and during comprehensive schedules of planned public involvement events.

The FFtF engagement survey invites respondents to say what they think the most important things to be considered in improving specialist hospital services. It asks them to share their ideas about how to improve specialist hospital services and, if services were to change in future, what things should be considered to reduce any negative impact on them or people they know.

The FFtF consultation survey invites respondents to indicate their level of support or opposition to each CoE proposal. Respondents are also invited to say why they think this; this is the qualitative data used for the secondary analysis (see 3). In the case of the creation of a CoE for planned lower GI (colorectal) general surgery at CGH or at GRH, respondents are also invited to express a preference for which site. No opinion is also an available option for all questions.

2.4.5.1 NHS Information Bus

The NHS Information Bus is a traditional feature of NHSG's engagement and consultation activities during the research period. It toured the county to raise awareness of the opportunity to comment. The FFtF consultation took place during the COVID-19 pandemic, resulting in requirements to change the approach to consultation to meet COVID-19 restrictions (see Fig. 10).

Fig. 10 NHSG Information Bus

Sustainability and Transformation Plan Engagement 2016/17 - IDEAS	Fit for the Future Engagement 2019 - POLICY

Cirencester Market Place (east) in February 2017	Outside Marks & Spencer in Cheltenham (east) town centre in August 2019

Fit for the Future Consultation 2020/21 - PROPOSALS

In 2021 Fit for the Future Consultation Bus visits were frequently cancelled and rearranged at short notice in response to changing COVID-19 restrictions

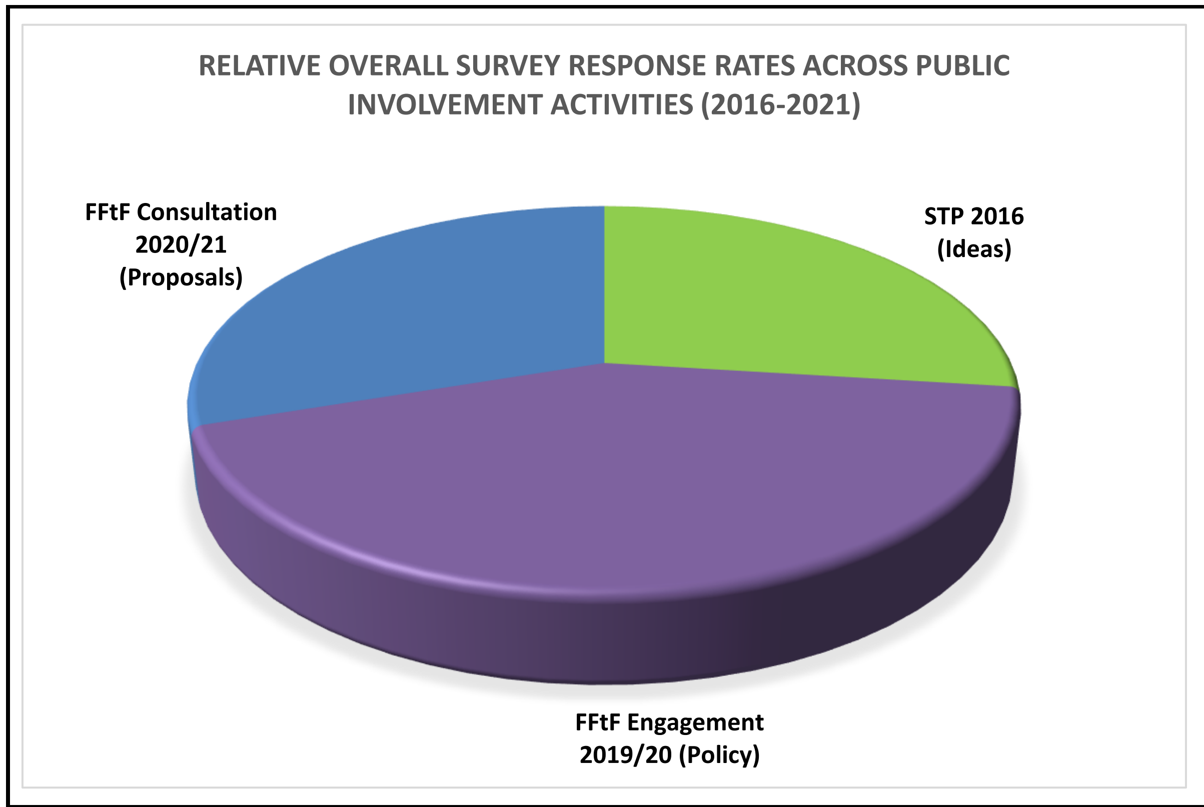
NHS staff on the Information Bus displaying FFtF material, with face masks and anti-bacterial gel in November 2021 at Chepstow Community Hospital (L) seeking views from people living across the border in Monmouthshire, Wales; and in December 2021 at Gloucester Quays (west) (R)

2.4.6 *Fluctuating Public Participation Rates during the Research Period*

The greatest level of public participation in the three case study conversations is recorded during the middle segment of the research period, during the FFtF engagement in 2019/20 (see Fig. 8). This period also shows a significant increase in participation from respondents from the east of the county. Participation during the

STP in 2016/17, and the FFtF consultation four years later, is more evenly distributed between east and west residents. It is worth noting that the percentage of responses with nil returns for demographics increases across the three stages (see Fig. 11).

Fig. 11 Survey participation across NHSG (2016-2021)[7]



The STP recorded 638 survey responses, with 44% from residents in the east of the county and 49% from the west of the county.95% of provided demographic information.

The FFtF engagement recorded 1013 survey responses. Of these, 61% were received from residents from the east of the county and 11% from the west; 26% of respondents chose not to provide any demographic information.

The FFtF consultation recorded 713 survey responses; 32% of respondents chose not to provide demographic information, 39% of respondents were residents from the East of the county, and 29% were residents from the West.

2.5 Primary Analysis

2.5.1 *Primary Quantitative Analysis*

Quantitative survey questions offer a choice for the respondent, using a Likert scale, to test level of agreement with early ideas for change, and subsequent proposals for

[7] NB – where percentages do not add up to 100, the missing responses are from people living outside Gloucestershire. There are always a few responses from one or more of Monmouthshire, South Gloucestershire, Oxfordshire, Herefordshire, Wiltshire, Worcestershire, and Warwickshire postcodes.

change, informed by feedback from the previous engagements. For instance, in case study 1, the STP survey questions invites respondents to focus on principles developed in the earlier Joining up your Care engagement in 2014. 69% of STP survey respondents agree with the principle most relevant to this thesis is: “We should bring some specialist hospital services together in one place” (NHS Gloucestershire, 2017). Respondents are also invited to choose from a list the most important thing for them if they need to see a specialist; 59% selected expertise whilst 8% selected distance to travel (see Appendix 1).

Below is an example from case study 3, the FFtF consultation, relating to the Acute Medicine proposal, showing results using a simple bar chart (see Fig. 12).

Fig. 12 Extract from FFtF ‘Output of Consultation’ Report

Please tell us what you think about our preferred option to develop: A ‘centre of excellence’ for Acute Medicine (Acute Medical Take) at Gloucestershire Royal Hospital.				
			Response Percent	**Response Total**
1	Strongly support		36.07%	215
2	Support		31.54%	188
3	Oppose		11.24%	67
4	Strongly oppose		13.59%	81
5	No opinion		7.55%	45
			answered	596
			skipped	28

As can be seen in Fig 12 above, overall there is a high level of support for this proposal in the quantitative data. As shown in Fig 13 below, this is reflected across all FFtF consultation proposals, with 60% or more support for all FFtF consultation proposal in both the east and the west. Further quantitative data can be found at Appendix 1.

Fig. 13 Quantitative data showing % level of support/opposition in the east and west to the three FFtF consultation change proposals and preference for site for Planned Lower GI Surgery

Proposal	Response from the east	Response from the west
Acute Medicine	Support: 60% Oppose: 33%	Support: 82% Oppose: 13%
Planned Lower GI Surgery at either CGH or GRH	Support: 81% Oppose: 7%	Support: 83% Oppose: 6%
Preferred site for Planned Lower GI Surgery	CGH: 60.5% GRH: 14% No opinion: 27%	CGH: 41% GRH: 29% No opinion: 30%
Planned Upper and Lower GI Day Case Surgery at CGH	Support: 76% Oppose: 7%	Support 75% Oppose: 10%

2.5.2 *Primary Qualitative Analysis*

Qualitative survey questions enable respondents to provide free-text feedback. Qualitative codes are added manually to each free-text comment received; multiple codes can be assigned to any comment. A list of frequently expected codes is created at the beginning of the process, with new codes added as new themes emerge from the data (Vaismoradi, et al, 2016). The primary analysis of the qualitative data uses the following codes to analyse the data (A-Z): Access; Capacity; Efficiency; Interdependency; Patient Experience; Quality; Resources; Transport; and Workforce. A good example of a new code added from 2020 onwards is COVID-19; this is only relevant to the FFtF Consultation.

All free-text comments are read, coded and illustrative quotes are highlighted to support presentation of the primary results. The example below shows representative quotations selected to illustrate specific themes, as reproduced in the FFtF 'Output of Consultation' report.

Supporting the proposal: 'Centralisation of this speciality will ensure that the clinicians with the right skills are always available. It will reduce risks to the public and reduce the need for potential transfer either to another facility or out of county' [Themes: Quality, Resources, Transport, Patient Experience].

Opposing the proposal: 'The preferred option would mean that people living in the east of Gloucestershire would have to travel further for urgent medical care' [Themes: Access, Transport].

The purpose of the primary analysis is not to draw conclusions or make recommendations. Its purpose is to provide data and analysis to support the conscious consideration of the response to the consultation, often alongside a business case, by the accountable decision-making organisation, in this case NHSG.

2.6 Secondary Analysis

The secondary analysis research design seeks to demonstrate reliability and validity, both internally and externally (Hsieh, et al, 2005; Mitchell, 1986). Given the nature of the research, a professional doctoral thesis, and my personal familiarity with the subject matter through my professional role and experience, I have considered at length my credibility and competence as the researcher, in particular relating to researcher bias (Delamont and Atkinson, 1995; Delamont, Atkinson and Pugsley, 2009; Hanson, 1994; Mannay, 2010) (see 2.2.).

I have taken a pragmatic approach as opposed to a positivist approach to maintain my own subjectivity in my reflections on the research and objectivity in the secondary data analysis (Shannon-Baker, 2015). This aligns better with the critical realist perspective, which posits that the positivist's perspective is only one way of knowing (Bryman, 2015).

The method used for gathering qualitative data for the primary and secondary analysis is rigorous. Survey questions are tested and independently assured prior to issue to the public (Bryman, 2016). Attention is paid to the validity and reliability of the data, and triangulation, or cross-case analysis of results is carefully undertaken (Patton, 1999, Vaismoradi, et al, 2016).

I have observed that those respondents more likely to oppose the proposals are also more likely to provide qualitative feedback.

2.6.1 *Framework Analysis*

The research uses a thematic framework analysis methodology (Attride-Stirling, 2001; Miles and Hubermann, 1994) to undertake a secondary analysis of data presented in three case studies. The analytical framework selected is Le Grand's models four models for organising public services (Le Grand 2007) (see 1.3.3).

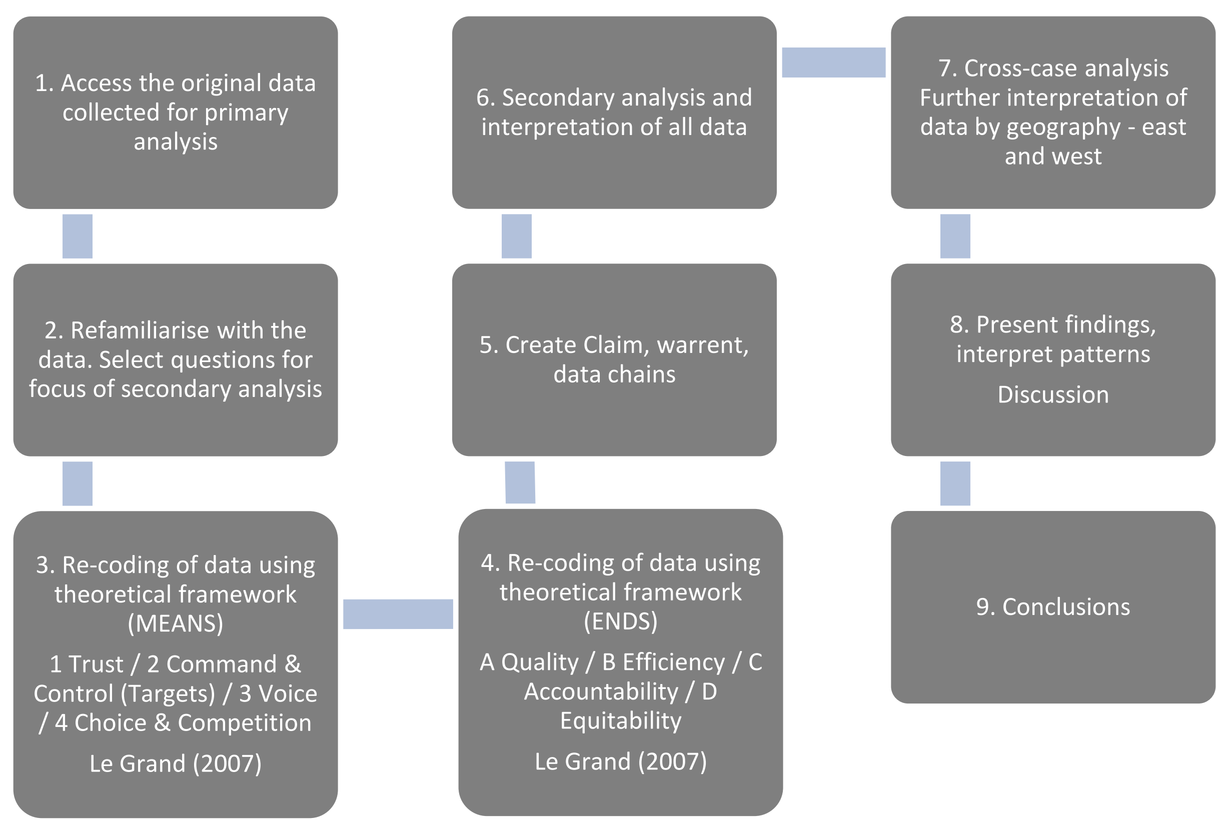
Having identified the two political speeches as context for the thesis (see 1.7.2) I considered using discourse analysis (DA) as an alternative analytical methodology. DA offers the potential to challenge thinking about aspects of the reality of health and health care practice (Cheek, 2004) by applying a mechanistic approach to

considering the content of a piece of qualitative data. Reading texts and listing the frequency of the use of key words or phrases within the text, comparing this to other texts and drawing conclusions would then be based on what would be a quantitative rather than qualitative exercise.

Given the nature of the case study data being thousands of individual qualitative quotations from several hundred individuals' responses to a number of survey questions, instead I selected the interpretative approach framework analysis offers. I selected this approach to maximise the dependability of the analysis and discussion to draw my conclusions (Curtin and Fossey, 2007). The rigorous nature of this method ensures that as the researcher I can be part of the interpretative process (Galdas, 2017).

I use a 9-point framework analysis process to identify themes or higher-order claims which can be both specific, i.e. not too repetitive, and broad enough to be seen across multiple data sets (see Fig. 14).

Fig. 14 Nine-point Framework Analysis Process



I systematically process the data to select qualitative survey responses to illustrate the analysis, discussion and interpretation, as illustrated in Fig. 15. (Attride-Stirling, 2001).

2.6.1.1 The Framework selected

As previously stated, the theoretical framework I selected from the literature to provide the underpinning structure for the analysis presented in this thesis is Le Grand's (2007) four models for organising public services: trust, command & control, voice and choice & competition (see 1.2.3). I chose to use this framework for several reasons. As previously noted, I first became aware of the influence of Le Grand's work on contemporary policy makers in the 2000s whilst studying from my MSc in Healthcare Policy and Management at the Health Service Management Centre, University of Birmingham. I used Le Grand's models, in particular 'choice', to support the discussion in my Masters dissertation, in which I considered patients' appetite for switching GP practice registration.

Le Grand's work actively influences the national and local healthcare policy setting which is the backdrop to this thesis. As an advisor to the Blair Governments; which passed the legislation for big 'D' devolution; he promoted policies which sought to increase patient choice through decentralisation creating the opportunity for localisation in small 'd' healthcare service commissioning geographical areas, such as Gloucestershire.

2.6.1.2 Secondary Coding Process

The secondary coding of the data uses the elements and attributes of Le Grand's models, providing opportunities to bring the results to light through recognising the different models' characteristics within the data (see 1.3.3) as well as highlighting any similarities and differences between the data attributed to each of the models (see Fig. 15 and Fig. 16). The contrast between the models is not only practical in terms of considering the appetite amongst patients for choice in healthcare and the divergent experience expressed through voice, but also the fluctuations in trust in potential changes to the way health services are provided and the relevance of efficiency achieved through command & control (targets). Data are deliberately coded to the voice model when respondents draw upon personal experience of existing service configuration to inform their views.

Fig, 15 Coding Framework using Le Grand's four models (2007)

MEANS: How do we get a good service?			
Trust	Command & Control	Voice	Choice & Competition
Code 1	Code 2	Code 3	Code 4
ENDS: What is a good service?			
Quality 'excellence'	Efficient	Responsive Accountable	Equitable
Code A	Code B	Code C	Code D

Fig. 16 Four-step Data Selection Process

Step 1	Step 2	Step 3	Step 4
Qualitative survey responses colour coded for Le Grand 'frames': trust, command & control (including political influence), voice and choice	Responses separated into 'frames'	Each set of 'framed' responses, in this case choice, sorted into categories e.g. qualitative responses relating to CoEs	Data designated by residency in east or west of Gloucestershire

2.6.1.1 Cross-case analysis and triangulation of results

Finally, I undertook cross-case analysis (see Fig. 16), stratifying the analysis by geography (i.e. responses from either the east or west of the county) to identify any similarities or differences between respondents based on their stated postcode. As stated above, the M5 motorway runs between the two major conurbations of Cheltenham and Gloucester. The M5 is the division used for the analysis in this paper, for east and west, with postcodes in the Stroud and some Tewkesbury District Council areas effectively neutral territory, due to the motorway bisecting those areas.

By isolating the results from the east and the west I was able to look for repeating themes such as 'accessibility' in responses from both halves of the county. I was able to triangulate the data by comparing the east/west results for 'accessibility' with the results for 'accessibility' in the data coded to each Le Grand model; for examples in the case of 'accessibility' it features in the results for three of the four models: command & control (targets), voice and choice.

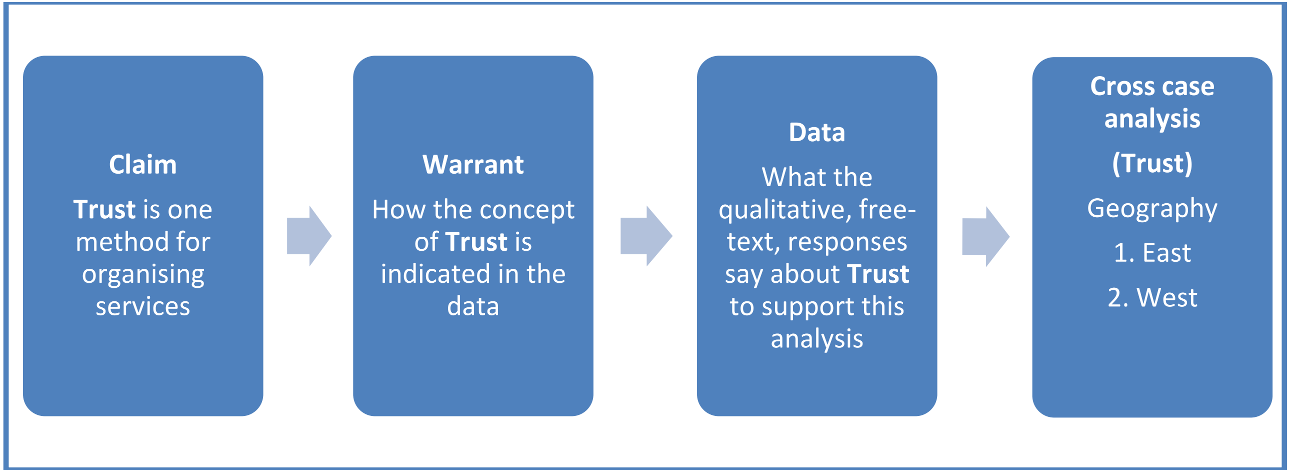
2.6.1.2 Claim, Warrant, Data Chain Schematics

Thematic network illustrations or claim, warrant, data chains (Toulmin, 1958) are used to unravel the complexity of the textual data to present systematic visual summaries of the main findings or themes. The higher-order claims arising from the data, capture the nature, meaning and essence of the data, thereby making sense of others' sense-making, using more than intuition (Attride-Stirling, 2001).

Toulmin's model of argumentation identifies three elements present in any argument: 'claims', 'warrants', and 'data' (or 'grounds') (Karbach, 1987; Toulmin, 1958). The Toulmin method helps the researcher to evaluate how several parts make up the whole of an argument, through a linear step-by-step process in which ideas build from each other. This process is illustrated in this thesis using a series of figures, created to support the interpretation of the data. Such thematic networks, in this case chains, are not analysis in themselves; they are tools used for illustrative purpose, to create non-hierarchical visual representations to support the detailed analysis (Attride-Stirling, 2001). The Toulmin (1958) method helps the researcher, not only to present their argument, but also to identify and admit any weaknesses in an argument, thereby creating an opportunity to challenge or strengthen the argument.

A 'claim' is the intent of the argument. What is it that I want to prove, or ask the reader to accept? The 'data' or grounds is the evidence to support the argument or 'claim'. What evidence do I have to prove the argument to the reader? There are four types of claims: claims of fact; claims of value; claims of rules (or policy); claims of definition. The types of claims used in the analysis which follows are value - and rules-based. A 'claim' is the aspect of Le Grand's models I have identified in the data; the 'warrant' is the analysis that links the claim to the data; the 'data' is the collection of qualitative survey responses or descriptive quotes. Fig. 17 shows the claim, warrant, data chain process using Le Grand's first model, 'trust'.

Fig. 17 Example Claim, Warrant, Data Chain, Cross-case Analysis Process



2.6.1.3 Interpretation of the Data

The final part of the process is to interpret the key findings coming from the qualitative data (Attride-Stirling, 2001). A challenge, across the three case studies analysed in this research, is the repetitive nature of much of the data. This will be addressed further in Chapter Four.

The key findings are then triangulated with relevant scholarly commentary identified within the literature. This has been shown to be applicable to a wide range of qualitative approaches; although time-consuming, it provides a structure to analysing the data which increases validity (Gale et al., 2013; Maxwell, 1992). These findings will form part of the discussion in Chapter Four.

2.7 Chapter Summary

This chapter started with the consideration of researcher familiarity i.e. my position in relation to the subject of the research. It noted that I am an 'insider' in that I live and work in the healthcare system, Gloucestershire, which is the locus of the case studies. It recognised that I was also responsible for the collection of the data analysed in this thesis and undertook the primary analysis of it in my professional capacity. However, it is made clear that I have sought to take a pragmatic approach to achieve objectivity in the analysis of the data and the identification of findings and learning.

Next the Gloucestershire case studies, spanning the five years evolution of the CoE policy and the FFtF programme, are introduced: IDEAS: STP Engagement (2016/17); POLICY: FFtF Engagement (2019) and PROPOSALS: FFtF Consultation (2020).

The remainder of the chapter focussed on the generation of the case study data including survey development, marketing and collection. Some challenges with the data collection not least fluctuations in response rates and obligations associated with Covid 19 restrictions in 2020 are shared. The process of the primary analysis of the data is briefly summarised before the remainder of the chapter presented the detail of the secondary analysis research design. The nine-point framework analysis, including cross-case analysis which uses Le Grand's four models for organising good public services was set out. The chapter concluded with an example of a claim, warrant, data chain, the methodology used to represent the framework analysis of the data visually. Many chains are to be found in the next chapter and supporting appendices.

3 Results and Analysis

3.1 Chapter Structure

Each of the selected case studies provides a significant amount of data for analysis, with repeating observations across each of the models in the framework, both within case studies and between case studies Therefore, in this chapter the priority findings are introduced first followed by more detailed presentations and analysis of the results. Two of Le Grand's models: voice and choice & competition are the key focus of the analysis, interpretation and discussion. Therefore, these are also the focus of the presentation of results and analysis in this chapter.

The voice and choice & competition headline findings are followed by detailed presentations of the data, including analysis, completed with summaries of findings for both models. However, where findings from the analysis of data relating to the other two models: trust and command & control (targets) are relevant to the later discussion, selected extracts from their full results and analysis are included. Such inclusion relates particularly to one of the trust findings and to some data relating to the political element of the command & control data. Full presentations of trust and command & control (targets) results and analysis can be found at Appendix 4.

It is important to note here that the themes identified in the qualitative data considered in this chapter only reflect the views of the individuals who chose to provide qualifying data in addition to a support/oppose rating response. As shown previously there was more than 60% support for all IDEAS, POLICY and PROPOSALS (see 2.5).

3.1.1 *Use of Le Grand's Framework*

As stated above, there are several parallels in the findings between the data coded into each of Le Grand's four models. This suggests that utilising the models to differentiate between and analyse the qualitatively expressed views of respondents to a series of surveys, or participation in a citizen's jury, is not an exact science. Le Grand is an economist, his models fit into a scientific approach to analysis. This thesis sits within the social science paradigm. However, as Le Grand acknowledges, although his preferred model is choice & competition, elements and attributes of all the models combine to make the best public services. By the same token, the findings of the analysis of the data across all four models using Le Grand's framework also combine into priority findings which have informed the learning for practice, policy and future research.

3.1.1.1 Adapting Le Grand's Framework

With respect to Le Grand's 'voice' model, which relies on service users influencing change in public services, is stated previously the rational I apply for coding focusses on personal experience being recorded in the data. If this adapted approach had not been taken in theory all the data from all three case studies could have been coded to voice due to method of collection i.e. general public surveys; and individuals' motivation to participate in the engagements and consultation. I also adjusted Le Grand's application of the 'choice' model to suit the choices available in the three case studies, which relate to choice of location for a service within Gloucestershire rather than the NHS Constitutional (see1.10.2) choice of NHS service provider.

3.2 Priority Findings

There are four priority findings which feature across the analysis and cross-case analysis of the data in more than one of Le Grand's (2007) models. The priority findings are set out below.

3.2.1 *Communicate to Increase Understanding and Trust*

This finding is attributed to the trust data, but it is also linked to the voice data and is associated with the second priority finding below relating to public involvement. Improvements and augmentations to communications suggested by the data include providing information about existing services and how to access them. It is clear from the interpretation of the data that accurate public understanding of current healthcare provision should not be taken for granted. Also featuring in the data is the advice to be clear that proposals for change are not necessarily predicated on saving money. This assumption is made by several respondents in the case studies; despite a very strong identification with the expectation of benefits through efficiency in public services seen in the command & control (targets) data. The qualified observations made by Jurors following the extended and concentrated opportunities provided to them; to receive, challenge and debate information provided, demonstrates tangibly the value of communicating to increase understanding and trust.

3.2.2 *Involve People and Communities in Policy and Service Design, Undertake Good Quality Engagement and Consultation and Listen to What People Say*

The fact that the case studies exist proves that this finding is already a priority. Without the voices of people and all communities across Gloucestershire, including those referred to as underserved in both east and west, being heard in shaping

ideas, policy and proposals for changes to specialist hospital services, there would be no data to analyse and interpret in this thesis.

The identification of findings in the voice data to improve practice for engagement and communications professionals such as myself underlines the value in itself of this activity. Identification of all findings in this thesis is made possible by people and communities getting involved over several years and the health and care system partners facilitating opportunities for them to get involved and listening to the outputs of those activities to inform their decision making.

3.2.3 *Accessibility, Accessibility, Accessibility*

Concerns about access to services is a key trait in the data across all three case studies. Accessibility features prominently as a theme in command & control, voice and choice data.

In terms of the voice data, the personal experiences expressed concern not only to the practical consideration of travel from A to B. Firstly there is the inconvenience of potentially having to travel further from home to access a specialist service, whether that in one's own vehicle or using public transport and the associated increased monetary costs. Secondly there is the perception that increased distance to travel could impact negatively on clinical outcomes.

Finally, a finding associated with theme of accessibility; which occurs in both the politics element of the command & control data and the choice data; is the suggestion to build a new hospital halfway between Gloucester and Cheltenham, along the axis of the 'hard grey tarmac' (see 1.9.1) thereby extending travel distance for more people but removing the need for comparisons between the relative ease of access to the two hospitals.

3.2.4 *Some Evidence of Divided Communities*

The cross-case analysis findings show there is not as much divergence between the views of people and communities in the east and west of Gloucestershire as anticipated; with two notable exceptions.

First, in the trust data the level of trust in the One Gloucestershire NHS system's FFtF programme diminishes more noticeably in the east across the trajectory of the three case studies; where the data from the east become more partisan as more people feel more services are likely to relocate to GRH in the west and they wish to

register their objection to this. The perceived downgrading of CGH also increases in the east.

Secondly, in the choice data relating to accessibility, there is noticeable difference in some attitudes between the east and the west with respect to a reasonable distance to travel to access a specialist health service. Eastern respondents in some cases are unconvinced by the suggestion that GRH is not far away, whereas a number of respondents from the west acknowledge that an extra 7 miles to travel to CGH is not a long way. Also there are examples of justifications for services to be retained in one hospital or another, more frequently at Cheltenham, because of either an increasing population or referencing earlier choices individuals have made to live in an area with a hospital providing specialist services based upon assumptions that the *status quo* in terms of the range of specialist hospital services provided would be maintained into the future.

3.3 Generalisability of the findings

The type of services focussed on in this thesis are publicly funded hospital based healthcare in England; specifically in Gloucestershire; which has an unusual configuration of two medium sized acute hospitals, located less than 10 miles apart, managed by the same NHS Foundation Trust. Even more specifically it focusses on three specialist services: acute medicine, planned lower gastro-intestinal surgery and planned day case upper and lower gastro-intestinal surgery. Therefore, it is reasonable to consider in the Discussion chapter (see 4) whether these variables influence the results and how generalisable the findings are to both the wider NHS practice and policy and other publicly funded and organised services.

Details of all findings are presented in this chapter and associated appendices (see 7.3 and 7.4) and are considered in the Discussion chapter (see 4), informing learning for practice, policy and future research.

3.4 Voice

Two of Le Grand's (2007) models take precedence in the title of this thesis: Informed Choice or Informed Voice? Therefore, it is appropriate that the results and analysis of the data relating to these two models are presented first and in full in this chapter.

In this section, the data coded as 'voice' are presented using a series of chronological claim, warrant, data chains. Key themes are identified and interpreted, illustrated by representative quotations selected from the data from both east and west, or from one side of the county as required to reflect the response to the IDEAS, POLICY or PROPOSALS. Voice headline findings are briefly summarised below.

3.4.1.1 Voice Priority Findings

'Voice' has been the most difficult model to code for in the data across the three case studies, simply because – due to the nature of the data being all free-text quotations from public feedback – in theory it could all be coded as 'voice'. Therefore, I have identified sub-themes within a pre-defined universal 'voice'. The approach taken to the selection here is to look for personal experiences in the data, e.g. attending one of the hospitals for an appointment, and for comments about the ease of expressing views. As with preceding models. there are recurring themes across the three case studies.

Accessibility, Accessibility, Accessibility!

Accessibility is a recurring aspect of the voice data across all case studies.

Involve People and Communities in Policy and Service Design and Listen to What People and Communities Say

Data from both the FFtF engagement and the Citizens' Juries stress the importance of involving the voices of people and communities. The data also reflect individuals' perspectives on the quality and validity of the engagement and consultation activity.

3.4.1.2 Other Voice Findings

Bring Back Cheltenham A&E Department

Calls to bring back CGH A&E start in 2016/17 with the STP engagement and continue through to the FFtF consultation in 2021.

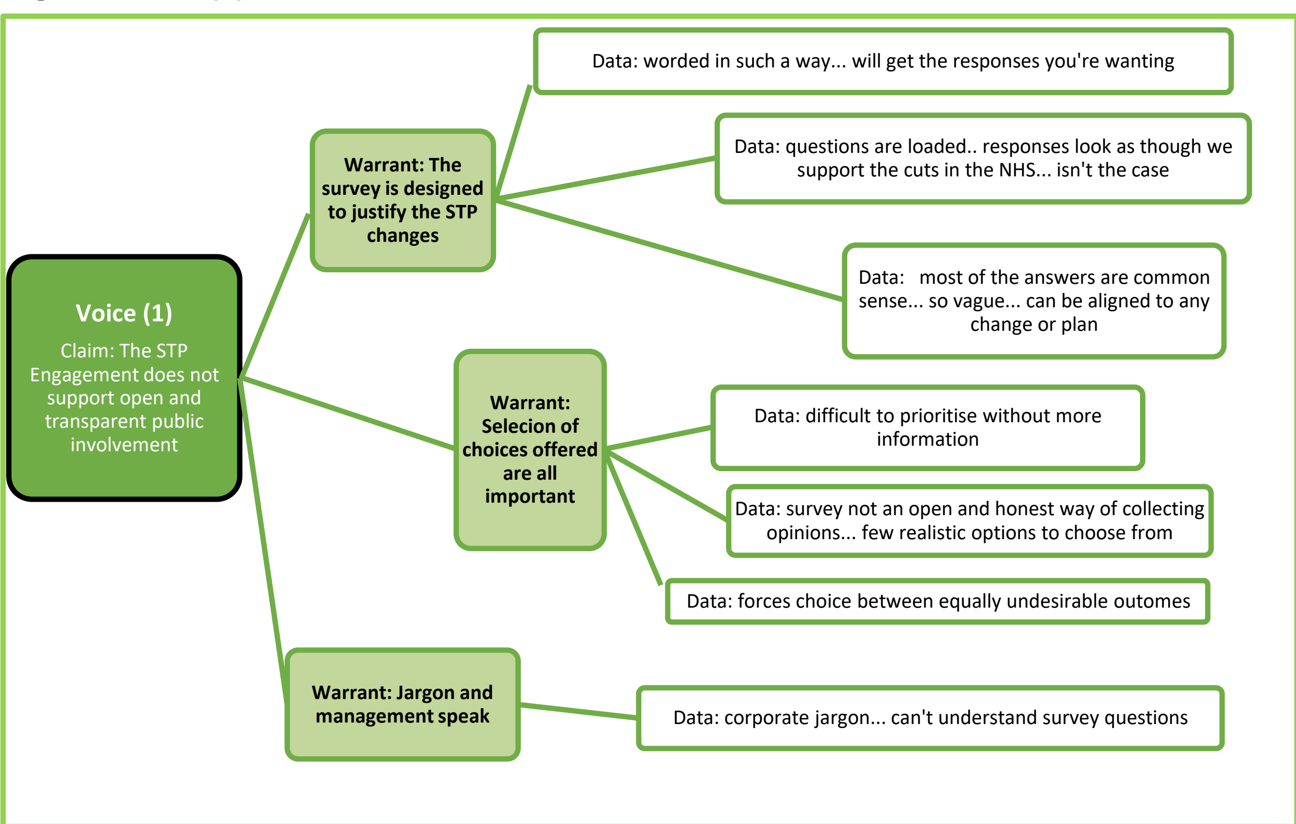
Personal Responsibility and Blame

In both the STP and the FFtF engagements, respondents are keen to stress the importance of health-promoting activities and healthy lifestyles.

3.4.2 *Voice IDEAS – Case Study 1: STP*

In considering Le Grand's voice model, I have identified in the STP response data two claims. The first claim is that the STP engagement, and specifically the engagement survey used to collect responses, does not support open and transparent public involvement (see Fig. 18). The second is that, based on their personal experience of services, respondents to the survey either supported the STP's principles for organising services to meet the challenge of delivering healthcare in the future, or offered alternative suggestions (see Fig. 19).

Fig. 18 Voice (1) Chain: IDEAS 1



The first warrant relates specifically to the view that the survey has been designed to produce a preferred response; a criticism frequently levelled from both sides of the county is that the questions are leading the respondent in a direction preferred by NHSG.

> 'Very loaded questions here which seem to suggest centralisation of services'. [East]
>
> 'I feel it is worded in such a way that you will get the responses you're wanting and then when people complain you will say "this is what you said you wanted"'. [West]

The second warrant is that the selection of choices offered are difficult to prioritise without more context, provided either by the system or personal circumstances.

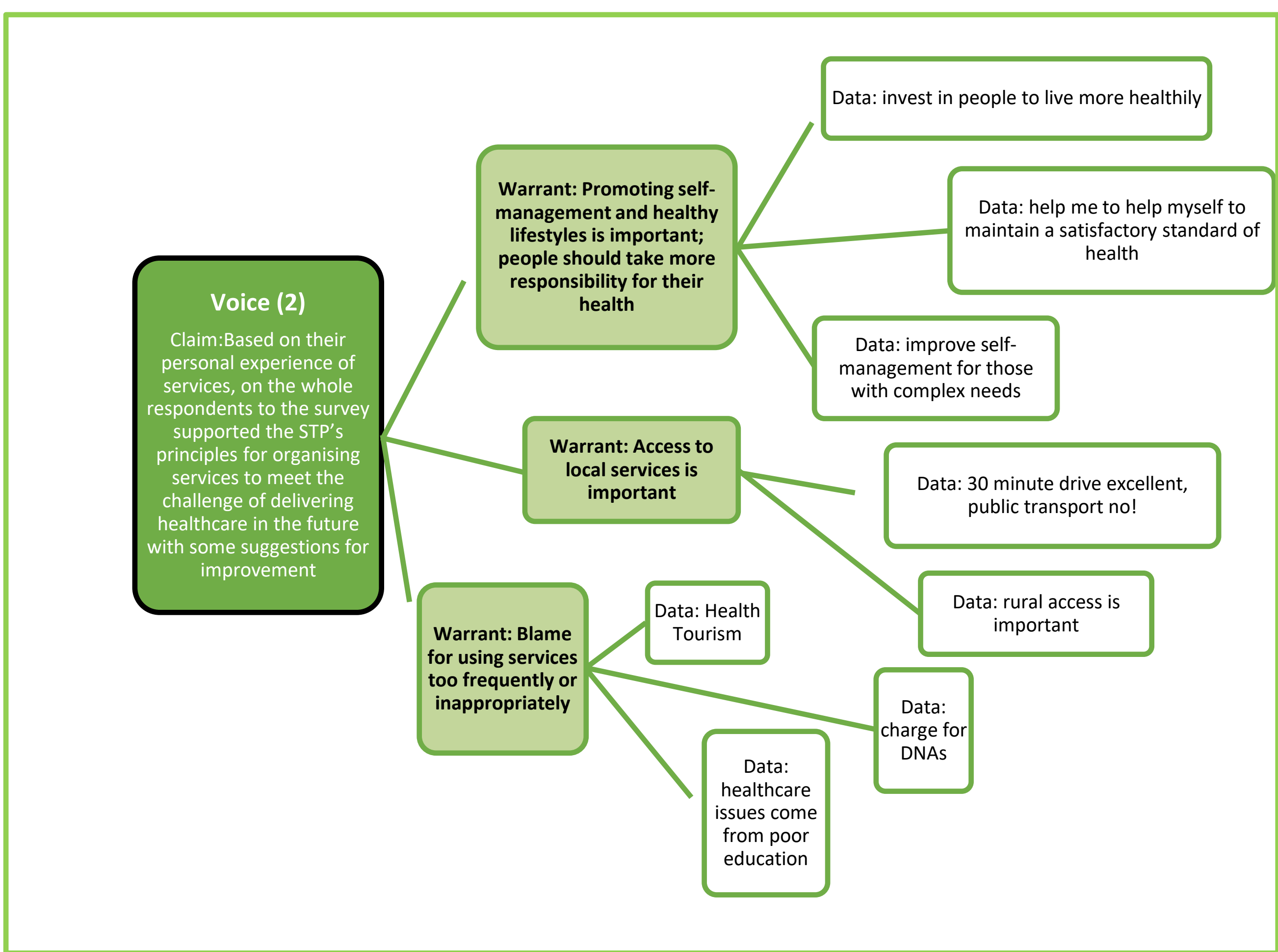
> ‘This survey is not an honest or open way of collecting opinions as very few of the choices offered show realistic options from which to choose – for example opting for more resources in one area does not say which areas would lose out’. [East]
>
> ‘This questionnaire is shocking in making people respond to a number of questions that force them into making choices between equally undesirable outcomes’. [West]
>
> ‘This is impossible to prioritise; of course we do not want a long wait for an appointment. Distance might be a problem if one is unable to drive and local transport is not available. One would expect to see an “expert” in the required field; why would you see someone who is not an expert?’ [East]
>
> ‘It was difficult to make just one choice as to preferences for services – e.g. re emergency care, where 7 day a week accessibility, but also appropriate skills of staff etc!’ [West]

The final warrant in the Voice (1) section is that the survey uses jargon and management speak. The inference from the extracts from the west below is that this is a deliberate action to confuse potential respondents.

> ‘Cut the corporate jargon so that people fully understand such survey questions!’ [West]
>
> ‘Some of the language is “management speak” and needs to be in plain English (long version) to avoid the impression that things could be being hidden’. [West]

This group of data suggest that participants feel that the opportunity to engage with the conversation about ideas is mis-sold; their view is that the true purpose of the engagement is affirmation of the NHSG ideas rather than a public discussion to shape ideas.

Fig. 19 Voice (2) Chain: IDEAS 1



The VOICE 2 Claim is that based on their Personal Experience of Services, on the whole Respondents to the Survey Supported the STP's Principles for Organising Services, with Some Suggestions for Improvement. The first warrant providing the analysis linking the claim to the data is that promoting the idea that self-management, and healthy lifestyles, are important echoing priorities set out in the NHS Long Term Plan (NHS England, 2019). The data from both sides of the county suggest that people should take more responsibility for their health, and that clinicians should trust patients to take responsibility for their health. In this warrant the ideas support positive public health promotion, and patient self-management principles8.

> 'I am generally in favour of investing in helping people to live more healthily and look after themselves and their families and friends more effectively. If this results in less demand for some services, then I have

[8] NHS England define 'supported self-management' as 'the ways that health and care services encourage, support and empower people to manage their ongoing physical and mental health conditions themselves' (NHS England, 2023).

> no objection to those services being reduced. However, if people live healthier lives and live longer, they are likely to develop more serious and more complex conditions as they get older, so the need for acute services may not be reduced by helping people to live longer'. [East]

> 'I think the plan of empowering the public is great; however, this is a massive culture change that is being embarked upon and there are plenty of people who just don't look after themselves and therefore health promotion would fail. In essence a good proportion of our healthcare issue comes from poor education and poor legislation over food products. Therefore, awareness and health promotion need to be targeted accordingly to deal with the future schools, academies, university and colleges as well as in other areas to try to improve outcomes'. [West]

The respondent above from the east makes a very interesting point about the future impact of people living healthier lives, living longer but still needing acute specialist services towards the end of their lives; thereby not reducing the need for services, only postponing it.

The next warrant is that access to local services is important. The debate about what is a 'local' service is at the heart of this thesis. Earlier, when considering the targets data, 'Accessibility, Accessibility, Accessibility' was a refrain. Below are countywide examples of how respondents' personal experiences inform their views on this matter. The cost and availability of public transport is identified as a barrier by other respondents.

> 'I have resorted at times to private treatment and self-education to take more responsibility for my own health, which has saved the NHS some money, but it is too expensive for me to rely on for all my healthcare needs. Even the "free at the point of use" NHS incurs costs in travelling to obtain it at the increasingly centralised hospitals'. [East]

> 'To have centres within a radius of a 30-minute drive is excellent – by car yes, public transport no!' [West]

There is a second group of data on the theme of access, relating to historical changes to the configuration of specialist services in Gloucestershire (see 1.9.4). Most comments are about services offered at CGH A&E, compared to the GRH A&E service eight miles away (see 1.9.5). There is a commonly held view that an overnight service provided by nurses is not an A&E service.

> 'Bring back the full 24 hour A&E service at Cheltenham General!' [East]

> 'Cheltenham General Hospital should have its A&E service restored to 24 hours a day rather than the current cut-off time. This just puts more pressure on Gloucestershire Royal'. [East]

> ‘Support Cheltenham A&E in a 24 hour service, or give it its own funding and not use it to support Gloucester at the expense of Cheltenham’. [East]

The next warrant is about criticising people who use services too frequently, or inappropriately, and blaming people who respondents perceive do not take responsibility for their own health. These views are equally distributed across east and west. Firstly, the data criticise individuals who do not attend appointments, for inappropriate use of services. Others are blamed for self-inflicted harm; for which it is suggested individuals could be charged a fee. Finally there is a reference to the concept of ‘health tourism’, a concern for which goes beyond the borders of Gloucestershire.

> ‘Specialist care should be prioritised for patients that have urgent and emergency need. Patients attending appointments and ED [emergency department] unnecessarily should be charged, and also charged for DNAs [Did not attend] (to avoid wasting clinicians time)’. [East]

> ‘People should not remain in hospital when treatment is completed, and enable our emergency services to be used for the correct people. Alcohol or drug injuries need to be addressed by payment, especially at weekends’. [East]

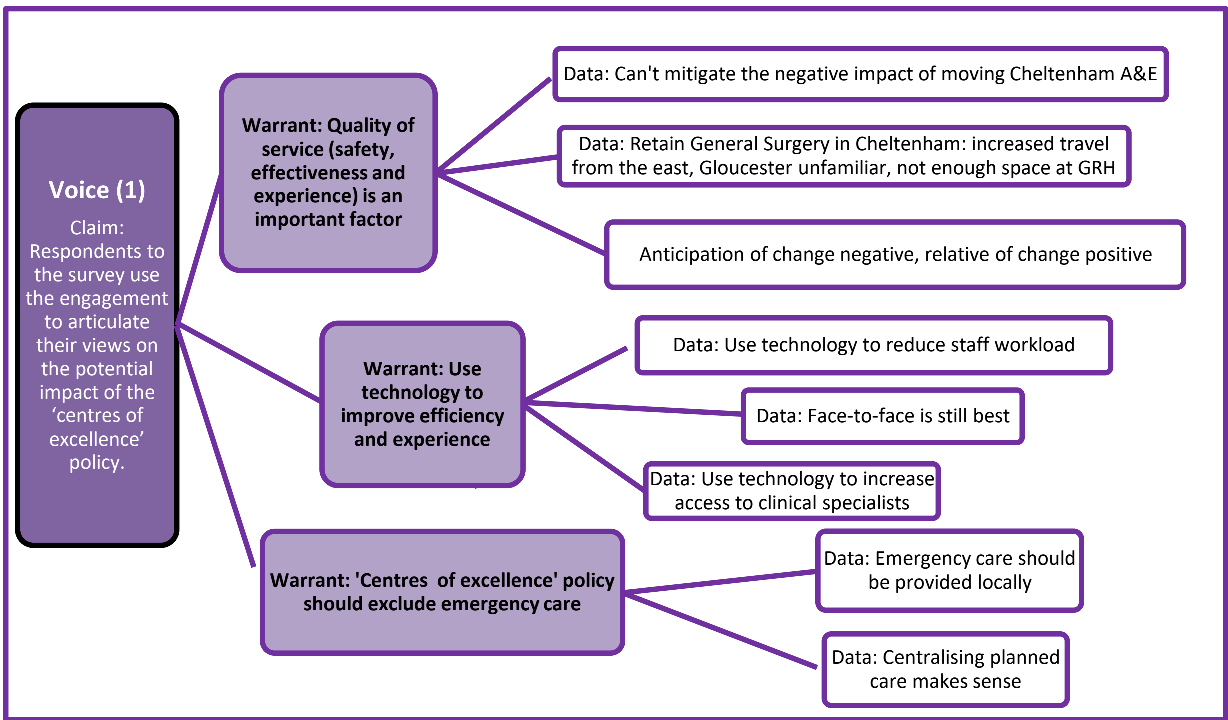
> ‘A&E services should be available 24/7 in ALL Glos hospitals. A rigorous system for combatting “Health Tourism” should be put in place in every Glos hospital – and throughout the UK for that matter.’ [West]

Regarding the comment about ‘remaining in hospital’ post-treatment; leaving hospital in a timely way might not be in the gift of the patient. Delayed discharges occur for numerous reasons, not least insufficient resources in the community to support people to return home following an inpatient stay.

3.4.3 *Voice POLICY – Case Study 2: FFtF Engagement 2019/20*

Two ‘voice claims’ emerge from the FFtF engagement data. The first claim relates to specific feedback about the impact of the CoE policy. Respondents were invited to comment on any potential negative impacts of the policy, on them or their families, and how these could be mitigated (see Fig, 20). The second claim is that feedback is influenced by individual’s experiences and perceptions about other people’s behaviour (see Fig. 21).

Fig. 20 Voice (1) Chain: POLICY 2



The first warrant is the quality of service, defined by the NHS in England by three aspects – safety, effectiveness, and experience (Department of Health, 2008) – and an important factor in policy development. Once again, the status of CGH A&E department shows up in the data; along with the impact on the safety of people from the east of the county because of any attempt to reduce the service provided in Cheltenham.

> 'I can't see how you can mitigate the impact of moving Cheltenham's A&E department and to suggest you can without impacting the safety of the local population is just fanciful'. [East]

However, there is a rare comment from a resident from the east, who having read about the CoE policy in the engagement materials, has revised their view.

> I was like many other people, keen for Cheltenham to maintain its emergency department just because of distances for access, but your excellent engagement booklet has persuaded me otherwise. I think it is the way forward - now!' [East]

The quote selected below from the east implies that for some there is a fear of change, whereas the reality may be more positive.

> I think that if the changes are a big improvement on the service somebody already receives, there will probably be less [sic] complaints about them. The problem will be if the service is just as poor, or even worse. For example, with my eye clinic appointments, I often have to wait an hour. If the service moved, but the appointment was on time

> (more or less), it would be such an improvement that I wouldn't really want to complain'. [East]

The comment below justifies the desire to retain General Surgery in Cheltenham, to avoid increased travel for patients from the east to an unfamiliar hospital in Gloucester; it suggests they have a poorer experience accessing services at GRH.

> 'Keeping general surgery in Cheltenham is also important. I had 4 stays in Cheltenham General in the last 3 years, including 3 operations. The standard of care was excellent, I could attend clinics on the bus, my family could visit on the bus and in reasonable time and I felt that it was within reach. When I had to attend a clinic in Gloucester it was hard to get to, parking was tricky, the hospital was unfamiliar and it took me a great deal longer to get there. It was a relief to have to go to Cheltenham after that'. [East]

The second warrant is the suggestion from both sides of the county to make more use of technology to improve efficiency and experience, whilst retaining the option of face-to-face clinical consultations.

> 'Do we need nurses and doctors spending hours sitting at computer, can you not invest in new technology where the staff have Dictaphones that can be plugged into computer and this info is downloaded. I am well aware record keeping is very important. I would like to add that current staff are incredible; no criticism of them at all'. [West]

> '… use improved audio/visual communications to make both centres operate as one. Highly technical operations are being trialled by experts based hundreds of miles away. Just giving all doctors smartphones and using readily available video chat would make one super expert available across the whole county, even into Cirencester, Tewksbury etc'. [East]

Without referring to it specifically, the idea of a 'super expert' suggested in the data above aligns very closely with the CoE vision (see 1.9.5). This extension of the concept is something the local NHS could consider when developing detailed implementation plans.

The final warrant in this chain is that the CoE Policy should exclude emergency care.

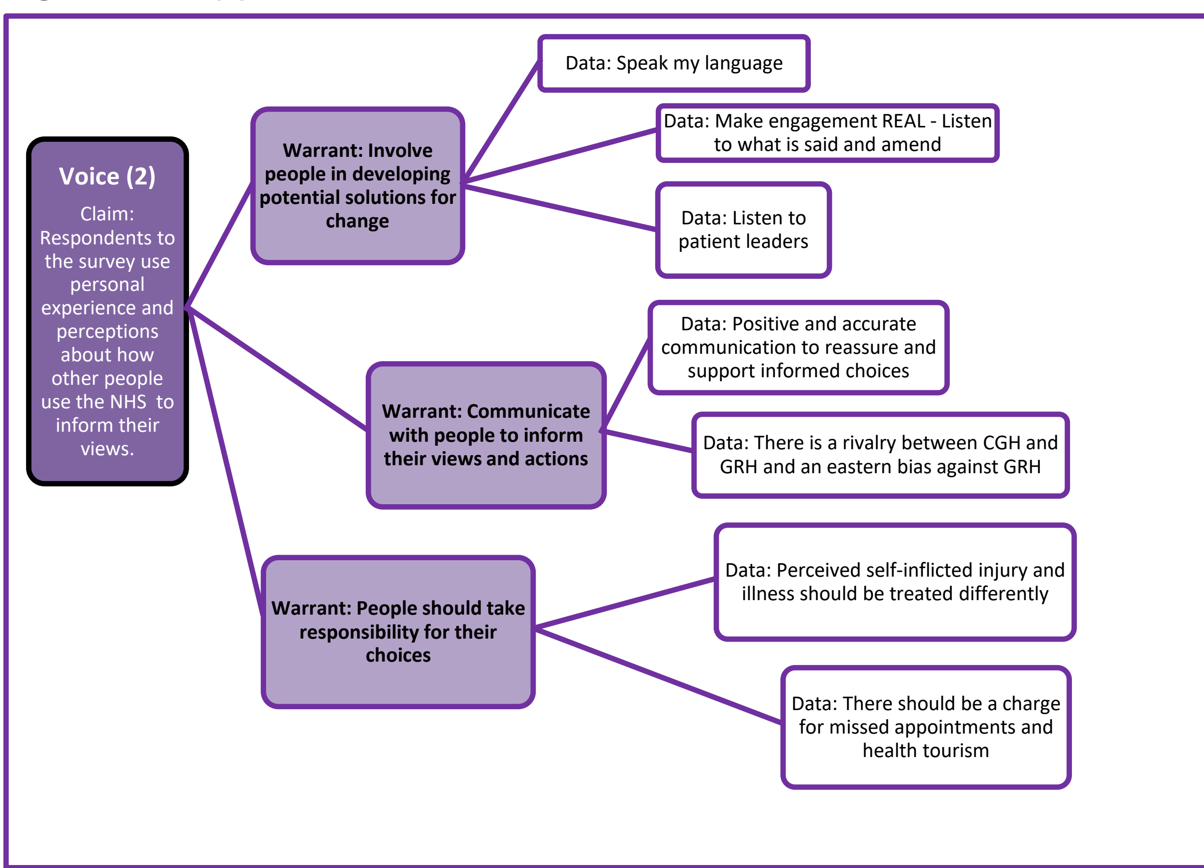
> 'Your question pre-supposes that there are substantial problems with the current arrangements. That has still to be demonstrated sufficiently for me to see the need for change in A&E. I have no issues with the plan to have areas of specialism in each hospital to avoid duplication; that works, and has the potential to be more efficient, but not in urgent services where speed is of the essence'. [East]

> 'There is a difference between a centre of excellence where the treatment is planned (such as attending a specialist heart unit for a planned operation) and genuine emergency care. For the latter, this

draws heavily on dependents, partners etc. and is usually a very highly stressed scenario. Having an A&E in the immediate location is better than having to travel further afield'. [East]

Explicitly, emergency care should be provided locally, but centralising planned care makes sense. All the responses above selected from the east are comfortable with the idea of centralising planned care; the location for which would be the CoE closest to them – CGH. The first respondent makes the point that the *status quo*, for the CGH A&E, is an overlooked option. Interestingly, as stated before, *status quo* is exactly the NHSG position with respect to the CGH A&E – this respondent is proposing a solution for a probem that in reality does not exist. The theme of information, misinformation, understanding, and misunderstanding is explored further in Chapter Four.

Fig. 21 Voice (2) Chain: POLICY 2



The Voice (2) claim is that respondents use their personal experiences of local health and their perceptions about how other people use the NHS to inform their views (see Fig. 21).

Unlike the earlier warrant, which implies engagement is a waste of resources, the first warrant here endorses the involvement of people in developing potential

solutions for change. The data encapsulate the voice model and make suggestions for improving the efficacy and impact of participation. The first piece of advice, which comes predominantly from respondents from the west, is to focus on the language used.

> '…ensure that all ethnic groups and disabilities are consulted. Literature provided in their own communication method'. [East]

> 'Being actively listened to. Communication using my language. See me as a person, not a label, not an issue and not a number'. [West]

The second suggestion is making engagement real by actively listening and reacting to what is said.

> 'Be prepared to amend your plans in response to feedback if your plans get a stronger than expected reaction'. [East]

The two responses from the east below suggest a method for NHSG to listen and learn more effectively from voices, by creating dedicated roles for selected individuals with lived experience of health services, whose role it would be to interpret from the data what matters to patients.

> 'Other hospitals have found that having a Patient Director is very helpful. Patients then have a dedicated place where they can go to find out more information or to explain when things don't work for them'. [East]

> 'It would be helpful if there were a dedicated team of patient partners looking at things like letters and other communications surrounding these changes. Often what staff think a letter says is not how the patients see it, or understand it'. [East]

The second warrant is an enabler for the first. The data suggest that the provision of good quality information enables informed voices. The term 'informed choice' is often used in relation to an individual patient's decisions about treatment; for example, a patient will be provided with patient literature about a surgical procedure, to read prior to them being asked to give informed consent for an operation to be undertaken. I have never heard the term 'informed voice' used in the context of involving people and communities. Using Le Grand's economic terminology, it could be a desired 'end', or outcome, for which communications and engagement plans are the means, or mechanism. This respondent from the west shares the idea of promoting positive and accurate communications, to provide reassurance to the public, and to support informed choices.

> 'The NHS is changing; most of us see the bad news of hospitals closing, wards being left unused, and lack of nurses and doctors. Of course we get worried. Publicise good news relating to the NHS, as there must be some. Please make it clear where we go and for what and what to expect'. [West]

This respondent from the east offers a communications-based solution to the perceived rivalry between CGH and GRH; which the CoE policy also seeks to address:

> 'I believe that you need to promote the message better that it is a Gloucestershire-wide initiative. At the moment people may think it looks like GRH vs CGH. They are defensive of their own local hospital. An analogy could be – take Gloucestershire University; they operate successfully across a multi-site campus in Cheltenham and Gloucester. If you are a resident of Cheltenham and you want to study bricklaying you go to lectures at Gloucester. In many ways the health-care scenario is the same. Try to get over the "us and them" culture, but recognise that people want good quality care at their local hospital. These proposals seem to suggest an over-emphasis of delivery at GRH'. [East]

The respondent above, whilst recommending communications about the bigger picture for the county, also demonstrates an underlying eastern bias against GRH, with the observation at the end of the comment regarding 'over-emphasis of delivery at GRH'. It should be noted again here that specialist services have moved between the two county hospitals for several decades (see 1.9.4). However, the more controversial moves, and hence those that have been reported more widely in the media and been drawn attention to by local elected representatives and campaigners, have seen services centralised in Gloucester – for instance, paediatric inpatients in 2008. These data might reflect a heightened anxiety amongst people living in the eastern half of the county, of CGH becoming a poorer relation to GRH due to the higher levels of awareness of the changes from right to left, geographically. Which brings consideration of this comment full circle; better communications, about the bigger picture of the entire county service provision, could serve to redress the balance of awareness of what is available at both CoEs, potentially leading to a reduction in rivalry between the two communities, and in concerns about the downgrading of services at CGH. By listening to this voice, the system can learn and act (see Chapter Four).

The third warrant is that people should take responsibility for their choices. As above, this is linked to the second warrant, which notes that information is required to enable people to make informed choices. As seen previously, scholars have

identified other reasons why people may be unable to make choices. Similar voice data are recorded here as were received in the STP. For example, there appear to be a lot of voices representing the belief that if ‘selfish’ people have self-inflicted injury and illness they should be treated differently to others, who they believe have legitimate reasons for seeking healthcare support from the NHS.

> ‘Limit access to A&E by denying or delaying (to the back of the queue) selfish people who are drunk, drugged, aggressive etc’. [East]
>
> ‘A&E waiting times must be improved. Suggest that inebriated people be placed in separate area to sober up, dealt with last, and charged for service’. [West]

Also seen again, in the data below from the east, is the view that people should be charged for missed appointments, and health tourists should be pursued to obtain payment for treatment provided by the NHS.

> ‘Penalties if people consistently miss appointments at surgeries or consultants’ offices. People need to be encouraged to not waste doctors’ time’. [East]
>
> ‘Charge people who don't turn up for appointments. Chase non-residents of UK who have treatment with no intention of paying’. [East]

It is worth noting that in England people not normally resident in the UK are charged for all NHS services except for A&E and GP primary care (UK government, 2020).

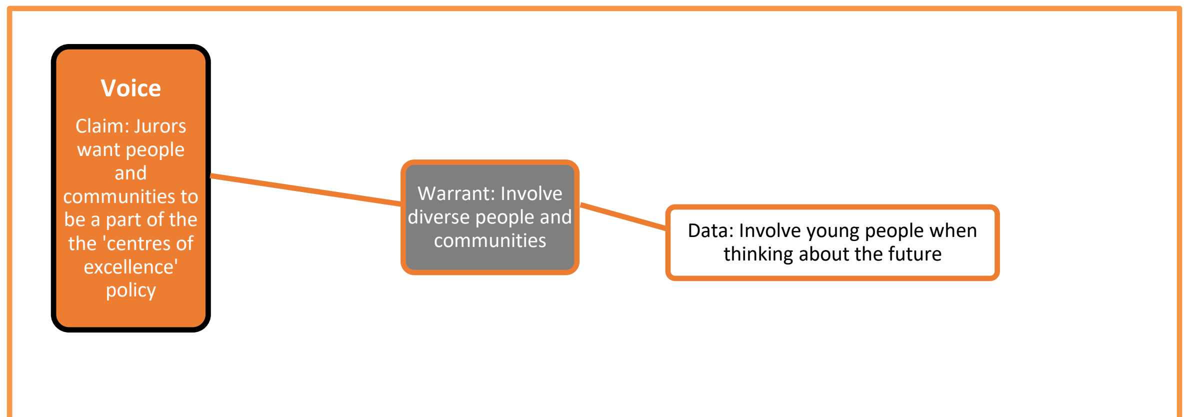
3.4.4 *Voice POLICY – FFtF Citizens Jury Number 1*

As previously described, NHSG commissioned an independently facilitated Citizens’ Jury as part of the FFtF engagement. Jurors were selected to provide a more demographically representative sample of views. It is particularly applicable to this paper that jurors lived across all areas of Gloucestershire. However, juror quotes cannot be attributed to east or west as this information was not recorded in the independent Jurors’ Report (Citizens’ Juries c.i.c., 2020).

In contrast to other participants to the engagement, jurors were given a significant amount of time and access to experts and information before reaching their conclusions. Jurors are given an identifying number, and there is an indication of their level of support for the CoE policy. The scale is very supportive, supportive, neither supportive nor unsupportive, unsupportive, and very unsupportive.

The claim is that people and communities should be involved in co-developing the CoE policy (see Fig. 22).

Fig. 22 Voice Chain: POLICY 2 Citizens' Jury



The warrant in this chain is about the importance of involving diverse people and communities. Juror 14 is very supportive of the CoE policy, and complimentary about the rigour of the engagement process. They highlight the importance of listening to the views of the younger generation.

> The whole team have been rigorous in the engagement process. I would stress that the next stage of this process must include engagement of the young people – school leavers and trainee medics – to include them in the conversation and in this way incorporate their priorities (they care about more than first rate equipment) into what the CoE approach will look like in Gloucestershire now and into the future'. [Juror 14. Very supportive]

It is important to note here that the independent Citizens' Jury methodology is restricted to participants over the age of 18 years. However, targeted activities with young people are incorporated into communications and engagement plans where indicated by EEIAs. During the presentation of evidence by NHSG to the jury, statistics regarding survey respondent demographics were presented. These indicated fewer participants from younger age groups. This information may have influenced Juror 14.

3.4.5 *Voice PROPOSALS – Case Study 3: FFtF Consultation, 2021*

The warrants and data where the focus of the discussion will be, are highlighted in the three boxes below illustrating claim, warrant, data chains for: Acute Medicine at GRH; Planned Lower Gastro-intestinal Surgery at either GRH or CGH; and Planned Upper and Lower Gastro-Intestinal Surgery Day Case Surgery at CGH (see Figs. 23, 24, 25). There are some data unique to individual proposals, and some cross-cutting themes.

Fig. 23 Voice Chain: Proposal – Acute Medicine at GRH

Voice

Claim: Respondents articulate a range of unsupportive views on the 'centres of excellence' proposal (Centralisation of Acute Medicine at GRH)

Warrant: Have a negative opinion of Gloucestershire Royal Hospital

Data:Had a poor experience as a patient/visitor

Data: Prefer Cheltenham for convenience/familiarity

Data: GRH has a poor reputation

Warrant: Believe CGH is being downgraded

Data: Cheltenham deserves a local service

Warrant: Don't like the use of the term 'centres of excellence'

Data: Others should decide 'excellence' classification

Data: 'Centres of excellence' is meaningless

Fig. 24 Voice Chain: Proposal – Planned Lower GI Surgery at either GRH or CGH

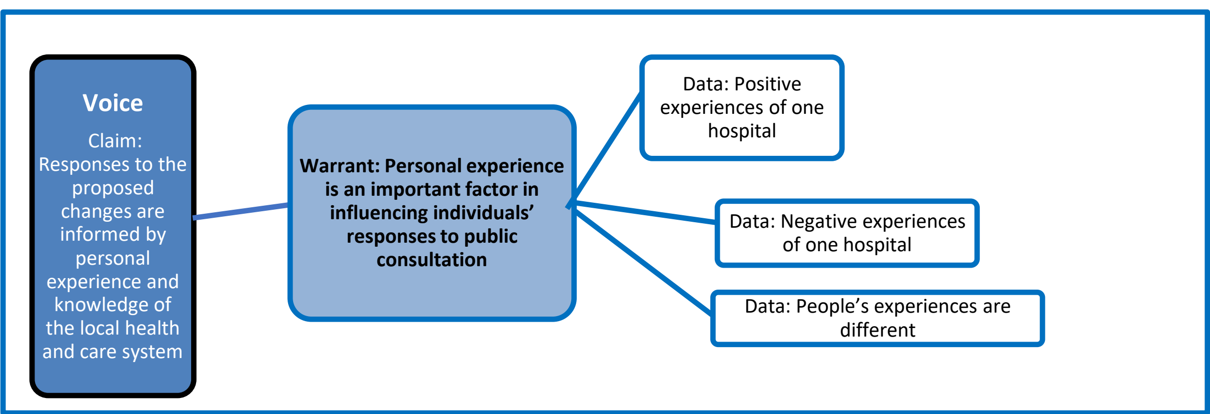
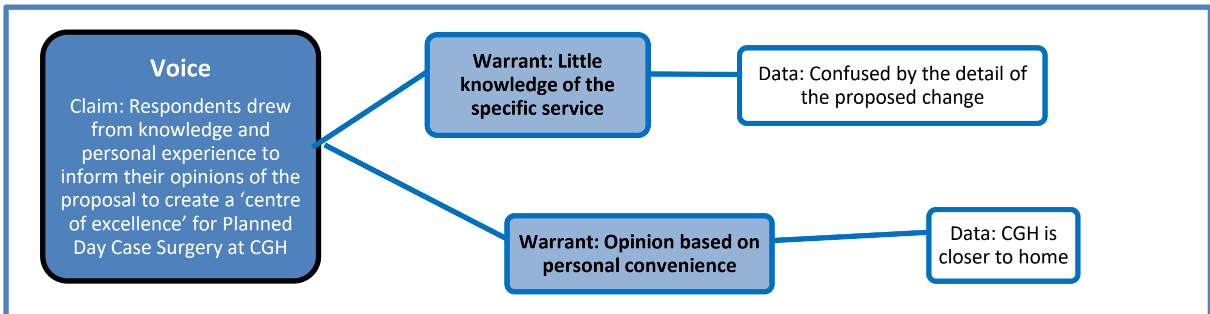


Fig. 25 Voice Chain: Proposal – Planned Day Surgery Upper and Lower GI at CGH



The Acute Medicine voice claim is that respondents are unsupportive of the proposal to centralise the specialty at GRH. The first warrant to bridge this claim to the data is that respondents from the east have a negative opinion of GRH because of previous poor personal experiences.

> ‘Gloucester Hospital cannot cope with Cheltenham patients – while I was in Gloucester with my Dad the relative of someone fainted as they had nowhere to sit and were enduring a long wait with their relative in the corridor. People were sitting on the floor – very shabby. We need both Cheltenham and Gloucester hospitals working a full range of services as they have always managed in the past’. [East]

> ‘From my observations of the medical wards at GRH they are not fit for practice. They are old, overcrowded, dirty, and poorly staffed; I would never wish to be a patient on these wards, from my parents’ experience of being a patient on them. This would not be a centre of excellence – just an overcrowded cattle market’. [East]

These respondents above provide quite a level of derogatory detail, not often recorded in the case studies data. They refer to ‘shabby’ and ‘dirty’ environments at GRH; which has clearly made a lasting impression on them. However, neither of them provides any comment about CGH for comparison.

Not all views are based on personal experiences of GRH. Rather, there appears to be an apocryphal awareness amongst the population of a poor reputation in Gloucester. This is expressed below by respondents from both the east and the west of the county.

> ‘Gloucester hospital is renowned for putting the fear of God into people when they have to go there for care. Removing options for Cheltenham – especially during a pandemic – seems insensitive to say the very least. We live in Stroud but have previously chosen to drive to A&E in Cheltenham to avoid GRH’. [West]

> ‘There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious’. [East]

The view above may be informed by legacy memories of earlier quality and performance variability between the two hospitals (see 1.9.4).

The data also show that respondents from the east prefer CGH for its convenience for themselves and their families, and their familiarity with travelling there as opposed to GRH. The first respondent even self-identifies as ‘selfish’.

> ‘I can understand the rationale for this proposal but Gloucester Royal is very difficult to reach from the south-east corner of the county (Fairford)… In our case, I would struggle to find GRH. I am concerned about the reduction in services in Cheltenham. One is a selfish reason – I am familiar with Cheltenham and can get there easily. My husband has been seriously ill a number of times and I know how stressful it is to find an unfamiliar hospital at night when you are panicking’. [East]

> ‘I want my care as I get older close to home so that family can visit. I would have no intention of being in a hospital away from my hometown. This has high priority for me’. [East]

The second warrant is that respondents believe that there is a plan to downgrade CGH, and that Cheltenham residents (and those across the eastern parts of the county) deserve a local service. Interestingly, this view is not exclusive to people from the east. However, the first comment from the east alludes to a geographically defined entitlement to a service, rather than simply a concern about reducing services across the county.

> 'I feel it is a shame that departments at Cheltenham Hospital are bit by bit being transferred to Gloucester. Eventually Cheltenham Hospital will become a minor community hospital. Cheltenham is large enough to warrant its own fully functional hospital… The people of Cheltenham deserve better'. [East]

> 'I worry that this is also a step to wind down care and service provision at CGH'. [West]

> 'It worries me hugely that a town the size of Cheltenham already hasn't got 24/7 Consultant Led A&E services. This seems another plan to reduce this even further'. [East]

Once again it is apparent in the data that there is a misunderstanding about the future of the CGH A&E. It is not clear from the data whether this confusion is due to lack of information or low levels of understanding about the terminology 'Acute Medicine', which it is proposed to centralise at GRH. Alternatively, the situation could be being used deliberately to open a debate about the A&E Department in Cheltenham, to refresh the long-standing dissatisfaction with changes made several years previously, and the campaign to restore services to pre-2014 arrangements.

The third warrant tackles the CoE policy head on. The selection of data below are less personal, more hypothetical responses to the question, from respondents from either side of the county. The respondent from the west suggests that it is not for the local NHS system to decide whether something is an 'excellent' service, commenting that others should award an 'excellence' classification – if indeed the accolade should be applied at all. In the opinions of the second and third respondents, from the east, the name of the policy, 'centres of excellence', is meaningless at best; at worst it is purely decorative.

> 'A centre of excellence is a title conferred on a centre by other institutions and is not something you can simply decide to be. Aspiration to excellence is essential but not if this is considered zero sum i.e., we can aspire to be a centre of excellence in A and therefore B will not be excellent'. [West]

> ‘The term centre of excellence is best avoided. It sounds good but means nothing. Why would anyone not want excellence? How do you define a centre of excellence?’ [East]

> ‘The term “Centre of Excellence” is meaningless. Why should this suddenly become an aspiration for the service that exists already, except as a piece of window-dressing?’ [East]

The quotation below, on the same theme, comes from a response to the proposal about Planned Upper and Lower GI Day Surgery centralising at CGH. Again it is a response from the east, but what is interesting about it is that it demonstrates suspicion about the CoE policy and its proposals, even when the proposal is to centralise a service in the eastern half of the county, where the respondent lives.

> ‘What does “centre of excellence” mean? This is a ridiculous phrase. Who wouldn't want a centre of excellence? As opposed to trying to frame the question for your desired answer, you could try phrasing the question in a more balanced way, e.g. admitting that it means focusing resources and personnel in one or both of the sites, so those taking the time to engage with your questionnaire do not feel manipulated’. [East]

The voice claim for the Planned Lower GI Surgery is that the responses to the proposed changes are informed by personal experience and knowledge of the local health and care system. The first warrant is that personal experience is an important factor in influencing individuals’ responses to public consultations. Two examples below, from the east and west, express previous satisfaction with a service provided at CGH.

> ‘Experienced good service/care at CGH’. [West]

> ‘We would prefer this service to be available at Cheltenham where my husband had excellent care’. [East]

The response above, from the east, is from someone who also states that they are a ‘sufferer in this speciality’ and that their priority is ‘to provide the best possible service’.

Once again there is a bias against GRH in the data below, with reference again to a poor reputation. However, this respondent is pragmatic about travelling to access a planned service and is mostly aggrieved about having to pay for hospital parking, wherever the service is located. Therefore, this respondent would be satisfied if the service was centralised at CGH, so that Cheltenham-based individuals might not need to use their cars to access the service.

> ‘If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can

> factor the distance into their preparations. There is still the question of the exorbitant parking fees on the GRH site. Although CGH also charges stupidly high parking fees, Cheltenham-based patients being treated in Cheltenham, and their visitors, might not need to use their cars and could avoid these phenomenally high charges. There is also historically a poor reputation for infection control at GRH. I would not feel confident going there for anything serious'. [East]

Once again, the voice claim for the proposal, this time to centralise Planned Upper and Lower GI Day Surgery at CGH, is about respondents using their personal experience or knowledge of the service, to shape their views of the proposal. Some respondents are confused about the FFtF consultation proposals.

The first warrant is that respondents indicated that they had little knowledge of the specific service. This is demonstrated in the quotes below from the east.

> Now very confused - how is this different to the previous two questions? Answers are as previous - support measures to cut last minute cancellations & being able to be seen & treated by the right person quicker. However, this needs balancing with concerns over travel distance and reaching capacity at one site. [East]

> 'Really can't imagine what day case GI surgery would entail'. [East]

> 'I cannot understand why all this has to be divided up, it is quite complicated'. [East]

The FFtF consultation, as previously stated, covers several specialist services. Despite the results from the second Citizens' Jury, which was complimentary about the quality of the public consultation communications, it is clear from the comments here that individuals are confused by the complexity of the narrative. This is something future public involvement activities should consider (see Chapter Four).

The second warrant returns to a recurring theme in the data – accessibility. In this instance, it is the practicalities of personal convenience or inconvenience for others that the respondents from across the county draw attention to.

> 'As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport, a very large minority do not, and they are frequently the elderly and less financially secure. For these people, centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites. Even for those with private transport difficulties in accessing parking at either site pose difficulties and high costs. [West]

> 'Biased. Nearer me!' [East]

This last response is disarmingly honest. Bias of this kind is addressed in Chapter Four.

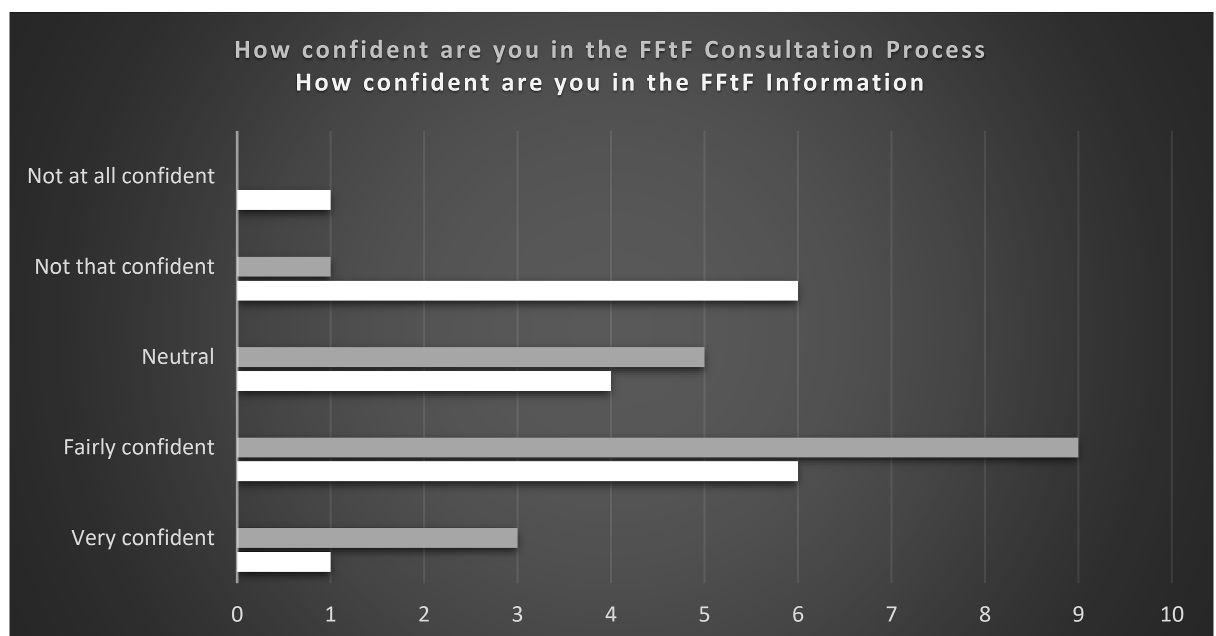
3.4.6 *Voice FFtF Consultation – Citizens' Jury Number 2*

As stated previously, a citizens' jury is a form of 'deliberative democracy', where a cross-section of the public is brought together for a few days to hear evidence, deliberate together, and make recommendations to policy makers about a particular public policy question (Chambers, 2009). The role of the second independent FFtF Citizens' Jury was not to consider the merits of the FFtF consultation proposals but to 'consider staff and public feedback including survey findings… hear evidence from expert witnesses on what makes a good public consultation, including consultation information provided, as well as observations about the strengths and weaknesses of the FFtF consultation from different community perspectives' (Citizens Juries CIC, 2021).

Once again 18 adults, different from the first jury, living in Gloucestershire were selected as jurors. Their demographics broadly reflect the county's residents in relation to age, sex, ethnicity, educational attainment, geographical district, and employment status.

The primary quantitative analysis of the juror's votes and opinions concluded in a statistical draw in terms of jurors' confidence in the FFtF consultation process. All but two of the 18 Jurors are within the range of 'Not that confident' through 'Neutral' to 'Fairly confident'. Only two jurors felt strongly enough in their views to vote for the extreme ends of the confidence scale. Jurors are more confident in the consultation information, with only one juror expressing less than a 'Neutral' confidence score. Quantitative results are shown below in Fig. 26.

Fig. 26 Jurors' Confidence in the FFtF Consultation Process



There is value in including secondary analysis of the jurors' views, in this thesis, for the same reason as the decision to convene a second jury; to consider the data from a 'control' group. The jurors identified themselves in their own report as '[a] jury containing a cross-section of Gloucestershire public were given enough information to form a view on the actual consultation process used by FFtF giving everyone an equal platform to discuss their own views and listen to others to form an educated opinion for our conclusion'*.* One juror reflected on their personal experience of the Jury process. 'This gave me the opportunity to engage with jury members drawn from a broad spectrum of the community. I was pleasantly surprised how quickly the members gelled and interacted positively and courteously with each other and achieved outstanding outcomes.

However, of particular interest to this thesis are the data about confidence in the consultation process, and the key messages for decision makers. All data selected for the first chain below in Fig. 27 have been coded as 'voice'.

As no geographical demographic information is available for individual jurors, the cross-case analysis below will consider confident versus unconfident data. The data are extracts taken from the jurors' report. The words used to describe the reasons for relative confidence are collectively identified by jurors themselves, supported by independent facilitators.

Fig. 27 Voice Chain: Proposal – Citizens' Panel

The two warrants in this chain relate to jurors' relative confidence in the FFtF consultation process. The data supporting the claim have several overlapping themes, and the analysis below is presented by theme rather than under the two separate warrants (see Fig. 27).

The first data group relates to the FFtF consultation information. These data reflect a high level of confidence in the FFtF consultation information provided to support the FFtF consultation process. 'Clear, concise language and limited jargon in materials' attained 11 votes, while 'Variety of versions of documents with varying detail was provided' achieved 8 votes.

It is worth noting that one of the reasons given by jurors for their confidence in the FFtF consultation information is relevant to the data with respect to the use of jargon in the STP documentation (seen earlier in the voice data at the IDEAS stage). Fifteen jurors express the view that the materials used "plain English" and noted that a glossary was included to explain jargon. It is reasonable to conclude that the approach to developing public-facing communication materials has evolved during the period from the IDEAS stage in 2016; with a greater emphasis placed on simplifying the presentation of policy and proposals. The FFtF consultation booklet, in both long (with glossary) and summary versions, was available online and produced in print. An adapted Easy Read version was also produced.

The second data group relate to the range of involvement options available. Jurors who were confident in the process note that there was ‘significant effort made to reach and involve harder-to-hear groups’ (6 votes), whereas jurors who were less confident about the process felt that ‘overemphasis on targeted groups may have reduced awareness among and participation among general public’ (8 votes).

The jurors express concern about the geographic demographics of the majority of FFtF consultation respondents, with such a large percentage coming from Cheltenham in the east of the county. The jurors observe that ‘the survey’s results may therefore be skewed and biased in favour of proposed changes, and therefore do not reflect the views of residents of Gloucestershire as a whole’.

The jury later observe that there is approximately 70% support for the FFtF consultation proposals overall, indicating that the proposals are acceptable to the wider public; and suggesting that the anxiety expressed above by the jury, about a potential negative Cheltenham bias affecting the results for proposals centralising services at GRH, and positively for proposals centralising services at CGH, was not validated by the overall results.

The third group of data relate to the application of evidence-based processes. This incorporates the recognition of the importance of scrutiny of the FFtF consultation process and seeking and acting upon external expert advice. Although this chain has been created under the voice model, much of the data here could also be aligned to trust. The data below demonstrate a high level of trust amongst some jurors, in statutory bodies and legal and professional experts. For example, jurors received a presentation from an NHS England Senior Programme Lead for Community Involvement about what ‘a good NHS public consultation process looks like’. This presentation referred to The Gunning Principles, which have a basis in the law (Sheldon, 2012) (see 1.10.3).

Adherence to these principles by the FFtF consultation process received 3 votes below. I should declare an interest; I am the ‘B. Parish’ referred to in the fourth quotation below, receiving 2 votes from the jury.

Process allowed for scrutiny from multiple outside bodies – 5 votes

Incorporated guidance from relevant outside bodies – 3 votes

Conducted in accordance to Gunning Principles (see 1.10.3) – 3 votes

NHS engagement staff (B. Parish) answered questions and presented confidently – 2 votes

The next group of data in this warrant relate to effectiveness of awareness-raising of the FFtF consultation, resulting in variable levels of response from the public. Jurors are divided on this point.

Number of responses statistically acceptable based on software – 4 votes

Marketing and advertising strategy did not raise awareness of consultation – 10 votes

Relying on Royal Mail Postal leaflet as primary outreach led to reduced awareness and participation – 9 votes

Use of self-selecting survey to gather responses may have decreased number of people who participated – 4 votes

Jurors suggest this is an important finding from the results of the FFtF consultation. Although 700 completed and returned surveys is considered satisfactory to the 'NHS experts', more than half of the jurors felt that citizens might not agree, and seven of the Jurors felt the response was not representative of the population of the county. NHSG uses a sample calculator called Raosoft[9]. This calculates that, with a 5% margin of error and a 95% confidence interval, 384 responses are acceptable for a population of 650,000.

The next observation from the jury is that the FFtF consultation took place during the COVID-19 pandemic. This is seen as a deterrent to public involvement, by two thirds of jurors.

Conducting consultation during COVID-19 pandemic compressed timeline, made it more difficult to participate, limited options for engagement, and reduced quality – 12 votes

This observation has been considered elsewhere, and the mitigations put in place described elsewhere (see 2.4.3). Jurors note that the decision to proceed with the consultation was taken after seeking expert advice. They recognise that the potential benefits the proposed FFtF changes could deliver outweigh the need for a pandemic-effect delay to the consultation.

[9] Raosoft: http://www.raosoft.com/samplesize.html

The next focus is on the degree of confidence in the impact public feedback, and jury recommendations, will have on the final decisions taken by NHS governing bodies.

> Input of past, current, and future users of services under consultation and patient experience not emphasised in materials – 5 votes
>
> Unclear whether or not, and how, CCG will utilise the results of the Citizens' Jury in decision-making – 2 votes
>
> Feedback from community groups may not have been responded to or may have been disregarded – 1 vote

The last comments from the Jury in this section encapsulate the unique element of the voice model in planning and delivering public services.

> We have been assured that the golden thread of patient experience is the reason for this project, but there is nothing about that in the proposals. It is important that at the same time as any reorganisation of medical services, there is a review of the way patients are treated, their dignity, and the facilities offered associated with new medical proposals. There is always something about this in external audits. (16 Yes votes / 2 No votes)

… and jurors say this matters because: 'it's about the patients!' (Citizens' Juries CIC, 2021).

If the public are to trust that their voices will be heard and their views considered conscientiously, public services must be able to demonstrate explicitly how feedback influences decision making. In this way trust can increase and public apathy, in terms of using their voice, can be reduced.

3.5 Voice Priority Findings

3.5.1 *Accessibility, Accessibility, Accessibility*

'Accessibility' is not just about the practicality of travelling from A to B; it encompasses: the comparison between the current convenience of a service close to home, against potential for increased distance to travel; the limitations of car ownership; public transport availability and costs and hospital car parking charges. Quality in terms of safety is also a factor associated with access. Respondents to the FFtF policy engagement identify increased travel times to a CoE as potentially having an impact on patient outcomes.

3.5.1.1 Bring Back CGH A&E

Calls to bring back CGH A&E are seen across the IDEAS, POLICY and PROPOSALS data. Despite repeated confirmation that the A&E services at CGH are not included in any proposals for change, at each opportunity for public feedback, CGH A&E is one of the most frequently occurring topics of conversation in the data.

This is because there is a prevalent misunderstanding that the CGH A&E is closed. This confusion has occurred as a result of an earlier service change that saw the 24/7 A&E at CGH change to an 8am-8pm consultant-led and 8pm – 8am nurse led service. The results presented in this thesis demonstrate that there remains both misunderstanding about, and dissatisfaction with, that previous service change.

3.5.2 *Involve People and Communities in Policy and Service Design and Listen to What They Say*

Data from both the FFtF engagement and the Citizens' Juries stress the importance of involving the voices of people and communities through good quality engagement and consultation activities and acting on what has been heard and telling people how their feedback has made a difference, and also ensuring that voices from underserved communities are heard and listened to.

3.6 Choice & Competition (Choice)

As mentioned above, two of Le Grand's (2007) models take precedence in the title of this thesis: Informed Choice or Informed Voice? Therefore, results and analysis relating to 'choice' data are presented in full in this chapter. Le Grand's application of the 'choice' model is modified to suit the choices available in the three case studies, which relate to the range of choices available through the potential application of the COE Policy and FFtF Programme proposals as opposed to the NHS Constitutional (see 1.10.2) healthcare consumer choice of NHS service provider described by Le Grand.

In this section, the data coded as 'choice' are presented using a series of chronological claim, warrant, data chains. Key themes are identified and interpreted, illustrated by representative quotations selected from the data from both east and west, or from one side of the county as required to reflect the response to the IDEAS, POLICY or PROPOSALS. Choice headline findings are briefly summarised below.

3.6.1.1 Choice Priority Finding

Accessibility, Accessibility, Accessibility – Once Again

The impact of access to specialist hospital services affecting patient choice is a frequently occurring theme in the data at the POLICY and particularly at the PROPOSALS stages. This is linked closely to the theme below – Location, Location, Location.

Under this priority finding there are two sub-headings:

A Single Hospital Site for Specialist Hospital Services is Acceptable for Most Specialties

The data show that the CoE policy is a popular choice. Factors influencing relative levels of support are personal convenience, retaining a specialist service in the county, increased efficiency, and quality. However, the choice of which of the two acute hospitals in Gloucestershire to access a service from remains a relatively polarising aspect of the data.

Location, location, location

The choices individuals make regarding where they live, and the impact this should have on health service provision, and the geographical location of hospitals in the county, is a recurring theme in the data, particularly in the last two case studies. The suggestion to build a new single hospital is seen again in the choice data.

3.6.1.2 Other Choice Finding

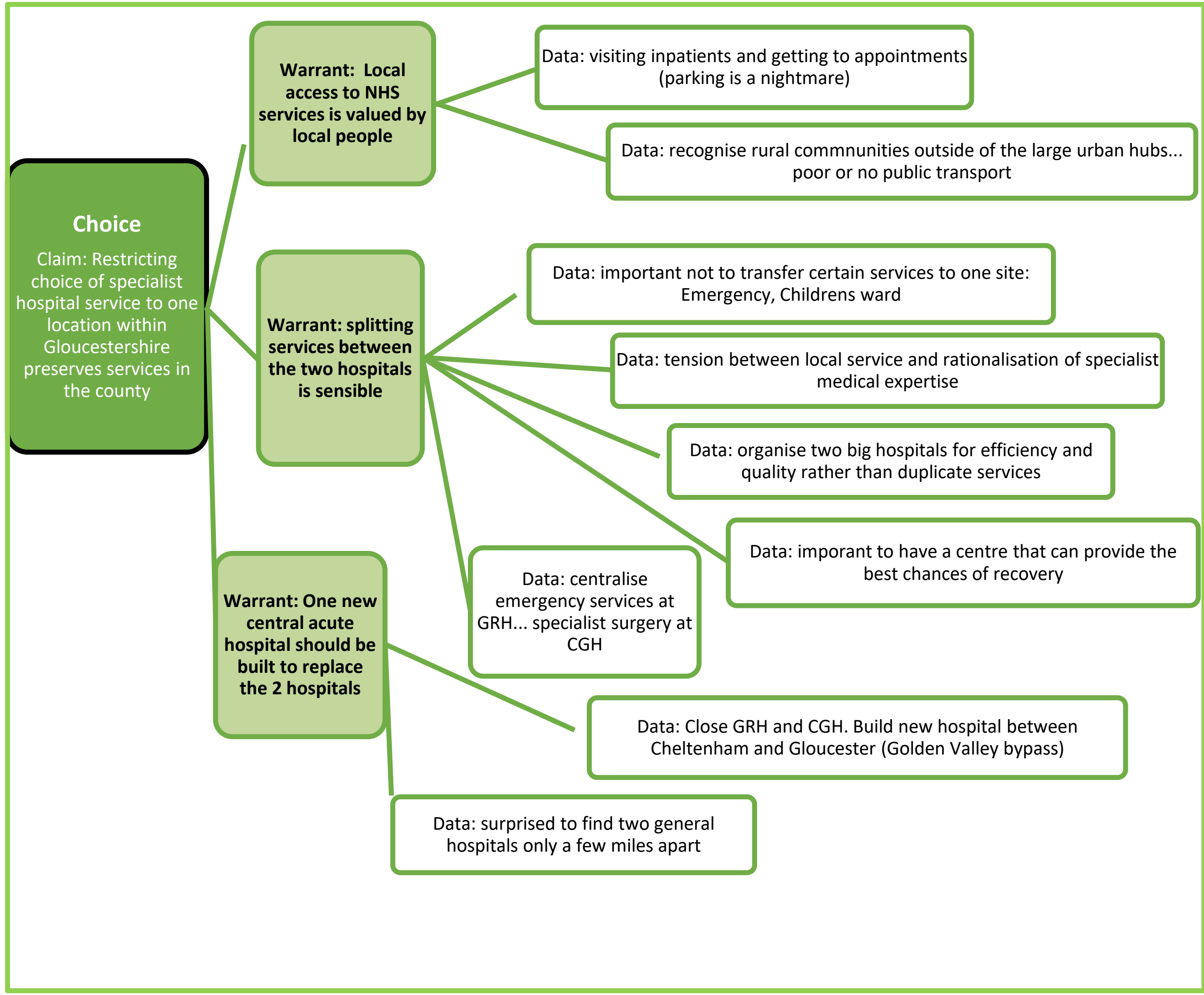
Choice Data Becomes More Binary

As observed in the trust data, as the analysis moves through the case studies from IDEAS to PROPOSALS between 2017 and 2021, the content of the data becomes more geographically binary, with respondents (with some exceptions) expressing preference for services to be provided at the hospital closest to where they live in the county. This finding is aligned to the priority finding that there is some evidence of difference in the views of residents in the east and west of Gloucestershire.

3.6.2 *Choice IDEAS – Case Study 1: STP Engagement 2016/17*

The 'choice claim' at the IDEAS stage is that restricting choice of specialist hospital service to one location within Gloucestershire preserves services in the county (see Fig 28).

Fig. 28 Choice Chain: IDEAS 1



The first warrant is that local access to NHS services is valued by local people. This is supported by respondents across the county, who cite challenges for travelling from rural areas, especially if one is reliant on public transport. It is interesting to note the comment below from a respondent from the east, about the distance between CGH and GRH being 'seen to be a short distance', suggests that this is not their definition of 'short' and that any extra distance to travel for this individual would be undesirable.

> 'It is very important to retain local services, in particular in the rural areas, where travel is a potential problem, and not to concentrate services in the major urban centres unless these are of a specialist nature'. [West]

> 'Although the most important thing is having the right (and experienced) doctor or consultant looking after you, it is important to people to be able to access help 24/7/365 and locally. Not everyone is able to travel (even what is seen to be a short distance – between GRH and CGH) as this costs and adds pressure to what could already be a pressure issue if you are unwell'. [East]

The second warrant is that CoE is a sensible approach. Again this is supported by respondents across the county. It is interesting in the context of the quote from the east below, that the support for CoE from the west suggests the distance between CGH and GRH is not considered a barrier, as they are relatively geographically close together (underlined for emphasis).

> 'With regard to the Gloucestershire Hospitals, residents of the county should be encouraged to see that having two General Hospitals so close together and both providing exactly the same services is not necessary'. [West]

> 'I do think it's wise to look at locating the most specialist and non-urgent services in one place, but there are a few services – most obviously A&E and maternity, but also children's inpatient services – where distance travelled is really critical. Shifting such services permanently away from a major population centre like Cheltenham is obviously hugely unpopular, and that in itself would undermine support for the many worthwhile objectives and strategies contained in the STP'. [East]

Data from the east qualify support for CoE with conditions, regarding the types of specialist services that could be provided at both hospitals, and those which could be centralised. The first quote below suggests the scale of the service, and the consideration of the urgent nature of the service response required, are factors to be considered.

> 'I am very concerned at the apparent downgrading of services at Cheltenham and transferring key services to Gloucester. I can see the

> benefit in small-volume services being focused in one or other (but not all in Gloucester); but large volume services (like A&E) should be in both locations'. [East]

> 'Important not to transfer certain services to one site only. E.g. keep a fully functioning 24hr A&E at Cheltenham as well as Gloucester. 24hr children's wards are now only available at Gloucester, thereby making it more difficult to access services quickly in an emergency/out of hours if you live the other side of Cheltenham etc'. [East]

The respondent from the west below identifies a 'difficult to resolve' dilemma – safe versus local. They capture succinctly the choices that local NHS systems, and the populations they serve, must make as clinical work becomes ever more specialised.

> 'There is a tension between health services being provided locally (e.g. at Cheltenham General) and the rationalisation of specialist medical expertise in one place in the county (e.g. at Gloucestershire Royal). There is not a simple answer'. [West]

The final warrant in this chain is the suggestion that one new central acute hospital should be built to replace the two hospitals, to avoid the necessity to choose between either current hospital site, thereby removing the competition between the two hospitals and restricting patient choice. This is the first time chronologically that this suggestion is seen in the data, i.e. at the IDEAS stage. This idea is also discussed above in the analysis of the targets data from the FFtF engagement, about the development of the CoE policy. Respondents from both sides of the county identify this as a potential longer-term solution for specialist hospital services in the county.

> 'I strongly believe that we should consider closing both Cheltenham and Gloucester Hospitals and building a new facility somewhere between the two, concentrating services in one place with maximum specialists available in a modern building which is fit for purpose'. [East]

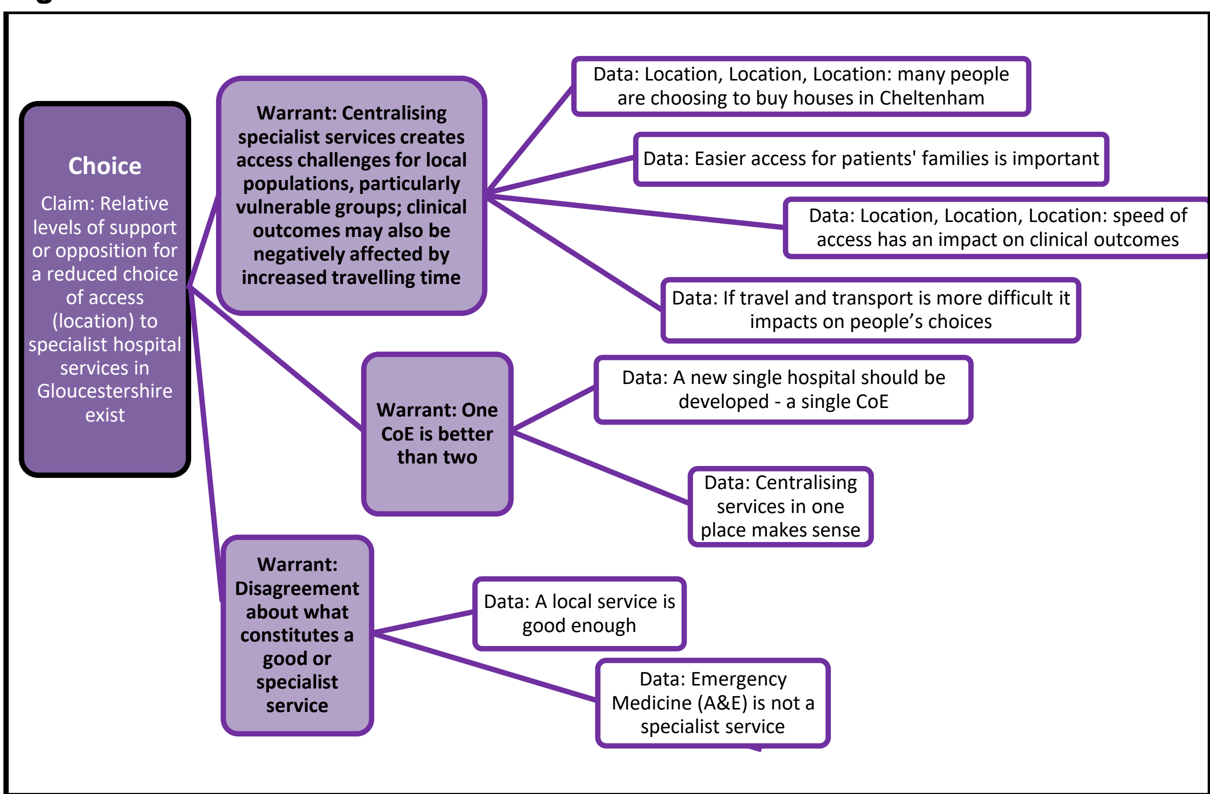
> 'Close GRH and CGH. Build new hospital on site between Glos and Cheltenham (Golden Valley bypass)'. [West]

The idea is simple – restrict the choice forever to one acute hospital in the county, located somewhere between Cheltenham and Gloucester.

3.6.3 *Choice POLICY – Case Study 2: FFtF Engagement 2019/20*

The 'choice claim' at the POLICY stage is that there are relative levels of support or opposition for a reduced choice of access (location) to specialist hospital services in Gloucestershire (see Fig 29).

Fig. 29 Choice Chain: POLICY



The first warrant is that centralising specialist services creates access challenges for local populations, particularly vulnerable groups; clinical outcomes may also be affected by increased travelling time. The data below from the east show that there is a view that many more people are choosing Cheltenham as the location to live; the implication being that specialist hospital services should be in the town people are choosing as their place of residence. Responses below from the east use word-for-word statements from the MP template survey (frequency included in brackets). It must be noted again that there is no reference to changes to the A&E Department at CGH in the FFtF engagement; despite this the MP includes it in the suggested discourse.

> 'Cheltenham is an expanding town. There are numerous rural communities who also rely on the provision of NHS care, and so it is vital the Cheltenham Hospital has A&E facilities 24 hours a day, 7 days a week'. [East] (x 24)
>
> 'A&E needs to be in Cheltenham as it is a growing town'. [East] (x 16)

Easier access for patients' families is an important factor for these respondents from the east; the first is supportive of the CoE policy in principle, while the other respondent holds very negative views about the policy. They suggest these views are also held by others.

> ‘The “Centres of Excellence” idea is basically good. I believe that an important part of recovery from accident or planned surgery is access for families and friends to visit the person receiving treatment; this helps that recovery and state of mind’. [East]

> ‘Stop centralising everything. It doesn’t work, people don’t like it; they don’t want it and do not feel it provides good outcomes. Not everyone finds it easy to travel, and for someone who say lives in Winchcombe [North-East of Cheltenham], going to Gloucester or having a relative admitted there can make a stressful situation worse’. [East]

Also important in relation to accessing service is the perceived link between distance to travel and the potential impact on clinical outcomes. The response below is from the east, and once again the misunderstanding about the status of the CGH A&E influences opinions in the east about the CoE policy.

> ‘Location, location, location… travelling an extra 40 minutes to get specialist provision of a service is fine if the condition hasn’t arisen without notice and needs urgent attention. A&E is a specialist service but it’s ridiculous to consider that in its case location and accessibility are not as important as the staff and equipment available. What’s the good to have a wonderful department if you are dead or permanently damaged before you access those services’. [East]

The data also suggest that when travel and transport is more difficult, it impacts on vulnerable people’s choices, in terms of the increased stress of navigating to a new location, and the costs associated with travel and parking. Again, the responses below are all from the east. However, as seen previously, the east is not the half of the county with the greater inequalities, and potential greater vulnerabilities other than age and rurality (see 1.9.3).

> ‘Concentration may seem more efficient in terms of your budget, but imposes significant cost on the most rural and poorest members of the community’. [East]

> ‘Good travel arrangements for patients as it is stressful to go to hospital, even more stressful to go to a town that is not your own and totally stressful to then have to get lost on the way and end up paying lots of money for parking in the hospital car parks’. [East]

Respondents from both sides of the county suggest improved public transport between the two hospital sites would ease transport issues and reduce patient and visitor anxiety. It should be noted that since 2008, there has been a shuttle bus service (the ‘99’), commissioned by the local NHS and provided by a local public transport company, operating during the day between the two hospitals. However, awareness amongst the general population of this service could be improved.

> ‘Public transport to access the services; this is normally the county council’s responsibility, but maybe hospitals can develop hospital shuttle bus services to ferry people between hospitals in the county’. [East]
>
> ‘Bus services such as 99 between Cheltenham and Gloucester hospital to be 24hours’. [East]
>
> ‘Transport needs to be looked at so that people do not need to use their cars so much for hospital visits, this would reduce some of the stress… People could park their cars somewhere between Cheltenham and Glos [Park and Ride] or close to one or another and catch a bus to the chosen hospital; esp. useful at visiting time as well as for patients already stressed at the thought of treatment etc’. [West]

The second warrant is that one CoE is better than two. This leads to the repeated suggestion from across the county to build a new centrally located hospital in the county.

> ‘The obvious solution is to build a new hospital equidistant from each conurbation in the golden valley’. [East]
>
> ‘I am not convinced your 2 “Centres of Excellence” vision is sustainable. Why have you ruled out creating a new one centre of excellence midway between Gloucester and Cheltenham? Such as a new hospital near Staverton / Churchdown [villages between Cheltenham and Gloucester] would have good transport links and much better serve the whole county’. [West]

The third warrant suggests that there is disagreement about what constitutes a good or specialist service. Many eastern respondents’ responses indicate that a local general service is good enough and that they are happy with the *status quo*.

> ‘Forget “Centres of Excellence”. Just provide good medical treatment as has always been offered in the past’. [East]
>
> ‘Cheltenham is a general hospital. Make Gloucester a specialist hospital by all means, but leave Cheltenham ED as part of a general hospital serving a geographical area that Gloucester cannot hope to cover’. [East]
>
> ‘Specialisms do matter, but most of the time, specialisms are services which can be accessed in slower time over several days. The need to handle emergencies very fast, before the patient dies, and to handle general medical conditions which do not need specialist care, are exactly the things that general hospitals do really well. We should be supporting and growing Cheltenham General to serve this need’. [East]

There are two misunderstandings here. The first, as seen previously, is about the status of CGH A&E; the second – which (due to the first misunderstanding) is not materially relevant but is important in terms of people’s expectations of NHS services today – is the view that emergency medicine is not a specialist service.

3.6.4 *Choice POLICY – FFtF Citizens' Jury Number 1*

As explained earlier in this paper, NHSG commissioned an independently facilitated Citizens' Jury as part of the FFtF engagement. The 'choice claim' derived from the jury data is that the CoE policy, if implemented, could have both negative and positive impacts (see Fig. 30).

Fig. 30 Choice Chain: POLICY Citizens' Jury

Choice
Jurors identified both positive and negative aspects of the 'centres of excellence' policy

Warrant: There are potentially some negative impacts of restricting choice of location

Data: Further travel for staff

Warrant: There are some potential positive impacts of restricting choice of location

Data: Concentration of skills and equipment

Data: Positives outweight the negatives

Juror 5, who is 'fairly supportive' of the policy, identifies the potential negative impact on the morale of staff who are already working in challenging circumstances if they had to relocate their place of work. This is not a consideration found in the data from the overall public response to the FFtF engagement, where many data about the impact on staff focuses on the benefits of the policy for recruitment and retention of staff.

> 'Concerns on travel/transport for those who live near border county and elderly. Staff already under-staffed, over worked! Will this have a positive or negative impact? Will it affect staff moral [sic] (having to potentially move locations for their role but may not want to)'. [Juror 5. Fairly supportive]

Possible positive impacts on the quality of services through the development of specialist clinical teams in one location in the county are identified by jurors below.

> 'Expertise knowledge equipment all in one area which will give better patient care and staff retention'. [Juror 2. Very supportive]

> 'We already see evidence of excellent work where Centres of Excellence exist. It cuts out many problems of operating 2 centres. Overall, the positives far outweigh any negatives'. [Juror 16. Fairly supportive]

Having listened to the evidence and weighed up the pros and cons together, jurors are more positive than negative about the aims of the CoE policy.

3.6.5 *Choice PROPOSALS – Case Study 3: FFtF Consultation, 2021*

A significant amount of data is coded as representing choice. In Le Grand's model (2007), choice is about equality of access, giving users of services more than one option, and the power to make choices based on quality of services available (see 1.3.3.4). Many of the respondents to the FFtF consultation proposals are content to restrict their choice from a two-site option to a single-hospital option for themselves, and as shown in the primary analysis of the quantitative data, 68% of survey respondents supported the proposal to centralise the Acute Medical speciality in Gloucester (61% from the East and 82% from the West) (see 2.5.1). However, concerns regarding limits on choice because of centralisation, such as increased travel time, improvements needed to public transport, and lack of space in Gloucester, can once again be found in the secondary analysis of the qualitative responses below.

Fig. 31 Choice Chain: Proposal – Acute Medicine at GRH

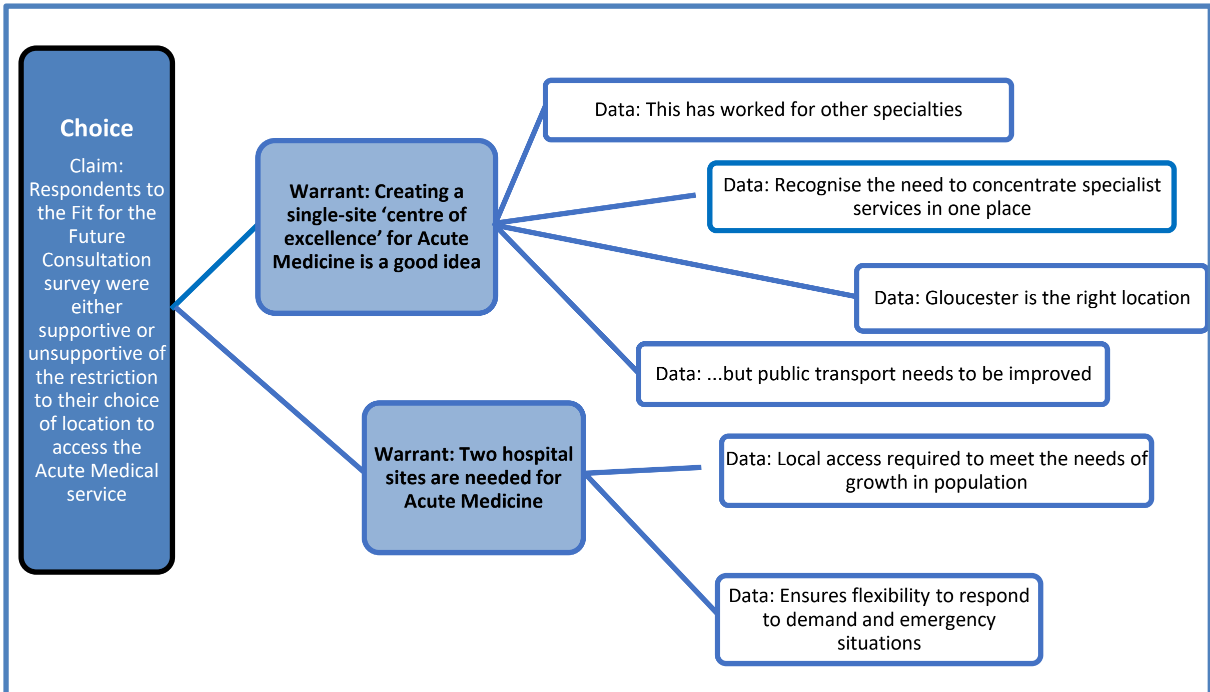


Fig. 32 Choice Chain: Proposal - Planned Day Surgery Upper and Lower GI at CGH

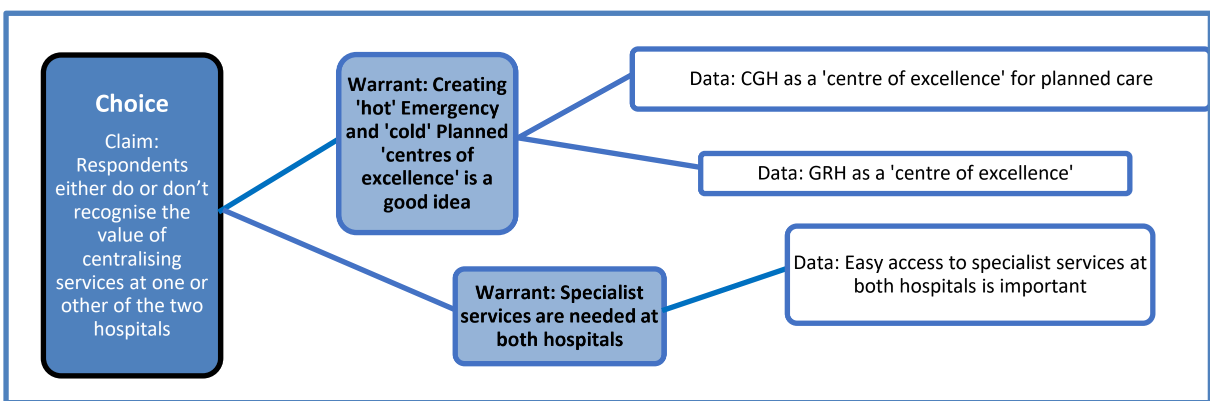
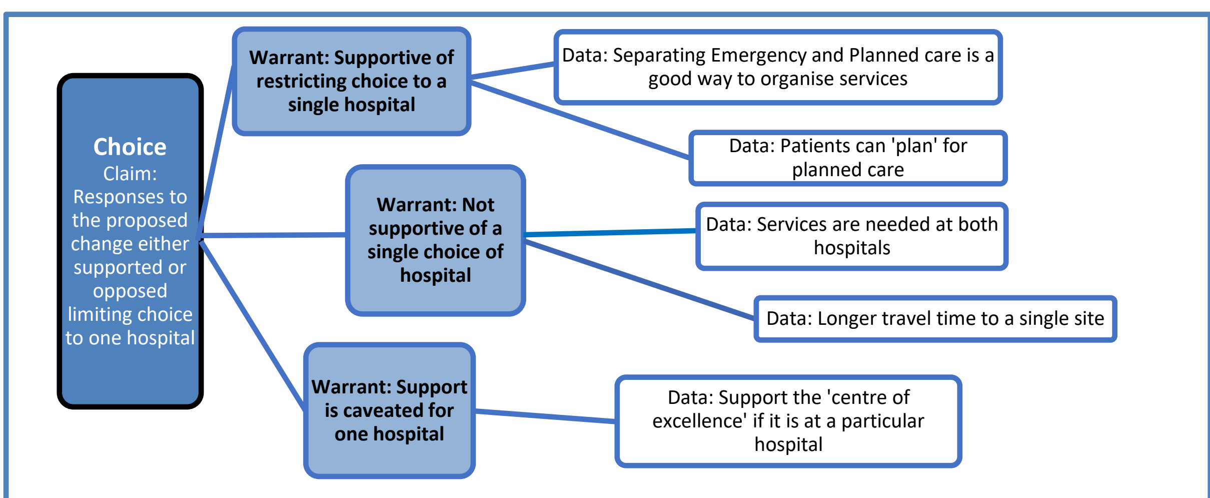


Fig. 33 Choice Chain: Proposal Planned Lower GI Surgery at CGH or GRH



3.6.5.1 Proposal: Acute Medicine Centralised at GRH

Considering the restriction to choices of location, the first 'choice claim' is that there is relative support for the FFtF consultation proposal to centralise Acute Medicine at GRH (see Fig. 31).

The first warrant linking the data to the claim is that creating a single site CoE for Acute Medicine is a good idea. The data which illustrate this view are grouped into four themes. The first, described in this quotation from the east below, is that centralisation has worked for other specialties in Gloucestershire previously.

> 'The idea of creating 'centres of excellence' at either CGH or GRH makes sense and has worked well for other specialty inpatient services e.g. cancer services at CGH and children's services at GRH. It is important to remember that both CGH and GRH are "centres of excellence" for distinctive specialist services'. [East]

The next group of data shows that respondents from both east and west are convinced by the Acute Medicine centralisation argument and, in the case of the second east respondent, are prepared to travel to access the service, echoing the collective views from the original STP IDEAS engagement five years earlier.

> 'Whilst GRH is further travel time for me, I recognise the need for focusing practice'. [East]
>
> 'After having experienced "inpatient" services at both CGH and GRH on two separate occasions resulting from pneumonia, I would fully support the objective of developing a 'centre of excellence' at GRH. The disadvantage of extra travelling for Cheltenham residents is outweighed by the improved facilities, [and] better use of and more focused staff'. [West]

The third theme in the data in this warrant is support for Gloucester being the right location for Acute Medicine. The first response comes from the east, the second from the west. The response from the west acknowledges the proposal is unlikely to be a popular choice in Cheltenham (in the east), but the respondent from the east acknowledges and accepts the need for extended travel.

> 'Cheltenham would be more convenient for me, but Gloucester is potentially bigger and within easy reach'. [East]
>
> 'In a county this size, with the shortage of doctors and nurses, we need to ensure that we have the safest care available and to do this [as] efficiently as possible we need to have services centred on one site, in acute medicine GRH is the preferred site. This will not be popular with Cheltenham people but they have to accept that they will never ever have a fully functioning hospital on their site'. [West]

The second warrant is that two hospital sites are needed for Acute Medicine. The data show firstly that respondents from the east think centres in both Cheltenham and Gloucester will give greater flexibility to respond to demand and emergency situations.

> 'I believe Gloucestershire needs more than one centre of excellence. This will give options should GRH be overloaded or temporarily unavailable (infections, disaster of some type)'. [East]
>
> 'This is a hospital stay (even if 1 night) for which the patient and their family/carers have not planned. Hard enough to cope if it is local but very stressful if it is not. This is a case where both hospitals must be centres of excellence'. [East]

Once again, but on this occasion from data coming from the west of the county, respondents want local access to meet the needs of growth in population.

> ‘If this means moving acute patients from Cheltenham to Gloucester then I oppose. These are normally time-critical cases and travel is clinically detrimental. There are large and growing populations in both towns and future demand will require acute services at both sites’. [West]

All areas of the county identify travel and transport issues associated with centralising services in one place. Once again, the data below specifically identify inequities created for some people, particularly individuals who could be classed as more vulnerable due to their age, access to resources (such as a private car), or income to pay for public transport. These individuals could be disproportionately affected by the proposed change due to personal characteristics. Many respondents to the survey overall report having a long-term condition or disability; very few refer to these in their qualitative responses. The second respondent below is unusual in commenting directly on the adverse personal impact of the proposed change, due to lack of wheelchair accessible transport. It is worth noting that wheelchair accessible transport is available between hospital and home for all hospital appointments or episodes of care. This is another example of lack of awareness, misinformation, or misunderstanding.

> ‘As with all your proposals to centralise services the problem is that of access for patients and their families. Whilst many have access to private transport, a very large minority do not, and they are frequently the elderly and less financially secure. For these people centralisation poses a major difficulty in accessing your services unless you propose to offer free transport between the sites’. [West]
>
> I'm disabled and have no transport to get to and from the hospital in Gloucester would very difficult especially as wheelchair accessible transport is no longer provided to bring me home on the day of discharge. [East]

3.6.5.2 Proposal: Planned Day Surgery Upper and Lower GI centralised at CGH

The ‘choice claim’ for Day Surgery is that respondents either do or don’t recognise the value of centralising services at one or other of the two hospitals (see Fig. 32)

The first warrant which bridges the claim above to the data is that creating ‘hot’ emergency and ‘cold’ planned CoEs is a good idea. As part of the clinical response to COVID-19 in the county, CGH was designated a ‘cold’ non-COVID-19 site (apart from Oncology/Cancer), and GRH was designated the ‘hot’ COVID-19 site. As noted earlier, the FFtF consultation took place during the COVID-19 pandemic, with consultation activities modified to meet social distancing restrictions. The awareness of separating services across the two hospitals may have been greater during the

2021 FFtF consultation than at any time in the previous 20 years. This may be reflected in the data below, from both sides of the county, which support the policy of using GRH for specialist emergencies and CGH for planned services.

> ‘Keeping planned activity in CGH if emergency services are going to GRH makes sense’. [West]
>
> ‘I like the emphasis of removing emergency from CGH so that all the planned can proceed without interruption by the obviously unpredictability of emergencies’. [East]

The second warrant, the same as the response to the Acute Medicine proposal above, is that specialist services are needed at both hospitals in Gloucestershire, to facilitate easy access for patients and visitors, wherever they live in the county. However, the responses selected below mostly come from the west. The rationales for this view include concerns about population growth, over-dependence on GRH, and a comment this time about Cheltenham’s location on the map not being central to the county.

> ‘I think it should be at both hospitals, leaving it easier for people to go to hospital nearest to where they live’. [West]
>
> ‘Because of the increased local population both sites should be used’. [West]
>
> ‘Cheltenham is not central to county’. [West]

This respondent suggests an alternative to either CGH or GRH.

> ‘Why go to Gloucester when you can go to Oxford?’ [East]

This last view contradicts one of the aims of CoE, which is to retain specialist services in the county to maintain local access for residents. As seen previously, the geography of Gloucestershire means that is has many county (and one country) borders; this respondent is from the east, and possibly lives closer to Oxford than Gloucester, explaining their comment above.

And finally, the respondent from the west below, who supports the CoE policy and Acute Medicine proposal, and comments on the relative distance between the two county acute hospital sites. This data point echoes previous comments and indicates some mild frustration with other views which suggest the distance to travel between the two hospitals is too far.

> ‘Having an excellent readily available service that treats me, even if I have to travel, is preferred to waiting, and perhaps getting a second-class service because of a dilution of resources/service, simply to

> accommodate operating on both sites. It is 7 miles, not travelling to the moon'. [West]

3.6.5.3 Planned Lower GI Surgery Proposal: Centralise either at GRH or CGH

The 'choice claim' relating to Planned Lower GI Surgery is once again binary, with respondents either supporting or opposing the proposal to centralise the service in one location in Gloucestershire (see Fig. 33). However, as no preferred site is identified by NHSG, where the data support the proposal, they often recommend a preferred site. The data from across the county show again that there is a view that separating emergency (hot) and planned (cold) care is a good way to organise services.

> 'The service needs to be split across the county with two centres of excellence. A dedicated standalone day case unit in CGH will enable the vast majority of Gloucestershire's patients to have their elective surgery in a protected cold unit'. [East]

> 'Planned at CGH, Emergency at GRH. It would be a neat way of organising activities'. [West]

The respondent below, from the east, is happy with the 'hot/cold' split, referring to COVID-19 experience in their response. However, their challenge is that they feel 'patient choice' is not a characteristic of the CoE policy, or the FFtF programme.

> 'Making Cheltenham a centre for elective surgery makes sense if you are wishing to centralise emergency at GRH, especially with COVID-19. However patient choice does not seem to factor in your decisions'. [East]

It could be argued that the conversation about choice and preference was conducted during the IDEAS engagement, which set the direction of travel for the development of CoE and FFtF. This will be explored further in Chapter Four.

The quote below, from the east, makes the practical observation that patients can 'plan' for planned care, thereby allowing time to make travel arrangements to a different location.

> 'If it is planned surgery the patient will have had time to plan how they will get to and from the hospital, and anyone who wishes to visit can factor the distance into their preparations'. [East]

NHSG would do well to consider adopting this discourse when promoting the CoE policy.

The second warrant is that respondents are not supportive of a single choice of hospital, preferring to access a closer local service. The first respondent, from the

east, gives a practical reason for their opinion; that of potentially being stranded further away from home.

> ‘Both Cheltenham and Gloucester need to do general surgery, I was released from hospital in Gloucester at 11.30pm, and as I was taken there by ambulance, I didn’t have my car. Thankfully I have a son who drives, but many people would be stranded. I could have walked home if I had been taken to Cheltenham’. [East]

> ‘You should be able to go to nearest hospital for treatment, staff should be split between the 2 hospitals if necessary so this can be done’. [West]

The final warrant is that support for the proposal is caveated by a preference for one hospital providing the specialist service.

Preference for GRH: there is support for this option mostly from the west, but the first respondent in the data group below is from the east and, from the detail in the observations made, has experience of both hospital sites.

> ‘Gloucestershire Royal is the most [sic] modern of the two hospitals and parts of the Cheltenham Hospital are 200 years old and unsuitable for 21st century health care provision. The most recent blocks in College Road Cheltenham could be used to complement the services provided at the Gloucester base’. [East]

> ‘It needs to be Gloucester for access from the Forest of Dean [in the west]’. [West]

> ‘CGH not central to the county. Parking nightmare, travel time hours away’. [West]

Preference for CGH: there is support from both east and west for this option. The respondents from the east are vehement in their preference not to have to receive services in Gloucester.

> ‘Strongly support PROVIDED that site is Cheltenham’. [East]

> ‘At Cheltenham General without a doubt, this has been in place for years and has worked without failure to a high standard. I, my family, and friends have received care on this ward to a fantastic degree and then have unfortunately been subjected to GRH due to current events this year [COVID-19]; to say that we were disgusted by this change would be a vast understatement’. [East]

These responses come from the west, and all support the service location in the east.

> ‘Locate the planned specialties into CGH if emergency medicine and surgery are going to GRH’. [West]

> 'Often have to go to Cheltenham for appointments so makes sense to do it at Cheltenham'. [West]

To conclude this section; some of the responses, from both sides of the county, do take a neutral position.

> 'Personal preference Cheltenham but would support either or shared'. [East]

> 'It doesn't matter which site, so long as the service is there and available'. [West]

3.7 Choice Priority Finding

3.7.1 *Accessibility, Accessibility, Accessibility – Again!*

Inadequate public transport infrastructure, cost of public transport, and hospital car parking are frequently occurring themes. Data illustrate the limitations of choice due to personal circumstances of more vulnerable members of the population. The geography of Gloucestershire is a feature of the analysis in this section, with frequent references to the 'centre' of the county used to justify choices. Many responses comment on the distance between CGH and GRH, with respondents from the east casting doubt on the suggestion that 'it's not that far' and respondents from the west stating that an extra 7 miles is 'not a long way to travel' for a specialist service.

There is a theme about the choices individuals make regarding where they live, and the impact this should have on health service provision. This choice is first highlighted from the east at the POLICY stage, who draw attention to population growth around Cheltenham. This observation is also made from the west two years later at the PROPOSALS stage. The suggestion to build a new single hospital is seen again in the choice data. This is a recurring theme across STP and the FFtF engagement feedback, where it was also a feature of the targets data. In the data respondents again pinpoint exact locations to build it alongside the 'hard grey tarmac'.

3.7.2 *Other Choice Findings*

3.7.2.1 A Single Hospital Site for Specialist Hospital Services is Acceptable for Most Specialties

The data show that the CoE policy is a popular choice. Factors influencing relative levels of support are personal convenience, retaining a specialist service in the county, increased efficiency, and quality. However, the choice of which of the two acute hospitals in Gloucestershire to access a service from remains a relatively

polarising aspect of the data. However, when it comes to the proposal relating to Planned Lower GI Surgery – the only proposal where no preferred location is indicated by NHSG – respondents from both east and west (surprisingly, given the generally partisan nature of most of the data across the three case studies) consistently both select CGH as the location of choice for the service; frequently the rationale for this is because CGH is presented by NHSG as the preferred CoE for planned care in the county.

Many of the respondents at the POLICY stage are content with CoEs, if the choice for them is to continue to access services in Cheltenham. As set out earlier when analysing the trust data, many respondents' choice is to retain the *status quo*, trusting that the service is good enough. This observation in the data particularly refers to A&E services, which are considered by some to be general and not specialist services, meaning there should be access to these services at both acute hospitals in the county. It must be noted again that A&E services are not part of the CoE and FFtF conversations.

At the PROPOSALS stage, the impact of the COVID-19 pandemic, on awareness of the potential of two hospital sites to specialise in different aspects of healthcare, is a big factor influencing respondents' choices relating to CoE. The practicalities of 'hot' and 'cold' hospital sites, as they were configured in response to COVID-19, and the potential impact on efficiency and quality, are key features of the data.

3.7.2.2 Location, location, location

As seen previously in the voice data the suggestion to build a new single hospital is seen again in the choice data. Chapter Summary

3.8 Trust

Data coded as 'trust' are presented in this thesis using a series of claim, warrant, data chains. In this section, the data, analysis and interpretation included is that which is relevant to the priority findings that:

- opportunities should be found to increase levels of trust amongst the population through honest communication and
- that there is some evidence of divided communities illustrated by diminishing trust being polarising feature between the east and west.

The finding with respect to communications is found in the data from the second case study, the FFtF Engagement 2019/20 about the development of the CoE policy. Whereas observations regarding division amongst communities apply across the three case studies, peaking at the proposals stage in case study three, where partisan tendencies are more obviously displayed in the data from the east, with preferences expressed for improved services to be centralised at CGH and more negative responses to proposals to centralise services at GRH.

The full analysis and interpretation of all trust data can be found at Appendix 3.

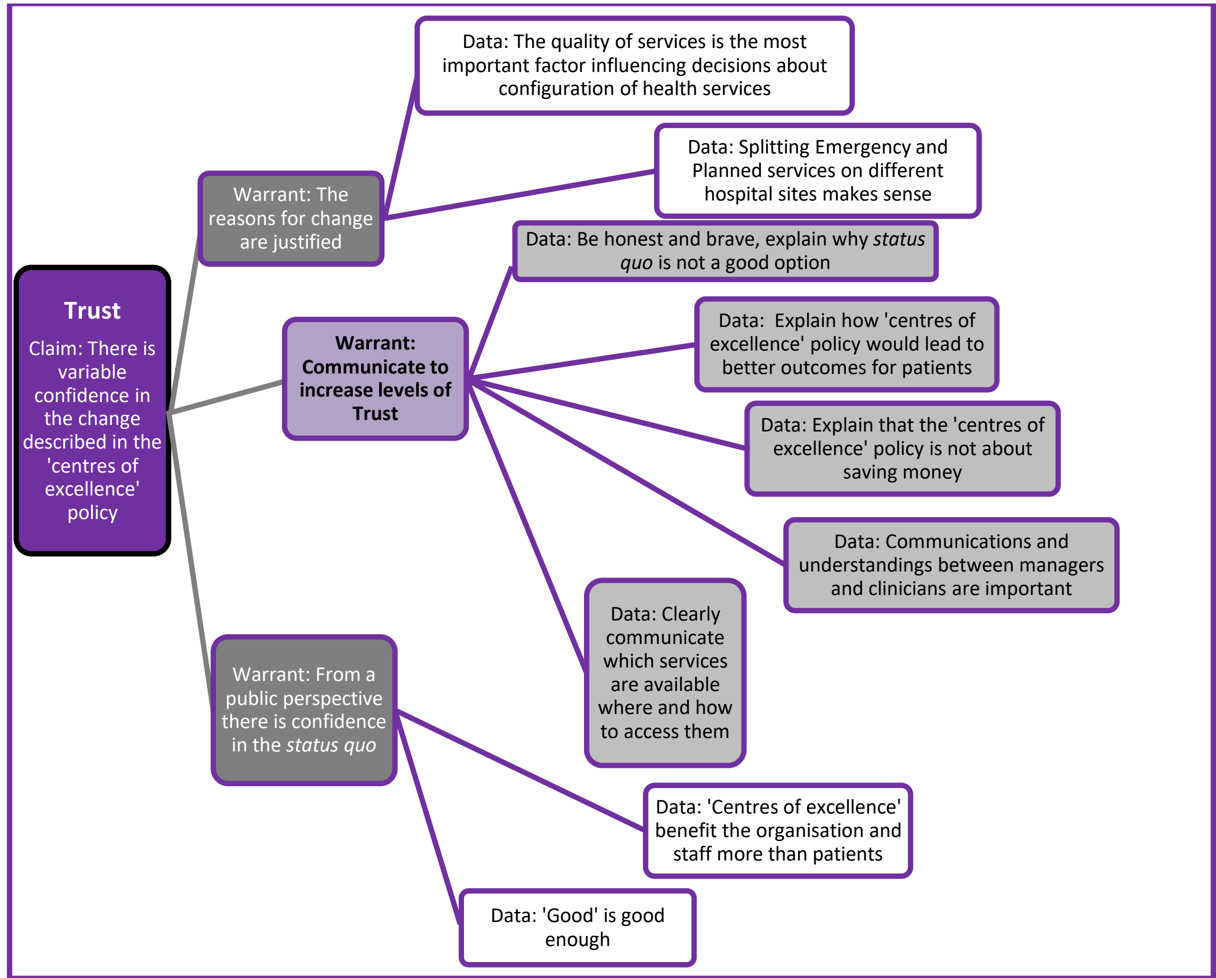
The agency in 'trust', as conceived by Le Grand (2007), lies in the power of the professionals who commission and provide public services, whereas for this framework analysis I have chosen to shift the balance of power to the people and communities in receipt of those services (Department of Health, 2001). I consider their level of trust in the healthcare system, and their confidence in the rationale put forward for potential changes, based on their personal experiences of health care, and any other influences on their degree of trust within or external to the system. I will consider trust in this way in each of the three case studies, tracking any observable changes in the levels of participants' trust, and identifying any potential influences on their degree of confidence. Participation is highest when participants have the greatest opportunity to influence the policy which will ultimately lead to the development of potential changes which may affect them personally. It appears that participants judged their most powerful opportunity was to influence the development of local policy.

3.8.1 *Trust POLICY – Case Study 2: FFtF Engagement 2019/20*

The 'trust claim' for case study 2 is that there is variable qualified confidence in the change described in the CoE policy. This claim is supported by the three warrants;

which include the key trust finding: communicate to increase levels of trust and the data to support the claim. The key finding is discussed below and highlighted in Fig. 34.

Fig. 34 Trust Chain: POLICY



The warrant highlighted as a priority finding relates to the theme found in the data that the local NHS should communicate to increase levels of trust. Here the data divide into five groups: be honest and brave and explain why *status quo* is not an option; explain how 'centres of excellence' policy would lead to better outcomes for patients; explain that the 'centres of excellence' policy is not about saving money; communications between managers and clinicians are important; and clearly communicating which services are available where and how to access them.

The data here clearly show that NHS professionals should not assume that people and communities will accept change without clear explanations of the potential benefits, with proactive communications advice offered by participants from both sides of the county.

> ‘To defend “Centres of Excellence” you have to be more upfront about [the] inadequacies of two-site working. That takes courage and is open to the riposte “just get more money and people”’. [East]

> ‘People will have different motivations, whether that be personal, emotional or political about any changes to either of the two sites... but this needs to be “background noise” and the focus should be on the hard facts around why these services do need to change. The case for change needs to be watertight with clear evidence of why retaining the “status quo” or to “do nothing” is not an option’. [West]

The data support the warrant that communication will increase trust in terms of the CoE policy leading to better outcomes for patients, with improvement in health being a ‘trust quality attribute’ as noted above.

> ‘People have to trust the hospital before they will trust the ‘Centres of Excellence’ contained therein. Generally, ordinary people are not aware of these (with notable exceptions such as Great Ormond Street for paediatrics, Frenchay [a former hospital in Bristol] – as was – for brain issues, etc.). In order to get people feeling that ‘Centres of Excellence’ is a good move, they need convincing that the medical service they receive will be better, not that it will be cheaper or more efficient (not typically what a patient focuses on!)’. [East]

The respondent from the east above literally spells it out in terms of the requirement for the system to earn the trust of the population by focusing on the argument that the CoE policy is about quality improvement rather than bureaucratic concerns, such as efficiency and cost saving; themes more associated with Le Grand’s next model – command & control.

3.8.2 *Trust POLICY – Fit for the Future Citizens Jury Number 1*

As explained earlier in this thesis, NHSG commissioned an independently facilitated Citizens’ Jury as part of the FFtF engagement. In contrast to other participants in this case study, jurors were given a significant amount of time, and access to experts and information, before reaching their conclusions. Given their level of exposure to information, and the luxury of time spent discussing the FFtF programme with expert witnesses, the trust claim for the Citizens’ Jury Number 1 is that jurors supported the CoE policy because they trusted the evidence presented to them. Many jurors expressed the feeling that they had ‘gained insight’ during the jury process.

> ‘We have a good understanding of what a Centres of Excellence approach is, why we need it, and how much it will benefit us. We discussed an important topic (not only for jurors but for everyone in Gloucestershire) and gained insight into the NHS in Gloucestershire.’ (Citizens Juries CIC., 2020)

3.8.3 *Trust PROPOSALS – Case Study 3: FFtF Consultation, 2021*

There are three separate proposals to consider. The trust claim relating to the proposal to centralise Acute Medicine at GRH is that there is concern about the impact of the 'centres of excellence' policy on clinical outcomes (see Fig. 34). The claim for the Planned Lower GI proposal, where no preference is expressed for the site of the CoE, is that the 'centres of excellence' is a positive policy, but some identify investment required at both hospitals (see Fig.35). The outlier is the third claim, relating to the proposal for Planned Day Case: Upper and Lower Gastro-Intestinal surgery, where the claim focuses unequivocally on trust or 'support' for the proposal to create a CoE at CGH (see Fig. 36). Perhaps this is not surprising, given that the demographic data relating to residence shows that most participants to the FFtF consultation live in east Gloucestershire.

The analysis below concentrates on the trust priority finding with respect to diminishing trust seen as a polarising feature between communities which is amplified in the response to the FFtF consultation proposals in 2021 (see Figs. 34, 35, 36).

Fig. 34 Trust Chain: Proposal – Acute Medicine at GRH

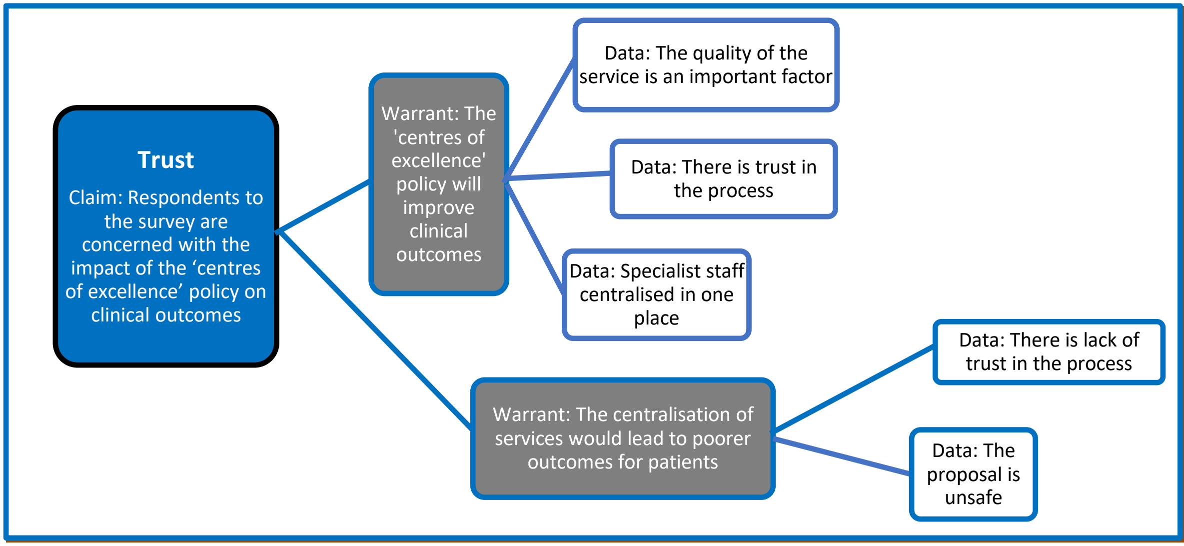


Fig. 35 Trust Chain: Proposal – Planned Lower GI Surgery at GRH or CGH

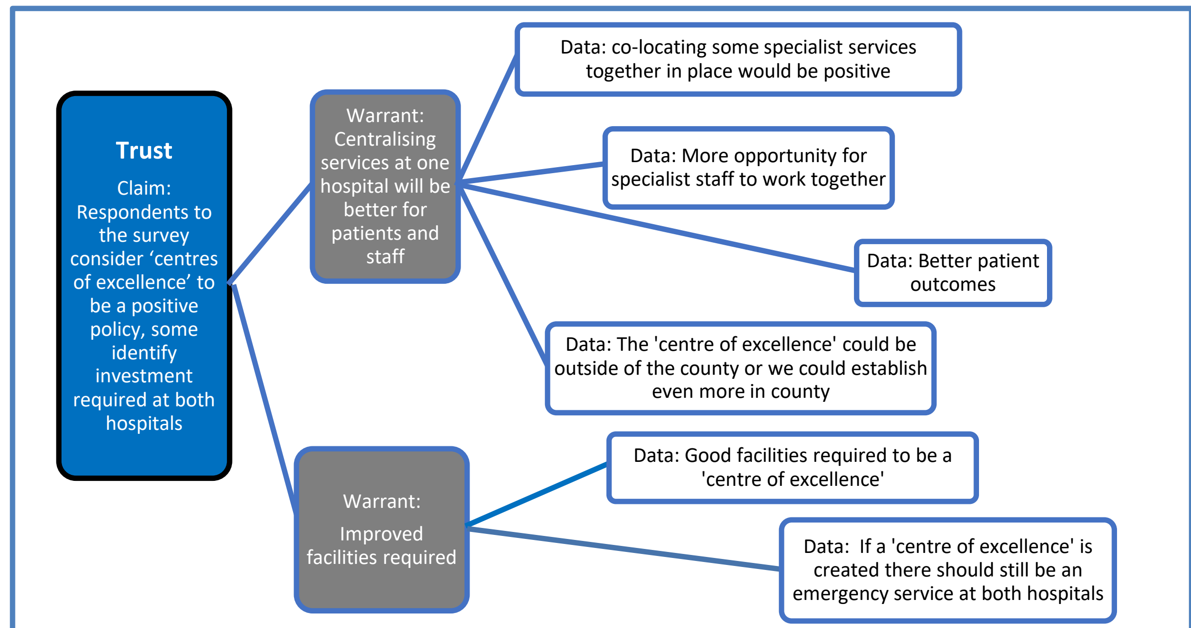
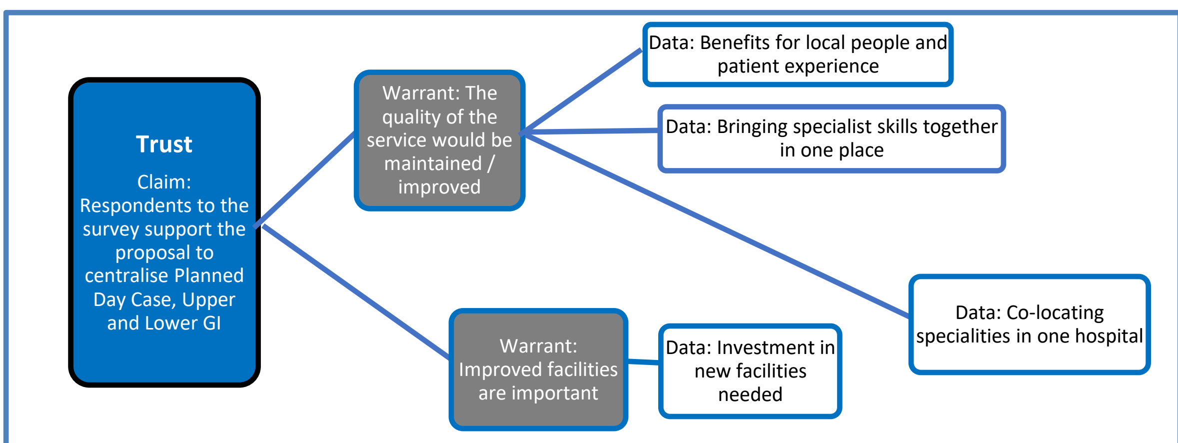


Fig. 36 Trust Chain: Proposal – Planned Day Case Upper and Lower GI (colorectal) surgery at CGH



With the focus at the proposal stage being on existing services, of which patients may have experience, respondents are able to make real comparisons between aspects of the current services and potential future services. Comments about the quality of the current facilities are recorded for the first time in 2021. The data show that respondents from both the east and west have confidence in the facilities at GRH; others felt there is insufficient space at GRH, so the service should be centralised in Cheltenham. This element of comparison is of interest with the proposal to locate Planned Lower GI Surgery at either GRH or CGH, as no preference for a site for the CoE is indicated in the consultation.

> 'I believe in current medicine, centres of excellence are a "good thing". GRH has the space and I trust facilities for this so I am happy to proceed'. [East]

> ‘Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence’. [West]

> ‘It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all’. [East]

The response below, from the east, suggests that by centralising a service at CGH, there is opportunity to create more space for specialisation at the other hospital site. This respondent is happy to see the creation of a CoE at CGH, but feels it is important to comment on current capacity at GRH.

> ‘I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded’. [East]

There is enthusiasm from the east for this service to be centralised in Cheltenham, but it is observed that the current facilities would not be adequate. Respondents are not satisfied by the prospect of potentially securing the site for the centre; their expectation is that current facilities will be improved.

> ‘Planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike’. [East]

> ‘Although I support the idea of a “centre of excellence”, I do think that CGH needs some significant investment in order to become this… if this is more readily available at CGH than GRH, then I am in support’. [East]

Respondents from across the county raise concerns about the safety of centralising Acute Medicine in the west of the county at GRH. The rationale for this belief is not explicitly made by respondents, but there is a suggestion from a response below that again there is a lack of confidence in GRH; this time, however, it is from respondents from the west. Also, the question as to whether acute/emergency services are maintained into the future at CGH as well as at GRH is raised by respondents from both sides of the county.

> ‘Gloucester Royal needs to improve’. [West]

> ‘This move is completely unsafe and a silly move. Cheltenham needs AMU [Acute Medical Unit] too’. [West]

> ‘It makes sense to consolidate planned care at either site, but does an emergency service need to remain at the other site?’ [East]

With respect to creating a CoE at CGH for Planned Day Case Upper and Lower Gastro-Intestinal Surgery, there is no dissent from respondents either side of the county; instead, benefits for local people and improved patient experience are cited. It is interesting to note the respondent from the west below, an outlier from the normal partisan view, who appears to define 'local' as the whole county, rather than differentiating between east and west. It also interesting to note the use of the word 'deserve' in relation to CGH having a 'comprehensive GI surgery facility' due to the likely number of potential patients resulting from visitors coming to Cheltenham. This misses the definition of 'planned' surgery, which would only be available on referral from a patient's GP.

> 'Benefits local people'. [West]
>
> 'I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year'. [East]

Respondents from both sides of the county, but particularly the west, state that they accept the premise of splitting emergency and acute services from planned services. These views align with the CoE vision (see 1.9.5).

> '…centralising all day case GI work at CGH would reduce pressure on GRH to focus on emergency general surgery'. [West]
>
> 'I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital'. [East]

3.9 Trust Priority Finding

3.9.1 *Communicate to Increase Levels of Trust*

The data identify the opportunity to increase levels of Trust amongst the population through honest communication; specifically making it clearer what services are currently available where and that FFtF is not about saving money.

Jurors at the first FFtF Citizens' Jury, convened at the end of the FFtF engagement in 2020, benefitted from increased levels of understanding following a week of intensive information-sharing and discussion. An intended consequence is that jurors' comments demonstrate a high level of trust in the professionals who talked with them about the rationale for the CoE policy. Jurors demonstrate Trust in the justifications made for the trade-offs associated with the centralisation of specialist hospital services. However, some are less confident about the ability to deliver the

benefits of the policy, namely improved quality, efficiency, and sustainability of specialist services in Gloucestershire.

The overall level of confidence amongst all respondents is specifically considered in relation to the extent of support or opposition to proposals for service reconfiguration. At the PROPOSALS stage of the research period, the FFtF consultation in 2021, the question of trust becomes more binary. The data suggest that support during this stage is largely influenced by the postcode of the participant. Respondents from the east generally demonstrate more trust in proposals to centralise services at CGH. They cite quality improvements as benefits of the proposed change. Respondents from the east generally express reservations about proposals to centralise any services at GRH. In the example where there is no preferred location indicated for the specialist service, the levels of trust focus on the CoE policy as a positive concept (so long as the centre is in Cheltenham), rather than the specific proposal presented.

3.10 Command & Control (Targets)

Data coded as relating to 'targets' are presented using a series of chronological claim, warrant, data chains.

3.10.1 *Targets Priority Finding*

In this section, the data, analysis and interpretation included is that relevant to the 'targets' priority finding attributed to political influence that:

- there is some evidence of divided communities. This is found in the data from all case studies.

It should be noted that 'Accessibility, accessibility, accessibility' also features in the targets data. I suggest it is used as a rhetorical device.

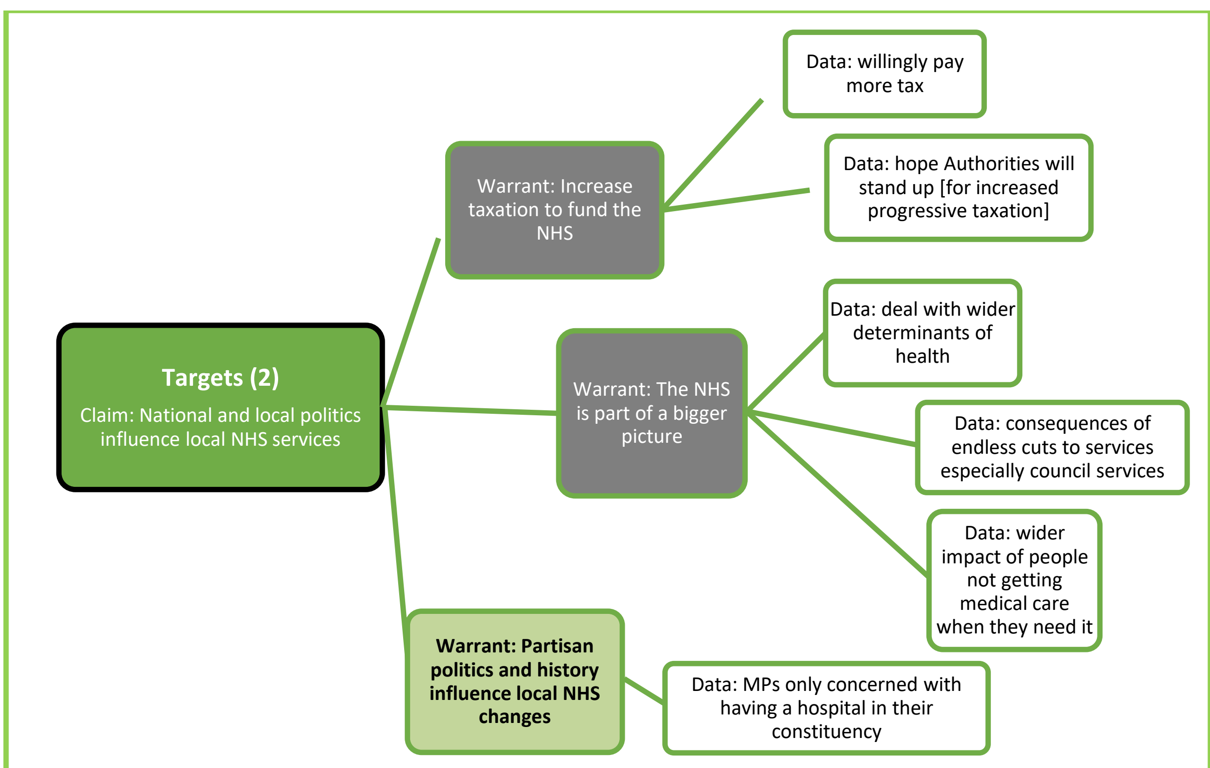
The full analysis and interpretation of all command & control (targets) data; which also find that relative efficiency of public services as a constant feature across the three case studies; can be found at Appendix 4.

Key themes are identified and interpreted and illustrated by representative quotations selected from the data from both east and west; or from one side of the county as required to reflect the response to the IDEAS, POLICY or PROPOSALS.

3.10.2 *Targets IDEAS – Case Study 1: STP Engagement 2016/17*

The targets claim selected for attention in this chapter is that national and local politics influence local NHS services (see Fig. 37). This is of particular relevance to the priority finding regarding division amongst the communities of Gloucestershire, which shifts focus from national political influence towards Gloucestershire's political history.

Fig. 37 Targets (2) Chain: IDEAS



The views come from the west of the county, suggesting local MPs favour a constituency partisan approach, rather than achieving a countywide party political consensus. At the time of the STP engagement in 2017 all but one of the six Parliamentary seats in Gloucestershire were held by Conservatives; the one exception being Stroud in the west, which changed to the Conservatives at the 2019 General Election.

> 'The NHS needs to be less risk-averse in its solutions to problems – I feel it is often constrained by history and local politics. It needs to be less tied to existing buildings and ways of working if you are truly going to achieve the change that is required'. [West]
>
> 'More money is going in all the time but outcomes are worse than ever; MPs are only concerned with having a hospital in their constituency even if the greater good would be served by combining resources with a neighbouring town and consolidating health care'. [West]

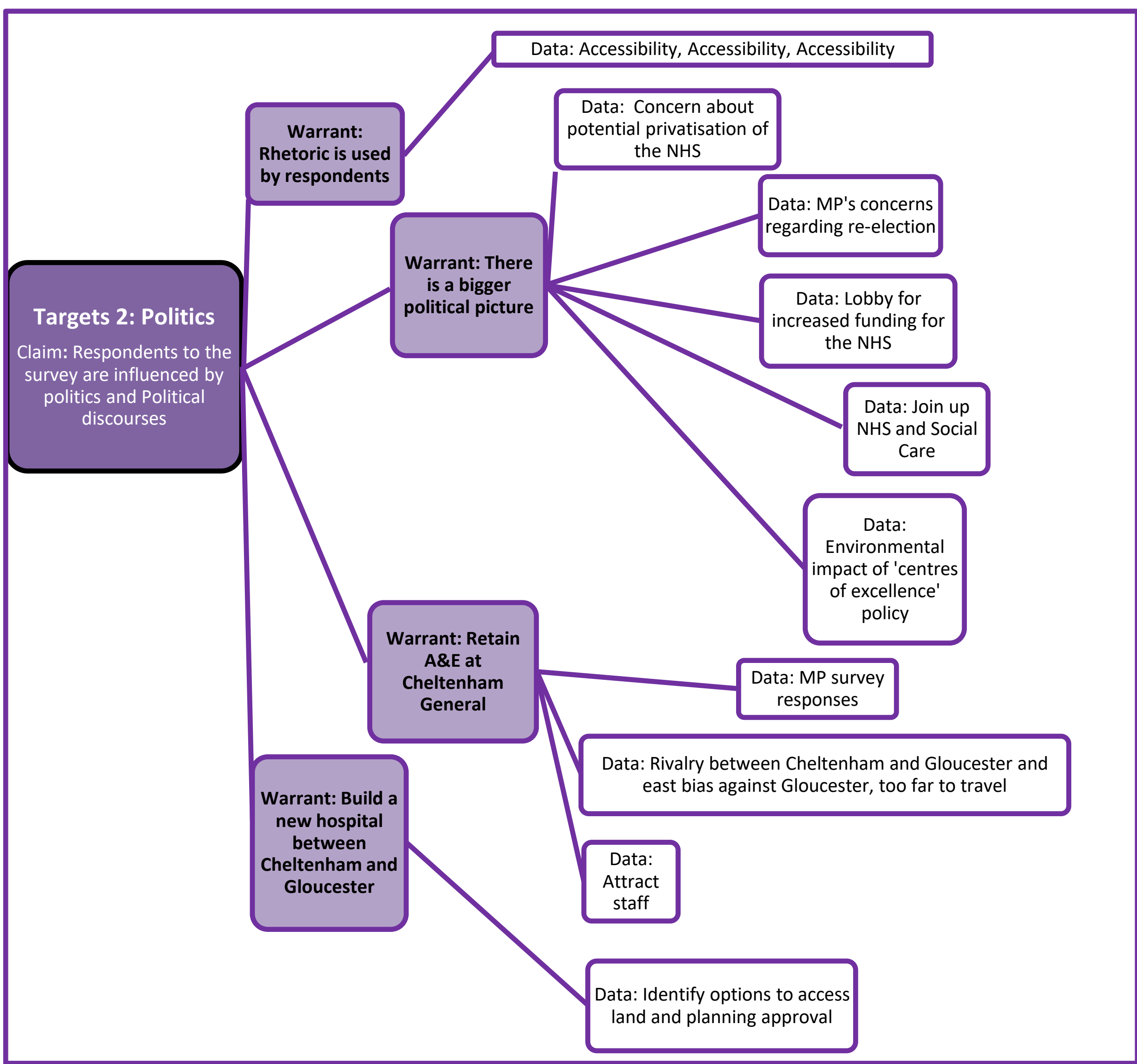
3.10.3 *Targets POLICY – Case Study 2: FFtF Engagement 2019/20*

The Targets (Politics) claim is that respondents to the survey are influenced by politics and political discourses (see Fig. 38).

'You must make a commitment to the people of Cheltenham!' is one of the quotes from the east which I selected to illustrate the claim above. This call to action is a theme which also runs through the Targets (2) Politics Claim. In commenting on the CoE policy in the FFtF engagement, respondents exhibit a diverse set of political

influences and perspectives. Almost all the selected quotes used to illustrate this claim originate from the east of the county.

Fig. 38 Targets (2): POLICY



The first warrant is that rhetoric is used by respondents. This is illustrated in the data from a respondent living in the east of the county.

> 'Accessibility, Accessibility, Accessibility'. [East]

Repeating a triple priority for emphasis is an established political rhetorical device. One of the best known examples of this, from UK politics during the research period, is 'Education, Education, Education' (Blair, 1997; Blair and Adonis, 1996). From the response here it is difficult to tell how accessibility is measured by the individual. Is it used in relation to the CoE policy, in terms of distance from home to hospital, or in terms of access to a service that might otherwise not be available in the county? Alternatively is it to do with equitable, physical, cultural, financial, or some other

factors which might restrict access for an individual or group. My assumption, when undertaking the primary analysis of the data (NHSG, 2020), was that the respondent from the east meant this comment to refer to distance to travel, i.e. accessibility of specialist services; too far to travel to GRH from the east of the county, or conversely not too far to travel to CGH from the east of the county. I think it is reasonable to assume that the respondent is using a rhetorical device to highlight an important issue from their perspective, but without further context, its impact in terms of influencing decision makers is limited. For people completing surveys it is important to consider how the data is provided to maximise its impact on decision makers, and for survey designers to increase clarity of meaning in the data collected. In response to this challenge, at the FFtF consultation PROPOSALS stage the following qualifier question was added – 'Please tell us why [emphasis added] you think this, e.g. the information you would like us to consider' (see Appendix 1).

The second warrant is that there is a bigger political picture to consider. There are lots of connecting themes. Particularly noteworthy are the potential threat to re-election of the local MP if NHS services move outside of constituency, and again, the suggestion to be brave and petition elected representatives for increased funding for the NHS. Also, linked to this, and an earlier observation about joint funding, the suggestion that the NHS and social care should be more integrated. The data below, from both east and west, illustrate the variety within this warrant.

MP's concerns regarding re-election –

> 'I believe that as long as any decision you make is not influenced by political fear over the loss of votes then I am comfortable with the outcomes. Allowing political intervention based on loss of voters is cowardly and puts people's lives at risk'. [East]
>
> 'Centres of Excellence approach sounds extremely sensible and clinically the right thing to do. Lots of politics and showboating when it comes to Cheltenham and Gloucester, but need to take a view about what is best for the patient'. [East]
>
> 'The Centres of Excellence idea is a good one and from a medical viewpoint it can't be argued with although politicians will'. [West]

Lobby for increased funding for the NHS –

> ‘Unfortunately things needed to be put in place ages ago, and then by now we might already have Centres of Excellence, to allow this country to again lead the world in medicine and many other things too. We need politicians to be brave and increase taxes a little to allow this to happen’. [East]

Join up NHS and social care –

> ‘To allow a system where poor social care facilities block hospital beds with patients who cannot be released because of inadequate facilities is appalling and shows a deliberate paucity of thinking from the Government, Social care should be a part of the NHS’. [East]

The third warrant is the request to retain A&E at CGH. As noted, several times already, no proposals to change the A&E department at CGH feature in the STP or the FFtF programme. This warrant is strongly linked to the data above relating to the re-election of the local MP for Cheltenham, who promoted the FFtF engagement and provided sample survey responses which refer to the potential loss of the A&E at CGH. These responses were replicated by significant numbers of respondents. The first quote below from the data is a sample MP response and the second quote echoes the concern about CGH A&E but does provide a qualifier regarding the impact on accessibility.

> ‘Specialisms should not be pursued to the extent that CGI loses its A&E. Cheltenham General Hospital is exactly that – a general hospital – and no reconfiguration that might undermine that status should be considered’. [East: MP sample]
>
> ‘Keep A&E Cheltenham open. No point in providing a wonderful service (at Gloucester) if patients can’t get there’. [East]

There is also a set of data linking the attraction for clinicians to work in Gloucestershire to the misunderstanding of the current and future status of CGH A&E; this is a typical example.

> ‘The ongoing uncertainty about the future of the Cheltenham hospital must have an impact on recruitment. It is essential that A&E is retained in Cheltenham for reasons outlined above and that the Trust commits to it for the long term’. [East]

The rivalry between Cheltenham and Gloucester, and bias against GRH, also comes through in the data. The two respondents below cite incidences of choices made to delay accessing treatment in Gloucester, in order to wait for the A&E department at CGH to switch, from a nurse-led unit service overnight, to consultant-led from 8am in the morning.

> 'The most important is to retain A&E at Cheltenham. Our 94-year-old relative has falls in the night but will not call for an ambulance because she knows it will take her to Gloucester, consequently she suffers'. [East]

> 'I recently had to use 999 for a close family member; we delayed the call for five hours until 7am as we did not want to be taken to Gloucester. Had we been able we would have driven ourselves to CGH. The paramedics delayed taking them until 8am so they could go to Cheltenham. They died the following day and we thank God that we did not end up at GRH, where dealing with the situation for 18 hours would have added to an already distressing time. I know of other people who have also delayed a 999 call until after 8am to ensure they go to Cheltenham'. [East]

The final warrant is the suggestion to build a new hospital between Cheltenham and Gloucester. This suggestion is also seen in the 'targets' and 'choice' data. However, there is a particular piece of data, which relates to local politics in the form of planners, and so is selected for inclusion here.

> 'When you take increase in population into account, how sustainable is the split-site scenario? Keep pressure on funders and planners to release land at Staverton/Elmbridge for a single site; modern hospital serving both towns'. [East]

This quote is particularly relevant to this thesis, as it pin-points an exact geographical position situated alongside the 'Golden Valley' bypass. This location is referred to earlier in this paper as the 'hard grey tarmac' creating a link between Cheltenham and Gloucester.

3.10.4 *Targets PROPOSALS – Case Study 3: FFtF Consultation, 2021*

As with the earlier analysis, the FFtF engagement data associated with the targets model shows potential efficiencies or inefficiencies, and value for tax-payer money. Principally, respondents from the east identify inefficiencies for patients in the Acute Medicine proposal to centralise services in Gloucester (see Fig. 39). The tension between the two hospital sites remains a feature in the data for the Planned Lower GI proposal, where no site preference is promoted (see Fig. 40). A new aspect emerges in the data at the PROPOSALS stage with respect to the proposal to create a CoE for Planned Day Case Upper and Lower GI Surgery at CGH. This proposal is seen as having the potential to 'preserve' CGH by retaining more specialist services on site (see Fig. 41). I will concentrate below on targets themes, particularly amplified by, or unique to, the FFtF consultation in 2021.

Fig. 39 Targets Chain: Proposal – Acute Medicine to GRH

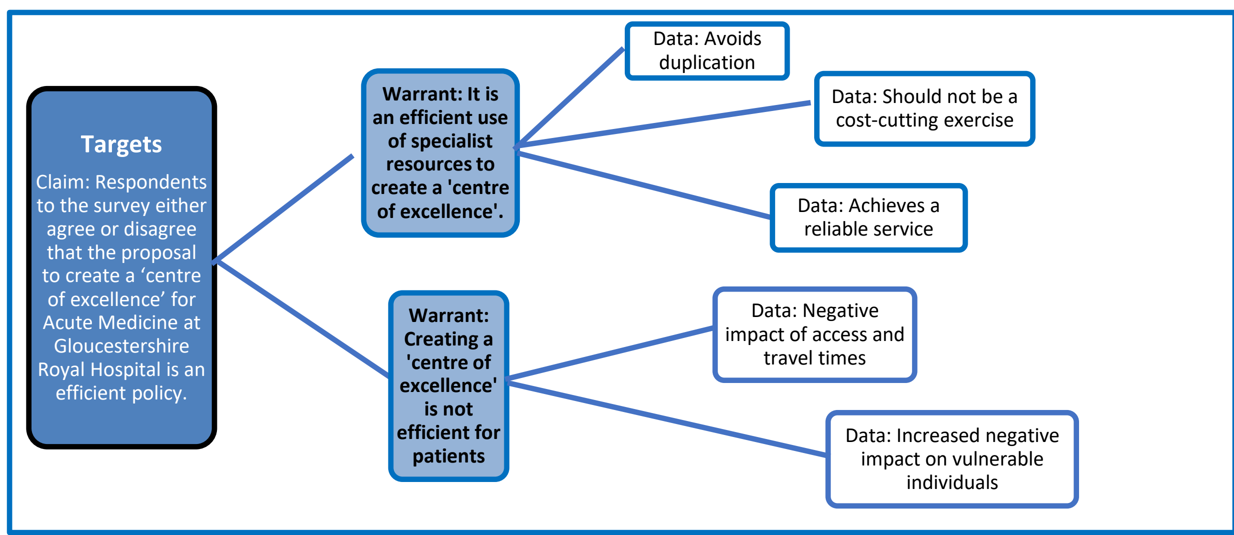


Fig. 40 Targets Chain: Proposal – Planned Lower GI Surgery at either CGH or GRH

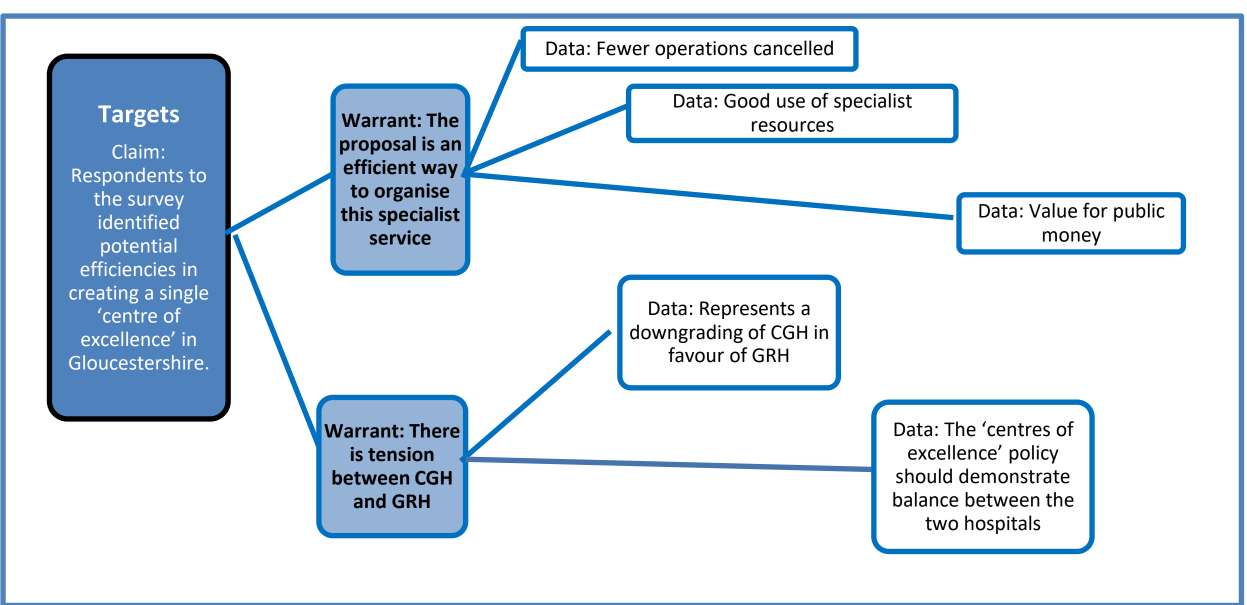
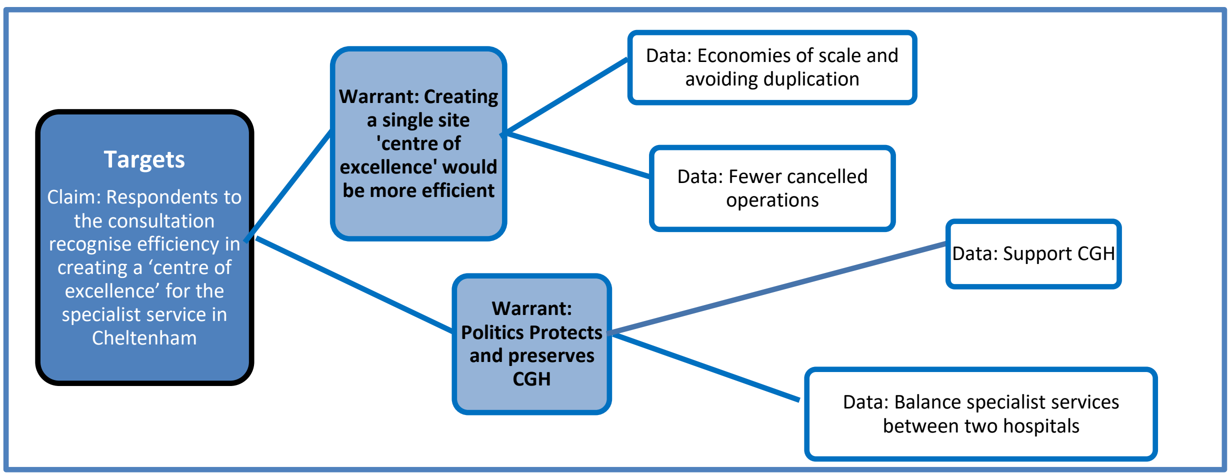


Fig. 41 Targets Chain: Proposal – Planned Day Case Surgery Upper and Lower GI at CGH



As seen in previous claims, there is evidence that respondents from both the east and the west felt that the proposals to create CoEs would be an efficient use of specialist resources.

Acute Medicine at GRH –

> ‘If it means reliable and consistent access to specialists regardless of the day or night then it deserves full support’. [East]
>
> ‘I wish to ensure that the best treatment is available as timely as possible and is not compromised by duplication of service across sites’. [West]

Planned Day Case Surgery Upper and Lower GI at CGH –

> ‘It is easier to manage and better cost savings for the Trust, taxpayer’. [East]
>
> ‘Specialist equipment in one place, more efficient use of resources and specialist staff’. [West]

Planned Lower GI Surgery at either CGH or GRH –

> ‘Planned care still requires experts and equipment; it’s unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other’. [West]
>
> ‘If it means fewer cancelled operations and less disruption in the busy winter months then it has to be a good thing’. [East]

Data from the Planned Day Case proposal, but applicable to all three, indicate respondents from across the county feel the centralisation of specialist services in one place represents value for public money.

> ‘I accept it is no longer practical/affordable to have all specialisms at both sites’. [East]
>
> ‘Focusing a specialism in one location makes the most sense, providing value for money’. [West]

However, this respondent from the west expressed the view that they support the policy of centralising Acute Medicine at one hospital, but that it must be adequately resourced and not be used as a cost-cutting exercise.

> ‘With ever more complex equipment and specialist staff required it makes sense to centralise the service providing the infrastructure, beds, and staff are provided. Such a move must not be seen as part of a cost cutting exercise’. [West]

Introducing a political angle to this point of view, a respondent from the east suggests the FFtF proposals have been prescribed by central government as a way to save money.

> 'This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site'. [East]

As seen previously in the analysis of trust data, there is a degree of acceptance of the logic of centralising services, but there is also a degree of suspicion about the motivation guiding the evolution of the CoE policy as it moves closer towards a real change proposal.

As well as suspicion about ulterior motives, there is also concern that, if implemented, this proposal would have a negative impact on patients, firstly in terms of accessibility. Unlike the previous data, which only highlighted 'accessibility' as being a priority in and of itself, the data below offer a very specific example in relation to the proposal to centralise Acute Medicine in Gloucester.

> 'Concerns about a bottleneck – effect at GRH – if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out'. [East]

The second Planned Day Case warrant is that the proposal to create a CoE at CGH will protect and preserve CGH for the future. However, the data from the east are influenced again by the misinformation about the status of A&E at CGH.

> 'Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH'. [East]

The misunderstanding about the status of the CGH A&E is not exclusive to the east of the county. This respondent from the west is pragmatic about a service being centralised in Cheltenham as a mitigation for the A&E being in Gloucester.

> 'If the 24hr A&E is at GRH then to have this option at CGH would be good'. [West]

When I look at the data for Planned Lower GI Surgery, where no preferred site is indicated, the arguments made to locate the service in Cheltenham, to prevent its downgrading compared to GRH, are forcefully made from respondents from the East.

> 'The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire'. [East]
>
> 'I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question'. [East]

Finally, where there is no site preference indicated by the NHS system (Planned Lower GI Surgery), responses seem more inclined to suggest that the CoE policy should demonstrate balance between the two hospitals; the response below suggests a redressing of the balance in favour of Cheltenham is required.

> ‘We need to establish strong bases in Cheltenham. Naive perhaps to suggest centres of excellence should be visible fairly equally in both hospitals, but there could be a tendency otherwise for one of the two (probably CGH) to have lesser standing, lesser research/funding potential’. [East]

3.11 Targets Priority Findings

3.11.1 *Some Evidence of Divided Communities*

Political influence emerges as a key differentiator of the views of participants from the east and west. This is despite the Parliamentary elected representative make-up of the county during the research period being exclusively Conservative. The data suggest that those participants who express more welfarist associated with the conception of public ownership of public services views appear more likely to express opinions at the IDEAS and POLICY stages rather than at the PROPOSALS stage. This may be associated with the drivers for the proposals not being about reducing staff, public service funding, or the characteristics of the services providers (NHS not private hospitals); rather, focusing on locations of services provided by a single NHS Foundation Trust.

During the POLICY stage there is a stronger political discourse in the east relating to the retention of the A&E department at CGH. An alternative idea put forward by several respondents, to resolve the longstanding competition between Cheltenham and Gloucester, is to build a single hospital for the county situated half-way between the two conurbations. This would be somewhere along the axis of the ‘hard grey tarmac’ (see 1.13.1). This is not a new idea; it has been a recurring topic of discussion between the Trust provider, the Commissioner, the local population, and locally elected representatives for over twenty years. The concept has been tested by the NHS system on several occasions during the period but has been ruled out as being unaffordable on every occasion. It remains an option for consideration by the system in future, should new enhanced NHS capital funding schemes become available. It also features as one of the potential amenities in Gloucestershire County Council’s 2050 Vision for a ‘Super City’.

> ‘Super City – Gloucestershire’s two main urban centres – Gloucester with its cathedral city status and heritage, and Cheltenham with its spa

> town elegance – could grow and regenerate by developing a third centre connecting the two to create a “super city”. This would create a vibrant heart in the centre of the county, offering integrated, creative communities to live and work. The benefits of the “super city” would ripple out to the rest of the county through varied transport links; changing perceptions of Gloucestershire as a group of separate districts (Gloucestershire County Council, 2018)

The ‘Super City’ idea has echoes of the CoE discourse, in that its purpose is to promote the benefits of the two parts of the county working together and to neutralise the negativity created by the distance (physical and historical) between Cheltenham and Gloucester; in the case of 2050 Vision by literally filling in the geographical space between with development.

Back in 2020, at the FFtF PROPOSALS stage, the tension between locating services at either GRH or CGH is a key feature in the data, especially where there is no preference expressed by the NHS system for the location for Planned Lower GI Surgery, and there is a real competition between the two hospitals to provide the service. In relation to the proposal to create a CoE at CGH, there is a sense that this reconfiguration will ‘preserve’ CGH, indicating that respondents feel that the hospital has been, and continues to be, under threat of downgrading.

3.12 Chapter Summary

This chapter commenced with a consideration of the use of Le Grand’s analytical framework and the adaptations required to make it fit for purpose to support the analysis of the data in this thesis. These adaptations primarily related to not coding all the data to the voice model, which could have been legitimate given the nature of its collection through public engagement and consultation activities. Instead data were allocated to the voice model when personal experience was referenced in the data. Prior to the presentation of the detailed analysis and interpretation of the data using claim, warrant, data chains and quotations, four priority findings were highlighted:

1. The value in communicating to increase understanding and trust;
2. The benefits of involving people and communities in policy and service design, and undertake good quality engagement and consultation and listening to what people say;

3. Accessibility, accessibility, accessibility being the most observable common factor for people and communities with respect to healthcare services; and finally
4. Some observable evidence of divergent views between the two communities' residents in the east and west of Gloucestershire. However less division than assumed prior to undertaking the research.

In this chapter, the presentation of the results and analysis of the voice and choice models was prioritised as being most relevant to the research, with relevant aspects of the trust and command & control (targets) models included, and the remainder recorded in the appendices.

4 Discussion

4.1 Chapter Structure

In this final chapter I provide a brief summary of the material presented in this thesis. I feature the priority findings from the analysis in this thesis, considering them in terms of the literature and commenting on their generalisability beyond healthcare policy development and delivery. I reflect on the original contribution of my research, identifying learning for future practice and policy, how it extends the literature and make recommendations for future research.

Finally I judge the outcome of the intention to test the efficacy of using Le Grand's models for organising good public services as the theoretical framework for this secondary qualitative analysis of data.

I conclude this chapter by reflecting on my positionality as the researcher and consider this in the context of potential strengths and possible limitations of the research.

4.1.1 *Thesis Summary*

The title of this thesis is: 'Informed Choice or Informed Voice? A consideration of the views of geographically divided communities regarding the centralisation of specialist hospital services.'

In the 'introduction' I declared that this thesis was about divided communities and why this was an important subject for my research. I presented the theoretical framework used to undertake the analysis (Le Grand 2007) and indicated that by undertaking a detailed secondary analysis of data from three case studies, the two research questions below would be addressed:

1. What influences the choices people make and what informs the voices they use to express their preferences regarding IDEAS for change, development of POLICY to implement change and specific PROPOSALS for change?

2. What do the expressed attitudes towards proposed reconfiguration of specialist hospital services of two geographically divided communities tell us about differential appetites for change?

A literature review situated the thesis within relevant literature providing an overview of scholarly works; which focussed on the core areas explored in this thesis: healthcare consumerism and patient choice policy; reconfiguration of healthcare and involving people and communities in healthcare reconfiguration.

The introductory chapter also provided background to the evolution of decentralisation the NHS in the UK and dominant theories informing healthcare policy; notably New Public Management, Rational Choice Theory and as a counterbalance New Public Philosophy (see 1.6).

To provide context for the consideration of divided communities, big 'D' divergent political appetites for promoting patient choice policy in England and Wales at a national macro-level post-Devolution were presented through a consideration of two political speeches (see 1.7.2). Chapter One then went on to focus on little 'd' micro-level geographical areas within England. Delegated commissioning arrangements were described including NHS commissioners' duties with respect to involving people and communities. The data analysed in this thesis were a product of such activities. The Chapter concluded with a guide to the characteristics of the county of Gloucestershire, and the evolution of the CoE Policy and FFtF programme (see 1.9).

Chapter Two described my relationship with the research, acknowledging that my work and life experience both afforded me a familiarity with the subject of this thesis and the research cohort. I discuss later whether my position as primary and secondary researcher as well as resident influenced the analysis, interpretation and identification of findings.

The remainder of Chapter Two went on to set out the methods used to consider the divergent national discourses and the undertaking of a secondary analysis of qualitative public survey data collected in Gloucestershire.

Detailed results and analysis were presented in Chapter Three.

4.2 Priority Findings

Four priority findings were identified from the analysis of the case studies' data:

1. The value in communicating to increase understanding and trust;
2. The benefits of involving people and communities in policy and service design, and undertake good quality engagement and consultation and listening to what people say;
3. Accessibility, accessibility, accessibility being the most observable common factor for people and communities with respect to healthcare services; and finally;

4. Some observable evidence of divergent views between the two communities' residents in the east and west of Gloucestershire. However less division than assumed prior to undertaking the research.

4.2.1 *Generalisability of the Priority Findings*

Two of the priority findings, those relating to increasing communications (1) and promoting involvement practice (2) I think have potential to influence learning for public service practitioners beyond healthcare services and across all publicly funded services subject to legal duties with respect to involving people and communities in the planning, delivery and evaluation of services. With that in mind most of the learning for practice identified below relates to these two findings.

Priority finding 3, relating to access to services, I would describe as 'descriptive', in that it identifies a common theme from the analysis of the specific Gloucestershire case studies data influencing responses to potential changes to healthcare services in the area. However, this theme is not unique to Gloucestershire. In the literature review, when considering the appetite for choice (see 1.4.1.2), ease of access to healthcare services is a key factor for individuals, with studies from the USA and UK indicating that significant numbers of patients are most likely to choose their closest local hospital (Schwartz et al., 2005; Exworthy and Peckham, 2006). In addition to this, the literature suggests that one of the reasons for the unpopularity amongst populations of centralising healthcare services is a perception that this will result in poorer access due to increased distance to travel. A strong preference for local general hospital type provision closer to where people live with shorter travel times is discussed across the literature (Barrett, 2012; Farrington-Douglas, 2007; Black, 2013; Costa-Font and Greer, 2016; Finlayson, 1999; Fulop et al., 2010; IRP, 2010; Kelly et al., 2016; Landau et al., 2013; 2016; Roberts et al., 2014; Turnbull et al., 2008; Victoor et al., 2014)

Priority finding 4, which relates to evidence of some divergence in views between the geographically divided communities in Gloucestershire, is informed by the specific scenario presented in the data from the three case studies. It features most prominently in the command & control or targets model associated with one of this model's attributes notably the influence of politics both small and big 'p'. However, as noted above in particular with respect to accessibility, there is evidence that communities generally have an affinity with, and are loyal to, their trusted local

hospital. I would argue these sentiments apply equally to other local publicly funded services such as schools or libraries.

4.2.2 *Contribution to the literature*

4.2.2.1 Priority Findings

The first priority finding, relating to increasing trust amongst the public through communication, supplements the literature reviewed associated both with the practice of involving people and communities, more specifically cases for and against centralisation of specialist healthcare. The unique characteristic of the Gloucestershire data considered in this thesis is the subject of centralisation of specialist hospital services within a shire county in England; whereas the literature reviewed is more interested in the cessation of an entire service as opposed to a reconfiguration within a relatively small geographical area where the intention is for the service to be retained in county but in one rather than two locations. However in both the scholarly literature and the analysis in this thesis, for both scenarios the data indicated that both are controversial and unwelcome amongst the certain populations.

The second priority finding that identified the value in involving people and communities is supported by the scholarly literature and the grey literature which places a legislative emphasis on the duties to involve the public.

The third priority finding, which I describe as being 'descriptive' resonates with what scholars identify as a key consideration for patients and the public when considering choices in healthcare. In undertaking a review of the scholarly literature I noted a considerable scholarly interest in patient choice amongst scholars between 2000 and 2010 and then a marked decrease in academic research in the subject in the last decade as choice has become ubiquitous in publicly funded healthcare.

The fourth priority finding, does relate specifically to the Gloucestershire scenario. However, closer observation of the detail in the data indicate that individual communities may be influenced by a number of factors such as loyalty, history or political rhetoric; not an idiosyncrasy of the Gloucestershire population.

4.2.2.2 Choice

Choice seems to be ubiquitous today in public services in the UK; there is an expectation that choice will available and a recognition also that most patients (in England) are unlikely to exercise their NHS Constitutional (see 1.10.2) right to

choose with respect to healthcare provider, preferring mostly to access the closest service under the assumption that quality and efficiency are also ubiquitous. Therefore, because of this, I believe that the scholarly gaze has transferred elsewhere. I suggest it may have shifted away from individual patient choice and towards individual and collective voice.

4.2.2.3 Voice

The literature review showed that there is now growing interest amongst social scientists in exploring the experience of public conversations about significant changes to healthcare services. I think this shift in scholarly interest enhances the relevance of the research presented in this thesis. However, the focus in the scholarly articles selected in the review, was on public consultations about 'all or nothing' full scale hospital closures; whereas the scenario considered in the three case studies in this thesis; is what I describe as: 'fewer or nothing' i.e. the proposed reconfiguration of services from two locations to one 'centre of excellence' within a shire county.

There is no evidence in the literature review of scholarly researchers being interested in the trade-offs between establishing larger centralised sustainable specialised services at the expense of multiple unsustainable small units within semi-urban rural counties. I was also unable to find any longitudinal studies relating to healthcare service reconfiguration in the same locality over an extended period.

The Gloucestershire case studies considered in this thesis span a five year period, but as demonstrated in the guide to Gloucestershire (see 1.9), they represent only three episodes in a long-running pattern of healthcare reconfiguration in the county; which began almost 20 years ago; and which will continues into the 2020s. Therefore, I suggest that the decision to focus on a long-running scenario, augmented by having continuity of the lead researcher, justifies the presentation of this thesis and thereby warrants it as a valuable contribution to the literature.

4.2.3 *Learning*

To support the discussion which follows I have first grouped the priority findings in four tables, together with their associated learnings for practice and policy, under the four models for delivering good public services described by Le Grand (2007) (see 1.3.2).

The learnings for practice and policy identified focus largely on priority findings 1 and 2. Figures 42, 43, 44 and 45 below show the learning identified associated with each priority finding and its relevant model (Le Grand, 2007). The numbering of the learning points is not consecutive in the figures below because it refers to the order in which the learning is presented later in this chapter.

Fig. 42 Learning points associated with the trust model (Le Grand, 2007) and associated priority finding

Trust: Communicate to increase understanding and trust
L1. Learning for practice and policy is that every effort must be made to raise awareness amongst the public of opportunities to get involved, to provide assurance that public feedback regarding potential service change will be taken seriously by decision makers adhering to the fourth Gunning Principle of conscientious consideration L3. Learning for practice to strengthen messages of reassurance regarding use and storage of all survey data. L10. Learning for practice is that misunderstandings and misinformation can contribute to mistrust of health service change and the rationales presented for it. This can be mitigated by designing public materials which provide accurate, up-to-date, open, honest information not only about proposals for change but also about existing services. L17. Learning for practice to work in an equal partnership with people and communities, public services need to be clear about whether alternative choices are viable in the short, medium, or long term; explaining the criteria used to consider viability and involve the public in solutions appraisal processes. This would increase trust, acknowledge the need for efficiency – an element of command & control and demonstrate that voice has been considered and acted upon.

Fig. 43 Learning points associated with the command & control (targets) model (Le Grand, 2007) and associated priority finding

Targets (Politics/Policy): Some evidence of divided communities.
L11. Learning for policy and practice is that public service engagement and consultation activities should emphasize the national policy directives influencing local policy development and implementation.

Fig. 44 Learning points associated with the voice model (Le Grand, 2007) and associated priority findings

Voice Accessibility, Accessibility, Accessibility! Involve People and Communities in Policy and Service Design and Listen to What People and Communities Say
L2. Learning for practice is that adaptations to engagement practice in response to circumstances, should be evaluated both for efficacy against contextual objectives and unintended positive and negative consequences for future activity. L4. Learning for practice and future research is to consider reporting and analysis of multiple data sets (official and unofficial) produced using different designs relating to the same research subject. L5. Learning for practice is to ensure the link between what people said (the data), to how that feedback was used (the application), and the difference it made (the impact) is consistently repeatedly communicated at each stage of a change process. L6. Learning for practice for other significant public service variation programmes is to allow sufficient time and resources for an independent assurance process to be undertaken to minimise participant criticism and risk of successful judicial challenge to a process. L7. Learning for practice and future research is that detailed consideration should be given to the range of demographic variables needed to complement the nature of studies as an element of engagement and research design. L12. Learning for practice is to:

‘Ensure that all ethnic groups and disabilities are consulted. Literature provided in their own communication method’. [East]

L13. Learning for practice is that it is important to be:

‘Actively listened to. Communication using my language. See me as a person, not a label, not an issue and not a number’. [West]

L14. Learning for practice is that:

‘Other hospitals have found that having a Patient Director is very helpful. Patients then have a dedicated place where they can go to find out more information or to explain when things don’t work for them’. [East]

L15. Learning for practice is that:

‘It would be helpful if there were a dedicated team of patient partners looking at things like letters and other communications surrounding these changes. [East]

Fig. 45 Learning points associated with the choice model (Le Grand, 2007) and associated priority finding

Choice: Accessibility, Accessibility, Accessibility – Once Again!
L16. Learning for practice is to acknowledge that, when people and communities are faced with a potential move of a service to further away from the current location, it is necessary to raise awareness and correct misinformation by the provision of accurate information about car parking, public transport, reimbursement of travel costs and non-emergency patient transport. This information should be kept up to date and provided proactively and be available in accessible and multiple formats.

In addition to learning associated with the priority findings there is also learning associated with the application of the theoretical framework in this research: Le Grand’s four models (2007):

L8. Learning for practice for professionals is that secondary qualitative analysis of primary data affords the opportunity to extend engagement, consultation and service evaluation activity beyond the presentation of ‘what’ is said to ‘why’ it may have been said.

Finally, there is a point of learning associated with the consideration of the two political speeches with provide context for divided communities at a national big 'D' level which does not particularly align with the priority findings:

L9. Learning for policy is to consider whether choosing to contrast a policy against another areas' policy enhances or diminishes the value of, or confidence in, the original policy amongst its intended beneficiaries.

4.1 Limitations and Strengths

I have identified both limitations and strengths in this research reflecting upon what their effects may have been on this thesis' findings. The limitations frequently relate to analysis of the case study data regarding the primary case studies' data collection and activities; forming the basis for much of the learning for practice and policy identified here focussing on communication to increase understanding and trust and involving people and communities.

4.1.1 *Fluctuating Public Participation Rates During the Research Period*

The are significant differences in the quantity of data collated in the three data sets. The fact that people from each side of the county chose to get involved at different stages of the evolution of the CoE policy and FFtF programme is open to several interpretations. Lack of awareness of the opportunity to get involved and fatalism that one's opinions will not have an impact on final decisions may have been factors. Also the COVID-19 pandemic, despite the efforts made by NHSG to carry out an assured and approved consultation exercise may have influenced participation rates. Jurors identified apathy amongst the general population to get involved and lack of concern within the NHS system in not aspiring to higher numbers of survey responses received. However, jurors were reassured by the presentation of how sample sizes were calculated.

Another likely reason for the lower response rate for the FFtF consultation is that it took place during a period of restricted activities due to the emergency response to the COVID-19 pandemic in 2020. Consequently socially distanced consultation activities were designed and promoted. However, it may also be possible that the shift to greater use of online involvement methods, such as social media debates, increased exposure of the consultation to audiences who may not previously have been reached or inclined to participate in more traditional ways. It is reasonable to assume that fewer individuals got involved due to cautious behaviours and competing priorities with respect to their health. At this time the prevention of

infection and population health may have taken precedence in peoples' consciousness over details of proposed reconfiguration of specialist hospital services.

Jurors acknowledged the importance of taking expert advice and carefully considering whether to proceed with the consultation in 2020. They identified the adjustments made as strengths but concurred with the finding above that the pandemic may have reduced opportunities for people and communities to engage.

I conclude that the limitations relating to response rates are not restrictive, rather they add a different dimension to the findings, which have led to valuable learning for practice. In particular, the impact of the COVID-19 pandemic added an unexpected element to the findings.

L1. Learning for practice and policy is that every effort must be made to raise awareness amongst the public of opportunities to get involved, to provide assurance that public feedback regarding potential service change will be taken seriously by decision makers adhering to the fourth Gunning Principle of conscientious consideration (see 1.10.3)

L2. Learning for practice is that adaptations to engagement practice in response to circumstances, should be evaluated both for efficacy against contextual objectives and unintended positive and negative consequences for future activity.

4.1.2 *Diminishing Demographic Information Shared by Respondents*

A decline in the numbers of demographic information provided by respondents was also observed in Chapter Two. I identified that concerns regarding anonymity and future usage of personally identifiable data may have contributed to this. In my research I chose not to segment data by whether the respondent was a member of staff, focussing instead on residency east or west. This observation applies both to patients who may have concerns about the impact on their personal future care and to staff who may have concerns regarding effects on their working experience and relationships. I considered making a recommendation to reduce the risk entirely of the possibility of a connection between voice data and demographic data being possible by introducing the option to signpost survey respondents to a second separate survey to collect demographic information. However, I concluded that this option would only be viable if the practitioner or researcher was only interested in

overall representation, because it would not be possible to undertake take cross-case analysis.

L3. Learning for practice to strengthen messages of reassurance regarding use and storage of all survey data.

4.1.3 *Confidence in Ability to Influence Potential Solutions and Decisions*

A possible reason for the response rate been higher during the FFtF engagement may have been because people believed that expressing views at the formative POLICY stage of service change could have more influence over the potential changes proposed later for formal public consultation. Given the significant amount of hospital-based clinical specialty reconfiguration that had taken place in Gloucestershire in recent years (see 1.9.4), there was likely to have been considerable public awareness of the NHS's statutory requirements regarding the importance of involving the public in service development and change previously described (see 1.10.1). It can be argued that by engaging early in discussions, individuals preferred outcomes are more likely to form part of the proposals for change. As noted earlier that the FFtF engagement, case study 2, built on what had been heard during the earlier STP engagement, case study 1. The earlier feedback was a feature of the FFtF engagement materials and survey, but was not referred to in the FFtF consultation, case study 3, public facing documentation.

Jurors expressed concern about proactive demonstration of the impact of public voice on decision makers. They observed that evidence of the impact of previous engagement feedback was not visible in the FFtF consultation materials. This observation may be a justification for apathy amongst the population to express their opinions if they cannot see how previous public views have been considered.

Another interpretation is that potential participants at the FFtF consultation stage took the fatalistic point of view, feeling that their voices would not have influence the eventual outcome, so choosing not to participate. This interpretation supports the discussion below regarding relative trust in the process and the potential impact of people's collective voice to inform the development of solutions and the final decisions.

However, this interpretation does not necessarily fit with the observed reduction in response rate for the FFtF consultation in 2021, when one might argue that, at the final stage of the FFtF programme, the opportunity to influence the final decision

making is at its most critical. An explanation may be that potential respondents to the NHSG consultation survey may have chosen to participate in an alternative survey hosted by the REACH campaign (REACH, 2020); which did feature in the FFtF Output of Consultation Report presented to decision makers (see Appendix 1) A possible limitation of this thesis is that it does not consider the results from the other survey. My justification for this is that no demographic data from the survey was shared by REACH in the public domain, so it was impossible to differentiate between responses from the east or the west (REACH, 2020 and 2021)

L4. Learning for practice and future research is to consider reporting and analysis of multiple data sets (official and unofficial) produced using different designs relating to the same research subject.

L5. Learning for practice is to ensure the link between what people said (the data), to how that feedback was used (the application), and the difference it made (the impact) is consistently repeatedly communicated at each stage of a change process. In the current NHSG strategy for working with people and communities this approach is referred to as 'you said, we listened, we did... (and so what?)' (NHSG, 2022:16).

4.1.4 *Data Collection and Selection*

From the perspective of participants identified during the secondary analysis of the qualitative data under the frame of 'voice', the potential shortcomings in the primary data collection process included: poor survey design, questions were leading, and in the case of the IDEAS survey, that there was no option to choose more than one option, or indeed an 'all' option choice in the ranking questions.

During my professional practice, a frequent criticism is that surveys are leading. In response to this, and to reduce the potential judicial challenge with respect to the case studies considered in this thesis. As previously described, The Consultation Institute was invited to quality assure the final stage of the CoE/FFtF process. This included a review of all survey questions.

L6. Learning for practice for other significant public service variation programmes is to allow sufficient time and resources for an independent assurance process to be undertaken to minimise participant criticism and risk of successful judicial challenge to a process.

With the benefit of hindsight, from my perspective as a practitioner, a further weakness in the surveys' designs may have been not inviting respondents to identify

whether they had recent personal experience of using any FFtF services. To inform the thesis findings it may have been useful to extend demographic cross-case analysis to include other variables, as discussed earlier, such as staff/non-staff responders, as this data was available to me in the original data set. However, a novel strength of this thesis was the inspiration taken from devolution to focus on geographical difference, real or hypothetical. Therefore, I feel it was legitimate to focus on the east/west variable in the research design.

L7. Learning for practice and future research is that detailed consideration should be given to the range of demographic variables needed to complement the nature of studies as an element of engagement and research design.

Another potential limitation from both practice and research perspectives, was the self-selecting nature of the surveys, limiting the range of voices heard. Scholars suggested that those more politically or civically active are more likely to participate in activities of this kind (Powell and Greener, 2009). However, I believe this objection was offset to some extent by the work targeting marginalised groups identified though the Engagement and Equality Impact Assessment to increase diversity in survey responses and by including data from the independently sampled jurors in the secondary analysis. Therefore, I conclude that this limitation is not relevant to the validity of the findings presented in this thesis.

4.1.5 *Consideration of the Application of the Theoretical Framework*

The first group of literature reviewed related to Le Grand's (2007) four models to support the framework analysis presented.

I believe that a strength of this thesis is the application of a theoretical framework as a unifying factor. Le Grand's four models for organising good public services were applied both to the consideration of divergent healthcare policy choices made at a big 'D' level post-devolution in the UK. This provided the context for the detailed secondary analysis of data relating to the small 'd' decentralisation and to the evolution of the CoE policy and FFtF programme in Gloucestershire from 2017-2021. Le Grand's 'voice' and 'choice' models dominate this research which has considered the appetite for choice in the literature and in practice and the differentiated roles, or voices of people from citizens and patients to consumers and campaigners.

Whereas the primary analysis was a straightforward thematic analysis, the secondary analysis used Le Grand's theoretical framework. This added a scholarly

rigour to the interpretation of the data, requiring different skills to those used commonly in professional practice. I believe by concentrating on using the analytical framework to guide the analysis I was able to minimise potential positional bias.

I used Le Grand's framework initially to identify which models most influenced policies promoted at a macro-level. I found that in Wales, where a welfarist ideology was predominant, the 'trust' and 'voice' models were most favoured by policy makers, whose focus was on improving collective public health. Whereas in England, consumerist policies represented by 'command & control' and 'choice & competition', such as the creation of NHS Foundation Trusts and the introduction of patient choice of secondary care hospital, had the dual policy aims of increasing efficiency and equity and improving quality of experience (Le Grand, 2007).

The application of the framework worked well to differentiate between the two national extremes (see 1.7) aligning policy priorities to the narrow model definitions provided by Le Grand (2007) was straightforward. This is unsurprising given that Le Grand's framework is conceptually designed to inform public policy as opposed to analytical philosophy. In a study of diversity and relationships within societies, I consider the use of Le Grand's framework translated particularly effectively in the consideration of the two post-devolution political speeches (Milburn, 2002; Morgan 2002 (b)) (see 1.7.2). I had hoped to identify policy contrast; which I did; and I also found divergence in the rhetoric easily using Le Grand's four frames.

The second application of the framework explored micro-level small 'd' delegation of policy development in Gloucestershire. Using a coding framework adapted from the elements and attributes of Le Grand's four models, the analysis identified themes and, through cross-case analysis, sought to show whether there were observable differences in the views or 'voices', with respect to the choices available to respondents from the east or the west of the county.

It was a challenging part of the process to use Le Grand models' frames to differentiate the codes for the case studies' qualitative data. There were blurred boundaries between models, as can be seen in repetition in the themes presented in the results for each model. Access to services dominates as a theme, but I attempted to nuance the data selection to suit each of the four models. I made a specific adaptation with respect to the 'voice' model by coding data to this model which drew upon personal experiences of existing service configuration to inform respondents' views. As well as nuancing the voice attribution, I also significantly

adapted Le Grand's application of the 'choice' model. Le Grand's version of choice is not cross-sectional; informed by RCT (see 1.6.2). It assumed individuals would act like consumers using information to make informed choices. Whereas in the Gloucestershire scenarios choice was cross-sectional, there was context and limitations. Individuals as well as being multi-vocal were also faced with multiple consequences implicated by their choices. This goes some way to explaining the *status quo* bias seen amongst those whose preference was to just have a good local hospital, with no aspiration towards 'excellence'. An extreme version of this choice was the suggestion to restrict choice in the county to a new centrally located hospital. The data showed that other choices, or preferences, were often misinformed through lack of information, or indeed proliferation of misinformation. For example there was evidence in the data, predominantly from the east, of misunderstanding regarding the status of CGH A&E; which all NHSG materials clearly stated was outside the scope of CoE or FFtF. Another example was the suggestion to commission a shuttle bus between the two hospitals to alleviate travel issues, when one such has been operational for several years.

The choices the Gloucestershire population were invited to consider was not the one laid out by Le Grand or in national policy in England i.e. choice of secondary care provider. That choice was not affected by CoE or FFtF. I had to adapt the framework to suit the choices on offer to the participants in the case studies. The options they had to choose between were distributing specialist services between the two hospitals in the county or potentially facing a future with no in-county service. Two-site specialties were not operationally viable in the longer term for the reasons set out in the CoE policy, meaning patients would have to travel out of county for specialist treatment.

As stated in Chapter Two, I chose this framework because it provided opportunities to look for similarities and differences, or contrasts. The contrast between the four models was not only practical in terms of considering the appetite for choice, but also the fluctuations in range of trust, the relevance of efficiency achieved through command & control (targets), and the divergent experience expressed through voice.

However, Le Grand presented the models over fifteen years ago in 2007 and they represent approaches to public service delivery applied from the inception of the NHS in 1948. The relevance of the continuation of the distinctions made between the four models is questionable today and was challenged with respect to appetite for,

and equity and ability to choose in healthcare (Victoor et al, 2012), with a particular wariness of patient choice identified amongst the medical profession (Iliffe and Manthorpe, 2021). The concept of multi-vocal individuals exhibiting value pluralism challenged the concept of the homogenous health care consumer (Beresford, 2009; Clarke et al, 2007; Lang et al, 2009; Simmons and Birchell, 2009; Simmons and Powell, 2009). Le Grand himself confirmed in 2007 that a combination of the models, with the promotion of individual choice being the most dominant being his preference. However, he refocussed less than ten years later, a year after the publication of the NHS Five Year Forward View (NHS England, 2014); which prompted the NHSG IDEAS conversations; towards a consideration of the efficacy of more paternalistic or trust and voice collective approaches to population health improvement, like that adopted earlier in Wales (Le Grand and New, 2015). Scholarly references to Le Grand's models, and indeed academic interest in the development and application of patient choice policy in the UK, seem to have peaked between the 2000s and 2010s. However, scholarly interest in the last five years with respect to one of the models, voice, is vibrant. There is a wealth of literature informing evidence based voice policy and guidance to inform working in partnership with patients, people and communities; particularly in respect to the response of people and communities in significant service change (Collins et al, 2019; Coultas et al, 2019; Ferlie, 2022; Fraser et al, 2019; Greer et al, 2021; Stewart, 2019; Stewart et al, 2022; Welsh Government, 2023).

The use of Le Grand's models for the framework analysis presented in this thesis has provided an interpretation of the data which is novel. I would not necessarily recommend the use of Le Grand's framework in my professional practice for engagement, consultation or service evaluation. However I believe applying an analytical framework to the analysis of qualitative data is valid in practice. The most important factor would be the identification of a relevant framework. The application of relevant analytical frameworks for analysis of qualitative data should also be considered for both research and practice.

L8. Learning for practice for professionals is that secondary qualitative analysis of primary data affords the opportunity to extend engagement, consultation and service evaluation activity beyond the presentation of 'what' is said to 'why' it may have been said.

A consideration for future research studies is that using Le Grand's framework as a method for contrasting policy prioritisation in the case studies presented has been effective in the context of this thesis and this researcher's experience. In considering the use of framework analysis for future researchers, alterative analytical frameworks more relevant to the research subjects would need to be identified.

4.2 Emerging themes

4.2.1 *Macro-level Discussion: Big 'D' Devolution*

It would be reasonable to suggest that in an investigation into contrasts between two national policy approaches that it might have been preferable if the policy makers at the time in England and Wales had represented opposing political parties. However, as previously stated, this was not the case in 2002 when the two speeches considered in this thesis were delivered; nor is this the case for most of the period covered by the three local case studies (see 1.7.2 and 2.4).

The review of the literature suggested that, despite there being no marked policy differences between nations in the first year post-devolution (Jervis and Plowden, 2000), it was observed by scholars that the Welsh administration was determined to establish a distinctive national identity (Brown-Swan, 2023; Rawlings, 2022). This observation was borne out by the analysis in this thesis of the two political speeches (see 1.7.2). The fact that national difference was still evident and accepted across populations, whether they be 'citizens' in Wales or 'consumers' in England, is an interesting finding.

In the first speech the difference signalled was between nations, in the second it was within a single nation. This matters because both the voice in the first instance, and the choice emphasized in the second, are distinctive political ideological positions.

Morgan utilised a geographical metaphor to emphasize separation: 'clear red water'; the River Severn, a fluvial barrier between the countries (Morgan, 2002). In contrast Milburn made no comparison with devolved nations in his speech to promote greater investment in devolved local healthcare systems in England at a cost of accepting reform and new policies such as patient choice (Milburn 2002 (b)).

To appeal to his Welsh constituency, Morgan promoted welfarist 'Made in Wales' policies, which focussed on a common purpose of reducing health inequalities (Cost-Font and Greer, 2016; Holland, 2010; Morgan 2002). This is in sharp contrast to the consumerist approach described by Milburn, with its focus on the means to deliver

higher quality, more efficient services to individuals through NHS provider competition and patient choice (Greer and Rowland, 2007, Milburn, 2002 (b)).

Differences in individual autonomy promoted through patient choice policy were in practice not very marked; with GPs continuing to be clinical referring gatekeepers to secondary healthcare in both nations (Peckham et al, 2012). The only real difference for patients in England was the opportunity to choose to travel further outside of their local healthcare system to access specialist hospital services. However, as scholars have noted patient consumers generally prefer to choose locally trusted hospitals closer to where they live (Fotaki, 2014). These observations are also evident in the analysis of the case studies' data. Similarly, as was shown (see 1.7) the scrapping of prescription charges in Wales did not benefit a significantly higher percentage of the resident population than it did in England, where more than 90% of medicines are dispensed without cost to the individual (Barker, 2014).

As well as Morgan wanting explicitly to create a contrast between Wales and England; he also wanted Wales to be a laboratory for the creation of new [policy] ideas (Adams and Robinson, 2002; Costa-Font and Greer, 2016; Moon 2012; Morgan 2002). I think that the results presented in this thesis demonstrated that the delegation of responsibility to smaller healthcare systems in England also created 'policy villages,' able to make decisions locally, informed by the voices and needs of their populations (Jervis and Plowden, 2000:9; Costa-Font and Greer, 2016; Coultas et al, 2019). In terms of this research, I present Gloucestershire as an example of a 'policy village'.

Twenty years ago, ironically Milburn ignored policy competition from across the border in Wales, whilst achieving policy triumph over England, seemed almost as important as the policy outcomes to Morgan. Today (summer 2023) the situation is quite different. In a very recent example, the former Conservative Secretary of State for Health in England, Steve Barclay, compared waiting times in England to those in the devolved nations, suggesting waiting times were worse in Scotland and Wales under Labour administrations. Devolved nations rebutted this assertion, stating that waiting times targets and data collection are not consistent across the UK. The BBC News website has recently reported that: 'Mr Barclay has invited UK health ministers to meet to discuss … what "lessons can be learnt from different approaches taken in each nation" (BBC News, 2023).

L9. Learning for policy is to consider whether choosing to contrast a policy against another areas' policy enhances or diminishes the value of, or confidence in, the original policy amongst its intended beneficiaries.

4.2.2 *Micro-level Discussion: Gloucestershire Case Studies*

4.2.2.1 IDEAS, POLICY and PROPOSALS

The One Gloucestershire STP invited a public dialogue between the local NHS and the population of Gloucestershire about IDEAS to improve their health and wellbeing. It set out the challenges for publicly funded health and care services. The FFtF engagement and consultation conversations with local people took the STP IDEAS, tested them and used them to define the CoE POLICY, which in turn informed the development of FFtF PROPOSALS for change to specialist hospital services in Gloucestershire (see 1.9.5).

Specialist hospital service reconfiguration in Gloucestershire is an example of policy development at a 'small d' devolution scale. Gloucestershire is a 'policy village' (Jervis and Plowden, 2000:9; Costa-Font and Greer, 2016). Long memories; tension or acceptance relating to change; and acknowledgement that local health policy is not easy to plan or deliver, all featured in the data. Highlighted is the competition between the two county acute hospitals to provide services and the history of earlier reconfigurations of specialist services in Gloucestershire (see 1.9.3); notably the decision to move the children's inpatient ward to GRH.

As stated, there has been an assumption amongst NHS professionals that there are marked distinctions in the appetite for change to the way healthcare services were configured within Gloucestershire, depending upon an individual's postcode being either in the east or the west of the county. Differences are found through the analysis in this thesis but are not as significant as expected and are largely due to fluctuating survey response rates. Extremes and anomalies are observed but the main reason for resistance to change, notably concerns regarding the continuing accessibility of services, is the same irrespective of where someone lives. Therefore, the secondary framework analysis of the data has shown that labelling either of the two halves of the county as significantly more resistant to change than the other would be inaccurate.

4.2.3 *Discussion of the Four Models' Claims*

In this final section I consider and identify learning from the emerging themes taken from the headline findings grouped under Le Grand's four models:

4.2.3.1 Trust

Across the whole period, at the countywide level there is more quantitative evidence of trust in, or support for, the NHS system's plans overall than lack of trust. However, looking at qualitative trust data from an east/west perspective, there is an obvious distinction, a division which altered during the research period. This finding suggests that people who oppose change are more likely to explain their reasons for this in a survey than others who support them.

The degree of trust demonstrated by the public at the IDEAS, POLICY and PROPOSALS stages shifts. People seemed to trust that their voice would have an impact at the engagement stages, with the FFtF consultation showing the highest levels of mistrust in change, particularly amongst the population of the east.

Levels of trust in the west increased over time and cynicism diminished, as IDEAS were identified in response to local challenges and opportunities became change PROPOSALS informed by system POLICY. At the same time, levels of trust decreased in the east, as the IDEAS and the POLICY developed into more concrete PROPOSALS for change, which more respondents from the east felt affected them negatively. Ultimately, trust in change amongst the population, as shown in the data, moved closer towards a geographically polarised position during the research period.

I believe this point of view has been shaped over several decades of dissatisfaction in the east following the merger of the county's two acute hospitals into a single Foundation Trust in the early 2000s. This presaged the end of the final east/west accountability divide later in the decade, with the establishment of a single county NHS commissioning organisation. Some respondents reminisced specifically about reductions to the number of small community and cottage hospitals in the county during the 2010s. This view was expressed more by respondents from the west, where during the research period I was also leading a simultaneous consultation discussing the potential replacement of two community hospitals in the Forest of Dean with one. This may have heightened public awareness and anxiety in that geographical area.

This is a challenge I have heard many times in my professional life, from individuals linked to groups such as the 'Save Our Hospitals' campaigns. These two points of view taken together suggest to me that, as well as some people having long memories for how the NHS operated locally in the past, recollection of any negative aspects of how services were provided previously have been forgotten or were not well understood in the first place. The findings demonstrated the need to explain when the *status quo* is not an option, whilst taking the opportunity to explain what the reality of the *status* quo means, as there was clearly misunderstanding amongst many of the general population about local service configuration, notably the status of the emergency department at CGH. Several respondents believed incorrectly that the department was closed.

Both survey respondents and jurors, although jurors voted that the FFtF consultation materials were good, recommended providing good quality information as a method to increase trust. The literature review also confirmed that methods to obtain and maintain trust include producing communications materials, which provide reassurance that public views will be considered (Barratt et al., 2015; Dalton et al., 2016; Stewart, 2019). Practitioners and policy makers, as can be seen in the command & control section below, in the case of local NHS managers did not enjoy high levels of trust amongst the participants, must decide whether the purpose of communications is to inform, obtain credibility, correct misinformation or to persuade.

L10. Learning for practice is that misunderstandings and misinformation can contribute to mistrust of health service change and the rationales presented for it. This can be mitigated by designing public materials which provide accurate, up-to-date, open, honest information not only about proposals for change but also about existing services.

Further opportunities for learning relating to misinformation and misunderstanding are considered further in the 'voice' model discussion.

4.2.3.2 Command & Control (Targets)

Local Politics and national policy

During the period of the first case study, all but one of six parliamentary seats in Gloucestershire were held by the same party, this time Conservative. During the second and third case studies all six constituencies were represented by Conservative MPs. One might suggest that looking for different views about a

publicly funded service between residents in different geographies which had elected representatives from the same party might be flawed. However, what is clear from the findings is that constituents' expectations from their elected representatives are that they will defend their local services irrespective of whether proposed changes align with national policies. For example in 2005, whilst consultation was underway regarding proposals to create a single county children's inpatient ward at GRH, a hospital junior doctor stood for the Cheltenham parliamentary constituency, unsuccessfully, in the General Election on a platform of saving the children's ward at CGH. All other candidates standing in the election for the Cheltenham UK parliamentary seat supported the same position, thereby neutralising any advantage for any candidate.

An interesting finding linked to an element of the 'command & control' model, notably influence of politics and bureaucracy, showed that the actions of politicians, operating in their local constituencies prioritise supporting local 'save our…' campaigns over national policies. Political intervention at a street level may influence public views more than the local public service employees such as the NHS managers and clinicians who, in their a-political professional capacities, are responsible for developing local policy to deliver national policy drivers such as the One Gloucestershire STP response to the Five Year Forward View (NHS England, 2014). The 'trust' learning for practice regarding provision of public information seeks to address the proliferation of misinformation. However, I believe that there are also opportunities for future research in this area linked also to the trust findings with respect to who, and in what contexts, is more trusted: bureaucrats or politicians.

L11. Learning for policy and practice is that public service engagement and consultation activities should emphasize the national policy directives influencing local policy development and implementation.

Command & control was the least frequently occurring model identified in the data. The data suggested that targets which test efficiency have permeated public services, in a similar way to patient choice, are ubiquitous. As such, this model significantly restricts the application and relevance of Le Grand's framework.

4.2.3.3 Voice

I have chosen out of respect for respondents' voices to use the actual words of participants to set the scene for the discussion about the findings from the voice data. Involving the voices of people and communities in IDEAS and POLICY design

and development were suggestions observed in both the survey data and jurors' recommendations. The two quotations below came from the first stage of the process - STP IDEAS survey:

> 'The voice of the public should be taken into consideration, and not just commissioners who try to save money, but in the long term cost the NHS more money and adverse publicity. Common sense should prevail'. [Unknown]

Unfortunately, this comment, which resonates also with the trust and command & control discussions above, is from an individual who chose not to share any demographic details alongside their feedback. However, I had to include it because I think it perfectly encapsulated the attributes of the 'voice' model, which aim to achieve responsiveness and accountability (see 1.3.3.3).

The second comment from the east criticises NHSG's choice to invest resources in undertaking engagement with local people instead of delivering services:

> 'I assume that with a fixed budget these little exercises take a lot of people a lot of time, which is funded from the budget that should be used for actually dealing with people rather than talking about it'. [East]

The comment about 'these little exercises', suggested engagement is a waste of NHS resources – staff, time, and money that could be better used providing services.

If the public are to trust that their voices will be heard and their views considered conscientiously, public services must be able to demonstrate explicitly how feedback influences decision making. In this way, trust and credibility in local public service managers can increase and, continuing a theme from earlier, public apathy, in terms of the value of their collective and individual voices, can be reduced.

An opportunity for future research is to consider two questions posed by these two views. How can public services aim to hear and act in response to the voices of people and communities effectively? How can they justify the allocation of public funds to support proactive public engagement to support this aim?

It was very unusual to find reference in the NHSG survey data across the three case studies to indicate that respondents considered impacts on potentially marginalised groups or individuals. However, there are a few notable exceptions. The opportunities for learning set out below offer solutions for practice about accessible information and involving patients with personal experience of health conditions, often referred to as experts by experience. These suggestions link to the earlier

observations about ways to increase trust in the system and the process of involvement. Again, out of respect to these respondents, I will frame the learning for practice using their own voices.

L12. Learning for practice is to:

> ‘Ensure that all ethnic groups and disabilities are consulted. Literature provided in their own communication method’. [East]

L13. Learning for practice is that it is important to be**:**

> ‘Actively listened to. Communication using my language. See me as a person, not a label, not an issue and not a number’. [West]

L14. Learning for practice is that**:**

> ‘Other hospitals have found that having a Patient Director is very helpful. Patients then have a dedicated place where they can go to find out more information or to explain when things don’t work for them’. [East]

L15. Learning for practice is that**:**

> ‘It would be helpful if there were a dedicated team of patient partners looking at things like letters and other communications surrounding these changes. [East]

4.2.3.4 Choice & Competition

The choice data analysis frequently referred to the other three models. As Le Grand identified, all three models can work together, with his preference for choice & competition to be the dominant model at the time his four model was published in 2007.

Creating specialist centres of excellence was presented as a policy intended to attract and retain staff, at a single hospital the local NHS could maintain appropriate skilled staff, facilities and equipment to provide efficient and acceptable quality specialist services. The choice findings showed that the CoE IDEA and POLICY was popular across the county, with data showing a recognition of the benefits of retaining an in-county service, as seen above in the voice findings. Many respondents were content to engage with a conversation comparing choices between locating a service in one of two locations in the county against an alternative choice to travel to a hospital in another county if the local service could not be retained. Others preferred to focus on an in-county location choice between CGH and GRH.

The strongest, most frequently recurring theme in the choice and voice data was the importance of accessibility of services and the preference to leave services where they were; a bias towards the status quo and a fear of potential loss (Kahneman et

al, 1991; Samuelson and Zeckhauser, 1988; Stewart et al., 2022). It is worth remembering that in response to a survey question in 2014 about specialist hospital services, asking about the most important factors if someone needed to see a specialist, the expertise of the clinician seen by the patients trumped the distance to travel to access a specialist service, by quite a margin. However, as shown in Chapter Three, relative support for centralisation of services diminished through the IDEAS and POLICY to the potential reality of PROPOSALS.

The choice and voice findings both illustrated concerns about the impact generally on patients or their visitors having to travel further to access specialist services. The only identifiable protected characteristic referred to regularly in the data was age as a negative factor for increased travel for reasons to do with access to private transport, cost and availability of public transport and requirements for hospital visitors such as car parking. This finding concurs with scholars' observations that age is a limiting factor in individuals' willingness to choose to travel further to access health services (Bühn et al., 2020; Coulter, 2010).

L16. Learning for practice is to acknowledge that, when people and communities are faced with a potential move of a service to further away from the current location, it is necessary to raise awareness and correct misinformation by the provision of accurate information about car parking, public transport, reimbursement of travel costs and non-emergency patient transport. This information should be kept up to date and provided proactively and be available in accessible and multiple formats.

Accessibility was often linked specifically to access to A&E services mostly, but not exclusively, by respondents from the east. CGH A&E was not a service included within the FFtF Programme. However, it was an emotive subject amongst the population in the east and reference to needing to save it, or enhance it, featured regularly in the survey data. In the case studies' I could find only one reference to the exact phrase "patient choice". The individual from the east was convinced by the CoE concept because they were aware of its efficacy during the COVID-19 pandemic. However, they differentiated between an emergency response, where they felt it was acceptable to apply restrictions to choice but were not persuaded that this was applicable to the CoE policy as business as usual.

A permanent solution to the east/west debate was suggested by respondents from both sides of the county during the IDEAS, POLICY and PROPOSALS conversations. The choice to build a new hospital between Cheltenham and

Gloucester. As noted previously a new hospital had been promoted by locally elected representatives as a component of a hypothetical ‘Super City’ to be built by 2050 on land between Cheltenham and Gloucester (Gloucestershire County Council, 2018). This ultimate solution could resolve the ongoing debate about the configuration of healthcare services between the east and the west forever. I am aware that the idea has been tested informally on several occasions by NHS partners but found to be unaffordable. One relative newcomer to the NHS system commented recently on the idea, suggesting that some local people would likely raise concerns about the exact location of a new hospital building if there was a possibility that any sites suggested were geographically nearer to either Gloucester or Cheltenham. The final recommendation incorporates all four models in Le Grand’s framework.

L17. Learning for practice to work in an equal partnership with people and communities, public services need to be clear about whether alternative choices are viable in the short, medium, or long term; explaining the criteria used to consider viability and involve the public in solutions appraisal processes. This would increase trust, acknowledge the need for efficiency – an element of command & control and demonstrate that voice has been considered and acted upon.

4.2.4 *Researcher Familiarity*

I am conscious that others may consider that my familiarity with the subject matter and professional practice connection may have influenced the choices I made in relation to the research, the method used and the approach to analysis of the data (Holmes, 2020).

In this thesis I have defined myself as an ‘insider’ and I acknowledged that my personal positions meant that I was inextricably linked to the world I was researching (Arber, 2006; Coffey, 1999; Holmes, 2020; Hammersley & Atkinson, 1995; Mannay, 2010; Merton, 1972;) (see 2.2). With over 20 years hands-on experience of collecting, collating, analysing and reporting patient and public feedback about service developments and changes to the range and configuration of NHS services provided in the two hospitals at the heart of this research: CGH and GRH; I was uniquely placed to undertake this research. I consider this to be a strength of this thesis.

The method used in this thesis was certainly influenced by the access I had to the data for analysis. This was collected using three public surveys; which had already

been completed and informed the primary analysis; which I undertook as part of my professional role prior to undertaking this research. I was influenced in my choice of data to analyse and interpret by the access I had to a large amount of qualitative data collected through the three public surveys I had already subjected to primary analysis in my professional role. This data was originally intended for use for professional practice purposes for policy and healthcare service re design and, by comparison post implementation of service change, for future service evaluation. Whilst I rightly sought and obtained employer and university ethical committees support for the use of this data in this research, other researchers from outside the NHS may have anticipated restricted access to the data and needed to progress through time consuming NHS ethical approval. The data is available in the public domain in report format (see Appendix 1) but I had professional access to the raw data within the licensed survey software.

I do believe that my professional role has influenced the learning I identified associated with the practice of involving people and communities and conclude that other professionals may have selected other findings from the analysis of the data aligned more closely with their professional responsibilities. For instance, a communications professional may not have identified as many learning points for practice with respect to my priority finding to increase trust through enhanced and extended communications. Such a professional may believe a significant and proportionate amount of communications activity is already undertaken. For instance the misunderstandings regarding the status of CGH A&E; which all NHSG communications materials clearly stated was outside the scope of CoE or FFtF. However, my challenge back would be that communications may be going unnoticed or are being misunderstood for the data to have suggested such a finding.

I have reflected on what I may have missed in my interpretation of the data and identification of learning as a consequence of my familiarity with the research, its location, history and the case studies. If using the same analytical framework, I would hope that another researcher would have identified the same priority findings from the analysis of the case studies' data. However, their recommendations for learning for practice, policy and future research are likely to be different depending upon their personal experience and interests. I chose to focus on the voice and choice models because of my professional expertise and research interest most closely matched their elements and attributes. As a result of these choices, I may

have overlooked findings in the trust and command & control data that other researchers, perhaps those with clinical or technical backgrounds, may not.

4.2.5 *Chapter Summary*

The first half of this chapter presented a thorough consideration of the priority findings including their generalisability beyond Gloucestershire, the NHS and publicly funded healthcare. Their resonance with, and contribution to, the literature was considered and comparisons drawn with other scholarly research reviewed.

The second half of this chapter presented the learning from this research. It used tables to summarise the learning associated with each of the priority findings and the relevant Le Grand model. It also shared some recommendations future researchers and research. Limitations and strengths were also expressed, focussing on the primary data collection and the involvement activities associated with the case studies. There is learning for both little ‘d’ and bid ‘D’ levels and associated with elements and attributes of the analytical framework. The chapter concludes with a consideration of researcher bias and whether it was a factor in the analysis, interpretation and identification of findings.

5 Conclusion

5.1 Divided communities

This thesis has been about divided communities. The research has focussed on the informed, and sometimes misinformed, voices and choices informing healthcare policy development and service change. It has addressed two research questions:

1. What influences the choices people make and what informs the voices they use to express their preferences regarding IDEAS for change, development of POLICY to implement change and specific PROPOSALS for change?

2. What do the expressed attitudes towards proposed reconfiguration of specialist hospital services of two geographically divided communities tell us about differential appetites for change?

To locate the research within the literature, scholarly works concerned with patient choice and voice in relation to healthcare service reconfiguration and in particular the appetite for patient choice were reviewed. To provide context for the thesis, theories which have dominated public policy in the last 40 years, specifically rational choice theory which influenced neoliberal new public management approaches to public service policy development and delivery and, an alternative to this, new public philosophy promoting a welfarist approach, were presented.

To provide context and an example of divergence at a big 'D' devolved national level, a review of two political speeches demonstrated that, at least in the rhetoric of the presentations by policy makers, there is difference on either side of the 'clear red water' post Devolution in the UK.

However, at the heart of this thesis is Gloucestershire; its geography, population and its part in the history of little 'd' healthcare service reconfiguration. It is the location for the research; its CoE policy and its delivery mechanism the FFtF programme are the subject of the case studies.

An interpretative approach, using Le Grand's four models for organising good public services as the framework for the analysis, has underpinned the interpretation of the data from the three case studies and identification of findings and learning.

Four priority findings were identified. Priority findings 1-3 relate to the first research question, priority finding 4 relates to the second research question:

1. There is value in communicating to increase understanding and trust;

2. There are benefits in involving people and communities in policy and service design, and undertaking good quality engagement and consultation and listening to what people say;

3. Accessibility, accessibility, accessibility is the most observable common factor for people and communities with respect to healthcare services; and finally

4. There is some observable evidence of divergent views between the two communities', the residents in the east and west of Gloucestershire. However, there is less division than assumed prior to undertaking the research.

The first two priority findings concern opportunities to improve public professional practice and policy with respect to communications and involvement when working with people and communities. The third priority finding is a quality which resonates across both this research and the scholarly literature: people value services which are local.

With respect to the second research question, using Le Grand's theoretical framework to support the analysis, and following further cross-case analysis by postcode, the objective was achieved of identifying whether there were differences in opinion between divided communities about potential changes to healthcare services within Gloucestershire. Some evidence, albeit less than anticipated prior to undertaking the research, of division between the two communities was found. Therefore, this stands as the fourth priority finding.

5.2 Divided individual

This thesis has been about divided geographies. However, having regularly considered my familiarity with the subject throughout the research period, I conclude that it has also been about a 'divided individual'. I have had to navigate my professional role, my role as a citizen and my role as a researcher. It has been important for me to notice the shift from the prerequisite of neutrality in my professional practice to a position where I could interpret the data. In recognition of this, I have sought to take a pragmatic approach, achieving objectivity in the analysis of the data and identification of findings and learning.

5.3 Contribution statement

Using Le Grand's (2007) four models for organising good public services: trust, command & control (targets), voice and choice, as the framework, this thesis presents analysis, interpretation, findings and learning that prove that conversations

about divergence in healthcare policy development and delivery should not be exclusive to the level of devolved nations in the UK. It has shown that the experiences within divided communities at a smaller county level can make a valuable contribution to the development of IDEAS, POLICY and PROPOSALS for change and are important to research.

Applying Le Grand's four models:

The adoption of decentralisation within public services by national policy makers places 'trust' in local systems to develop their own approaches to service development. The Gloucestershire case studies demonstrate this local autonomy in action. However, priority findings in this thesis identify that there is often mistrust amongst the population with respect to potential changes to local healthcare services as a product of the new IDEAS, POLICY and PROPOSALS for change developed. A priority finding of this research is that the trust of people and communities can be enhanced by good quality communications.

With respect to 'command & control', healthcare 'targets' are set by policy makers for local systems to deliver against. This research has found that differences in views between geographically divided communities about locally developed IDEAS, POLICY and PROPOSALS for change can be informed, or misinformed, by local political priorities.

A priority finding of this research validates the importance of working with people and communities, listening to their 'voice' and taking into account what they say when codeveloping IDEAS, POLICY and PROPOSALS.

Finally with respected to 'choice', this thesis has shown that patient choice is ubiquitous today in healthcare policy. However this research suggests that the choices valued by people do not necessarily align with the choices on offer. Rather than choice between hospitals many people and communities' preference is for good access to a local hospital.

6 References

6.1 Case Studies

All Case Studies references can be found at Appendix 1.

6.2 Academic References

Adams, J. and Robinson, P., 2002. Devolution in Practice: public policy differences within the UK. London: Institute for public policy research.

Adolph, C., Greer, S.L. and da Fonseca, E.M., 2012. Allocation of authority in European health policy. *Social Science & Medicine*, *75*(9), pp.1595-1603.

Archer, M.S. and Tritter, J.Q., 2000. Rational choice theory: Resisting colonization. Psychology Press.

Attride-Stirling, J., 2001. Thematic networks: an analytic tool for qualitative research. *Qualitative research*, *1*(3), pp.385-405.

Bach, S. and Bordogna, L., 2011. Varieties of new public management or alternative models? The reform of public service employment relations in industrialized democracies. The International Journal of Human Resource Management, 22(11), pp.2281-2294.

Bach, S. and Kolins Givan, R., 2011. Varieties of new public management? The reform of public service employment relations in the UK and USA. The International Journal of Human Resource Management, 22(11), pp.2349-2366.

Ball, S.J. and Exley, S., 2010. Making policy with ‘good ideas’: Policy networks and the ‘intellectuals’ of New Labour. Journal of education policy, 25(2), pp.151-169.

Barker, K., 2014. A new settlement for health and social care. Interim report London: The King’s Fund.

Barratt, H., Harrison, D.A., Fulop, N.J. and Raine, R., 2015. Factors that influence the way communities respond to proposals for major changes to local emergency services: a qualitative study. PloS one, 10(3), p.e0120766.

Barrett, P., 2012. Safety, sustainability, accessibility–striking the right balance: reflections of a retiring chair. London: Independent Reconfiguration Panel, 10.

Basit, T., 2003. Manual or electronic? The role of coding in qualitative data analysis. Educational research, 45(2), pp.143-154. Reference in COREQ (see Appendix 2)

BBC News, 21 July 2004: Hospitals celebrate star ratings http://news.bbc.co.uk/1/hi/england/bristol/3912091.stm [Accessed 08/07.2023]

BBC News, 13 August 2023: Steve Barclay calls talks with Scotland and Wales on cutting NHS waiting lists. https://www.bbc.co.uk/news/uk-66490038 [Accessed: 13.08.2023]

Becker, Howard Saul. Sociological work. Transaction publishers, 1971.

Bennett, P. and Smith, S.J. (2007). ‘Genetics, insurance and participation: how a citizens’ jury reached its verdict’. Social Science & Medicine, 64(12),pp.2487-2498.

Beresford, P., 2009. Differentiated consumers? A differentiated view from a service user perspective. In The consumer in public services (pp. 197-218). Policy Press.

Bevan, G. and Hood, C. 2006 (a). What’s measured is what matters: targets and gaming in the English public health care system. Public administration, 84(3), pp. 517-538.

Bevan, G. and Hood, C., 2006 (b). Have targets improved performance in the English NHS?. BMJ, 332(7538), pp.419-422.

Beveridge, W., 1942. Social Insurance and Allied Services. HMSO. https://www.parliament.uk/about/living-heritage/transformingsociety/livinglearning/coll-9-health1/coll-9-health/ [Accessed 08.07.203]

Bhattacharya, A., 2020. When and why might choice in public services have intrinsic (dis) value?. Centre for Analysis of Social Exclusion, London School of Economics.

Bhattarai, N., Mcmeekin, P., Price, C.I. and Vale, L., 2019. Preferences for centralised emergency medical services: discrete choice experiment. BMJ open, 9(11), p.e030966.

Black, N., 2013. Can England's NHS survive?. The New England journal of medicine, 369(1), pp.1-3.

Blair, T. and Adonis, A., 1996, December. Education, education, education. In Speech to the Labour Party Conference, Times Educational Supplement (p. 6).

Blair, T., 1997. Launch at Millbank of Education Manifesto for 1997 UK General Election. [Accessed 10/02/2023] https://www.youtube.com/watch?v=kz2ENxjJxFw

Blair, T., 2002. The courage of our convictions: Why reform of the public services is the route to social justice (No. 603). Fabian Society.

Brown Swan, C., 2023. “We're socialists not nationalists”: British labour and the national question (s). Nations and Nationalism, 29(2), pp.467-481.

Bryman, A., 2016. Social research methods. Oxford university press.

Bühn, S., Holstiege, J. and Pieper, D., 2020. Are patients willing to accept longer travel times to decrease their risk associated with surgical procedures? A systematic review. BMC Public Health, 20(1), pp.1-10.

Burge, P., Devlin, N., Appleby, J., Rohr, C. and Grant, J., 2004. Do patients always prefer quicker treatment?. Applied Health Economics and Health Policy, 3(4), pp.183-194.

Carter, P. and Martin, G., 2018. Engagement of patients and the public in NHS sustainability and transformation: an ethnographic study. Critical Social Policy, 38(4), pp.707-727.

Chambers, S., 2009. Rhetoric and the public sphere: Has deliberative democracy abandoned mass democracy?. Political theory, 37(3), pp.323-350.

Cheek, J., 2004. At the margins? Discourse analysis and qualitative research. Qualitative health research, 14(8), pp.1140-1150.

Citizens’ Juries CIC, 2020. One Gloucestershire Centres of Excellence Citizens’ Jury: Jurors’ Report (v2). https://citizensjuries.org/wp-content/uploads/2020/02/Jurors-Report-1.pdf [Accessed 08/01/2023]

Citizens’ Juries CIC, 2021. https://citizensjuries.org/wp-content/uploads/2021/02/GLOS-CCG-FFTF-2021-CJ-Jurors-Report-v1.pdf [Accessed: 16.08.2023]

Clarke, J., 2005. New Labour’s citizens: activated, empowered, responsibilized, abandoned?. Critical social policy, 25(4), pp.447-463.

Clarke, J., Newman, J., Smith, N., Vidler, E. and Westmarland, L., 2007. Creating citizen-consumers: Changing publics and changing public services. Pine Forge Press.

Coffey, A., 1999. The ethnographic self: Fieldwork and the representation of identity. The Ethnographic Self, pp.1-192.

Colley L. Acts of union and disunion. Profile Books; 2014 Jan 2.

Collins, B.K., Kim, H.J. and Tao, J., 2019. Managing for citizen satisfaction: Is good not enough?. Journal of Public and Non-profit Affairs, 5(1), pp.21-38.

Connell, A., St Denny, E. and Martin, S., 2022. How can subnational governments develop and deliver distinctive policy agendas?. International Review of Administrative Sciences, 88(4), pp.1159-1175.

Costa-Font, J. and Greer, S. eds., 2016. Federalism and decentralization in European health and social care. Springer.

Coultas, C., Kieslich, K. and Littlejohns, P., 2019. Patient and public involvement in priority-setting decisions in England's Transforming NHS: An interview study with Clinical Commissioning Groups in South London sustainability transformation partnerships. Health Expectations, 22(6), pp.1223-1230.

Coulter, A. 2010. Do patients want a choice and does it work? British Medical Journal, 341, pp. 4989.

Coulter, A., 2010. Do patients want a choice and does it work?. Bmj, 341.

Crane, J., 2019. ‘Save our NHS’: activism, information-based expertise and the ‘new times’ of the 1980s. Contemporary British History, 33(1), pp.52-74.

Crisp, N., Stuckler, D., Horton, R., Adebowale, V., Bailey, S., Baker, M., Bell, J., Bird, J., Black, C., Campbell, J. and Davies, J., 2016. Manifesto for a healthy and health-creating society. The Lancet, 388(10062), pp.e24-e27.

Cruddas, J., 2012. On building the new Jerusalem. New Statesman, 28.

Curtin, M. and Fossey, E., 2007. Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. Australian occupational therapy journal, 54(2), pp.88-94.

Dalingwater, L., 2014. Post-New Public Management (NPM) and the Reconfiguration of Health Services in England. Observatoire de la société britannique, (16), pp. 51-64.

Dalton, J., Chambers, D., Harden, M., Street, A., Parker, G. and Eastwood, A., 2016. Service user engagement in health service reconfiguration: a rapid evidence synthesis. Journal of health services research & policy, 21(3), pp.195-205.

Daniels, T., Williams, I., Bryan, S., Mitton, C. and Robinson, S., 2018. Involving citizens in disinvestment decisions: what do health professionals think? Findings from a multi-method study in the English NHS. Health Economics, Policy and Law, 13(2), pp.162-188.

Davidson, D., Paine, A.E., Glasby, J., Williams, I., Tucker, H., Crilly, T., Crilly, J., Le Mesurier, N., Mohan, J., Kamerāde, D. and Seamark, D., 2019. Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study. Health Services and Delivery Research, 7(1).

Davis JR (1990) Adam Smith on the providential reconciliation of individual and social interests: is man led by an invisible hand or misled by a sleight of hand? History of Political Economy 22:2 pp 341 – 352

Delamont, S. and Atkinson, P., 1995. Fighting familiarity: Essays on education and ethnography. Hampton Press.

Department of Health., 2001(a). Learning from Bristol: The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. HMSO.

Department of Health., 2001(b). Shifting the balance of power. HMSO.

Department of Health., 2003. Building on the Best: Choice, Responsiveness and Equity in the NHS. London: Department of Health.

Department of Health., 2004. Choosing health: Making healthy choices easier. London: Department of Health.

Department of Health., 2008. High quality care for all: NHS Next Stage Review final report. https://www.gov.uk/government/publications/high-quality-care-for-all-nhs-next-stage-review-final-report [Accessed 13/02/2023]

Department of Health., 2009. The handbook to the NHS constitution for England. Department of Health.

Department of Health, 2012. Health and Social Care Act 2012. The Stationery Office.

Department of Health and Social Care., 2016. NHS Choice Framework. https://www.gov.uk/government/publications/the-nhs-choice-framework [Accessed: 25.08.2023]

Dopson, S., 1997. The Introduction of General Management in the NHS: An Example of Managed Social Change. In Managing Ambiguity and Change: The Case of the NHS (pp. 57-75). London: Palgrave Macmillan UK.

Dowding, K. and John, P., 2009. The value of choice in public policy. Public Administration, 87(2), pp.219-233.

Drakeford, M. and Campling, J., 2000. Privatisation and social policy. Harlow, England: Longman Publishing Group.

Durkheim, E., 2014. The rules of sociological method: and selected texts on sociology and its method. Simon and Schuster.

Endhoven, J., 2009 in Le Grand, J., 2009. The other invisible hand: Delivering public services through choice and competition. Princeton university press.

Exworthy, M. and Peckham, S. 2006. Access, choice and travel: implications for health policy. Social Policy & Ad

Farrington-Douglas, J., 2007. The Future Hospital. IPPR.

Ferlie, E., 2022. Why is large scale change to health service delivery difficult?: the case of the 2019 NHS Plan. Discover Health Systems, 1(1), p.3.

Finlayson, S.R., Birkmeyer, J.D., Tosteson, A.N. and Nease Jr, R.F., 1999. Patient preferences for location of care: implications for regionalization. Medical care, 37(2), pp.204-209.

Foley, C., Droog, E., Healy, O., McHugh, S., Buckley, C. and Browne, J.P., 2017. Understanding perspectives on major system change: a comparative case study of public engagement and the implementation of urgent and emergency care system reconfiguration. Health Policy, 121(7), pp.800-808.

Fotaki, M., 2014. What market-based patient choice can't do for the NHS. British Politics and Policy at London School of Economics. Administration, 40(3), pp. 267-287.

Fotaki, M., Boyd, A., Smith, L., McDonald, R., Roland, M., Sheaff, R., Edwards, A. and Elwyn, G., 2005. Patient choice and the organisation and delivery of health services: scoping review. In Workshop 1 15th March (Vol. 8).

Fotaki, M., Roland, M., Boyd, A., McDonald, R., Scheaff, R. and Smith, L., 2008. What benefits will choice bring to patients? Literature review and assessment of implications. Journal of Health Services Research & Policy, 13(3), pp.178-184.

Fraser, A., Baeza, J.I. and Boaz, A., 2017. 'Holding the line': a qualitative study of the role of evidence in early stage decision-making in the reconfiguration of stroke services in London. Health research policy and systems, 15, pp.1-9.

Fraser, A., Jones, L. and Stewart, E., 2019. the importance of sociological approaches to the study of service change in health care. Sociology of Health and Illness, 41(7), pp.1215-1220.

Fulop, N., Walters, R. and Spurgeon, P., 2012. Implementing changes to hospital services: factors influencing the process and 'results' of reconfiguration. Health policy, 104(2), pp.128-135.

Fulop, N., West, P. and Barwell, F., 2010. Evaluating Models of Service Delivery: Reconfiguration Principles.

Gabriel, Y. and Lang, T., 2006. The unmanageable consumer. Sage.

Galdas, P. (2017) 'Revisiting bias in qualitative research: Reflections on its relationships with funding and impact' *International Journal of Qualitative Methods;* 16 pp1-2

Gale, N.K., Heath, G., Cameron, E., Rashid, S. and Redwood, S., 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, *13*(1), pp.1-8.

Gerschlick, B., Charlesworth, A. and Taylor, E., 2015. Public Attitudes to the NHS. London: National Centre for Social Research. http://www.health.org.uk/publication/public-attitudes-nhs [Accessed: 07.09.2018]

Glaser, B. and Strauss, A., 1967. Grounded theory: The discovery of grounded theory. Sociology the journal of the British sociological association, 12(1), pp.27-49.

Gloucestershire County Council, October 2020. Agenda and minutes. Health Overview & Scrutiny Committee - Thursday 22 October 2020 10.00 am [Accessed 06/01/2023] https://glostext.gloucestershire.gov.uk/ieListDocuments.aspx?CId=772&MId=10089&Ver=4 and https://glostext.gloucestershire.gov.uk/documents/b17930/Supporting%20documents%20Thursday%2022-Oct-2020%2010.00%20Health%20Overview%20Scrutiny%20Committee.pdf?T=9

Gloucestershire County Council. (2023) Gloucestershire County and District Boundaries Map. www.gloucestershire.gov.uk/media/1521015/district_council_boundaries-9.pdf [Accessed: 13.05.2023]

Gloucestershire County Council., 2018. Gloucestershire 2050. https://www.glos2050.com/what-is-the-vision/ [Accessed: 27.06.2023]

Gooberman-Hill, R., Horwood, J. and Calnan, M. (2008). 'Citizens' juries in planning research priorities: process, engagement and outcome'. Health Expectations, 11(3), pp.272-281.

Gosling, G.C., 2017. Payment and philanthropy in British healthcare, 1918–48. Manchester University Press.

Green, D. and Shapiro, I., 1996. Pathologies of rational choice theory: A critique of applications in political science. Yale University Press.

Green, D.P. and Fox, J., 2007. Rational choice theory. Social Science Methodology. L.: Sage Publications, pp.269-281.

Greener, I. and Mannion, R., 2009. Patient choice in the NHS: what is the effect of choice policies on patients and relationships in health economies?. Public Money & Management, 29(2), pp.95-100.

Greener, I. and Powell, M., 2009. The other Le Grand? Evaluating the 'other Invisible hand' in welfare services in England. Social Policy & Administration, 43(6), pp.557-570.

Greer, S.L. and Rowland, D. eds., 2007. Devolving Policy, Diverging Values?: The Values of the United Kingdom's National Health Services. London: Nuffield Trust.

Greer, S.L., 2005. The territorial bases of health policymaking in the UK after devolution. Regional and federal studies, 15(4), pp.501-518.

Greer, S.L., 2012. Nationalism and self-government: the politics of autonomy in Scotland and Catalonia. State University of New York Press.

Greer, S.L., Stewart, E., Ercia, A. and Donnelly, P., 2021. Changing health care with, for, or against the public: an empirical investigation into the place of the public in health service reconfiguration. Journal of Health Services Research & Policy, 26(1), pp.12-19.

Greer, S.L. and Jarman, H., 2007, August. Policy styles and devolution. In Presented at the "Britain after Blair" conference of the British Politics Group (Vol. 29).

Greer, S.L. and Trench, A., 2010. Intergovernmental relations and health in Great Britain after devolution. Policy & Politics, 38(4), pp.509-529.

Griffiths, R., 1983. NHS Management Inquiry. The Griffiths Report. Department of Health

Gruening, G., 2001. Origin and theoretical basis of New Public Management. International public management journal, 4(1), pp.1-25.

Gusmano, M.K., Maschke, K.J. and Solomon, M.Z., 2019. Patient-centered care, yes; patients as consumers, no. Health affairs, 38(3), pp.368-373.

Hall, S., 2003. New Labour's double-shuffle. Soundings, 24(24), pp.10-24.

Ham, C., 2006. Reconfiguring acute hospitals in England. BMJ, 333(7579), pp.1135-1136.

Hammersley, M., 2005. Taking sides in social research: Essays on partisanship and bias. Routledge.

Hanson, E.J., 1994. Issues concerning the familiarity of researchers with the research setting. Journal of Advanced Nursing, 20(5), pp.940-942.

Hanson, E.J., 1994. Issues concerning the familiarity of researchers with the research setting. Journal of Advanced Nursing, 20(5), pp.940-942.

Harding, A.J., 2021. Older people, information-giving and active agency practices in health, social care and housing: theory, evidence and reflections. Ageing & Society, pp.1-13.

Harding, A.J., Sanders, F., Lara, A.M., van Teijlingen, E.R., Wood, C., Galpin, D., Baron, S., Crowe, S. and Sharma, S., 2014. Patient choice for older people in english NHS primary care: theory and practice. International Scholarly Research Notices, 2014.

Health Foundation, 2017. What does the public think about NHS and social care services? London: National Centre for Social Research. http://www.health.org.uk/sites/health/files/Polling2017_web.pdf [Accessed: 07.09.2018]

Heath, A. and Heath, L.E., 1976. Rational choice and social exchange: A critique of exchange theory. CUP Archive.

Hechter, M. and Kanazawa, S., 1997. Sociological rational choice theory. Annual review of sociology, 23(1), pp.191-214.

HM Government., 2010. Equality act. The Stationary Office, London.

Holland, W.W., 2010. Competition or collaboration? A comparison of health services in the UK. Clinical medicine, 10(5), p.431.

Holmes, A.G.D., 2020. Researcher Positionality--A Consideration of Its Influence and Place in Qualitative Research--A New Researcher Guide. *Shanlax International Journal of Education*, *8*(4), pp.1-10.

Hood, C., 1991. A public management for all seasons?. Public administration, 69(1), pp.3-19.

Hood, C., 1995. The “New Public Management” in the 1980s: variations on a theme. Accounting, organizations and society, 20(2), pp.93-109.

Hood, C.C. and Jackson, M.W., 1991. Administrative argument.

Hooghe, L., Marks, G.N. and Schakel, A.H., 2010. The rise of regional authority: A comparative study of 42 democracies. Routledge.

Hsieh, H.F. and Shannon, S.E., 2005. Three approaches to qualitative content analysis. Qualitative health research, 15(9), pp.1277-1288.

Hughes, D. and Vincent-Jones, P., 2008. Schisms in the church: National Health Service systems and institutional divergence in England and Wales. Journal of Health and Social Behavior, 49(4), pp.400-416.

Hunter, R.M., Davie, C., Rudd, A., Thompson, A., Walker, H., Thomson, N., Mountford, J., Schwamm, L., Deanfield, J., Thompson, K. and Dewan, B., 2013. Impact on clinical and cost outcomes of a centralized approach to acute stroke care in London: a comparative effectiveness before and after model. PloS one, 8(8), p.e70420.

Hunter, R.M., Fulop, N.J., Boaden, R.J., McKevitt, C., Perry, C., Ramsay, A.I., Rudd, A.G., Turner, S.J., Tyrrell, P.J., Wolfe, C.D. and Morris, S., 2018. The potential role of cost-utility analysis in the decision to implement major system change in acute stroke services in metropolitan areas in England. Health Research Policy and Systems, 16(1), pp.1-14.

Hutt, J. 2004. [press release] Second offer scheme helping to cut waiting lists, says Jane Hutt. http://www.wales.nhs.uk/documents/25068.PDF [Accessed 02.09.2018]

Iliffe, S. and Manthorpe, J., 2021. Medical consumerism in the UK, from ‘citizen’s challenge’ to the ‘managed consumer’—A symbol without meaning?. Health Expectations, 24(2), pp.182-187.

Independent Review Panel., 2010. Learning from reviews: an overview. London: IRP.

Jervis, P. and Plowden, W., 2000. Devolution and health. First Annual Report of a Project to monitor the impact of devolution on the United Kingdom’s health services. www.ucl.ac.uk/constitution-unit

Jones, L. and Exworthy, M., 2015. Framing in policy processes: A case study from hospital planning in the National Health Service in England. Social Science & Medicine, 124, pp.196-204.

Jones, L., 2015. What does a hospital mean?. Journal of health services research & policy, 20(4), pp.254-256.

Jung, T., 2010. Citizens, co-producers, customers, clients, captives? A critical review of consumerism and public services. Public Management Review, 12(3), pp.439-446.

Kahneman D et al. 1991. The Endowment Effect, Loss Aversion, and Status Quo Bias. The Journal of Economic Perspectives. Vol 5, No 1 (Winter 1991), pp 193-206.

Karbach, J., 1987. Using Toulmin's model of argumentation. Journal of Teaching Writing, 6(1), pp.81-92.

Kelly, C., Hulme, C., Farragher, T. and Clarke, G., 2016. Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review. BMJ open, 6(11), p.e013059.

Kelly, J.M., 2005. The dilemma of the unsatisfied customer in a market model of public administration. Public Administration Review, 65(1), pp.76-84.

Klein, R., 1989. The Politics of the National Health Service London : Longman (2nd Edition).

Klein, R., 2010. The new politics of the NHS: from creation to reinvention. Harlow, England: Radcliffe Publishing.

Knight, V.A. and Harper, P.R. 2013. The impact of choice on public services. European Journal of Operational Research.

Laing, A., Newholm, T. and Hogg, G., 2005. Crisis of confidence: Re-narrating the consumer-professional discourse. ACR North American Advances.

Landau, J.H., Novick, T.V., Dubois, L., Power, A.H., Harris, J.R., DeRose, G. and Forbes, T.L., 2013. Determination of patient preference for location of elective abdominal aortic aneurysm surgery. Vascular and Endovascular Surgery, 47(4), pp.288-293.

Le Grand, J., 1997. Knights, knaves or pawns? Human behaviour and social policy. Journal of social policy, 26(2), pp.149-169.

Le Grand, J., 2003. Motivation, agency, and public policy: of knights and knaves, pawns and queens. OUP Oxford.

Le Grand Knight or knave? The Guardian 17.03.2003 [accessed 04.01.2023] https://www.theguardian.com/society/2003/sep/17/thinktanks.futureforpublicservices

Le Grand, J. 2006. The Blair Legacy? Choice and Competition in Public Services. London: LSE.

Le Grand, J. 2007. The other invisible hand. Delivering Public Services through Choice and Competition. Princeton/New Jersey: Princetown University Press

Le Grand, J., 2010. Knights and knaves return: Public service motivation and the delivery of public services. International public management journal, 13(1), pp.56-71.

Le Grand, J. and New, B., 2015. Government paternalism: Nanny state or helpful friend?. Princeton University Press.

Lewin, C., 2005. Elementary quantitative methods. Research methods in the social sciences, pp.215-225. Reference in COREQ (see Appendix 2)

Lewis, L., 1975. Max Weber and Value-Free Society. London. Lawrence and Wishart.

Lipsey, D., 2009 in Le Grand, J., 2007. The other invisible hand: Delivering public services through choice and competition. Princeton university press.

Madden, M. and Speed, E., 2017. Beware zombies and unicorns: toward critical patient and public involvement in health research in a neoliberal context. Frontiers in Sociology, p.7.

Magee, H., Davis, L.J. and Coulter, A., 2003. Public views on healthcare performance indicators and patient choice. Journal of the Royal Society of Medicine, 96(7), pp.338-342.

Malpass, A., Barnett, C., Clarke, N. and Cloke, P., 2007. Problematizing choice: responsible consumers and sceptical citizens. In Governance, consumers and citizens: Agency and resistance in contemporary politics (pp. 231-256). London: Palgrave Macmillan UK.

Mannay, D., 2010. Making the familiar strange: can visual research methods render the familiar setting more perceptible? Qualitative research, 10(1), pp.91-111.

Marquand, D., 2002. How united is the modern United Kingdom?. In Uniting the Kingdom? (pp. 287-301). Routledge.

Marquand, D. 2004. Decline of the public: The hollowing out of citizenship. Oxford: Blackwell Publishing.

Martin, G.P., Carter, P. and Dent, M., 2018. Major health service transformation and the public voice: conflict, challenge or complicity?. Journal of health services research & policy, 23(1), pp.28-35.

Maslin-Prothero, S.E., Masterson, A. and Jones, K., 2008. Four parts or one whole: The National Health Service (NHS) post-devolution. Journal of Nursing Management, 16(6), pp.662-672.

Maxwell, J., 1992. Understanding and validity in qualitative research. Harvard educational review, 62(3), pp.279-301

McConnell, A., 2010. Policy success, policy failure and grey areas in-between. Journal of public policy, 30(3), pp.345-362.

Means, R. and Evans, S., 2012. Communities of place and communities of interest? An exploration of their changing role in later life. Ageing & Society, 32(8), pp.1300-1318.

Menon, D. and Stafinski, T. (2009). ‘Health technology assessment in Canada: 20 years strong?’ Value in Health, 12, pp. S14-S19.

Merton, R.K., 1972. Insiders and outsiders: A chapter in the sociology of knowledge. American journal of sociology, 78(1), pp.9-47.

Milburn, A., (Secretary of State for Health) (2002a). Delivering the NHS Plan next steps on investment next steps on reform http://www.nhshistory.net/deliveringthenhsplan.pdf[Accessed 22.09.2019]

Milburn, A. (2002b). New NHS Resources. https://hansard.parliament.uk/Commons/2002-12-11/debates/bae0065d-1544-412f-aeb2-4f1c223c51dd/NewNhsResources [Accessed: 18.08.2019]

Milburn, A. (2002c). Speech to the Annual Social Services Conference, 16 October 2002, Cardiff. Referenced in: Newman, J. and Vidler, E., 2006. Discriminating customers, responsible patients, empowered users: consumerism and the modernisation of health care. Journal of Social Policy, 35(02), pp.193-209.

Milburn, A. 2003. Choice for all. Speech to NHS Chief Executives, 11 February 2003. https://navigator.health.org.uk/content/alan-milburn-secretary-state-made-speech-%E2%80%93-%E2%80%98choices-all%E2%80%99-%E2%80%93-nhs-chief-executives-health [Accessed: 02.09.2018].

Miles, M.B. and Huberman, A.M., 1994. Qualitative data analysis: An expanded sourcebook. Sage.

Mitchell, E.S., 1986. Multiple triangulation: a methodology for nursing science. Advances in nursing science, 8(3), pp.18-26.

Mold, A., 2015. Making British patients into consumers. The Lancet, 385(9975), pp.1286-1287.

Moon, D.S. 2012. Rhetoric and policy learning: On Rhodri Morgan's "Clear Red Water" and "Made in Wales" health policies. Public Policy and Administration, 28(3) pp 306 - 323

Morgan, R. 2002. Clear Red Water [speech]. National Centre for Public Policy, Swansea. 11 December 2002. Available at: https://www.sochealth.co.uk/the-socialist-health-association/sha-country-and-branch-organisation/sha-wales/clear-red-water/ [Accessed: 18.08.2019]

National Centre for Social Research., 2015. British Social Attitudes 2015. https://bsa.natcen.ac.uk/latest-report/british-social-attitudes-33/introduction.aspx [Accessed: 25.08.2023]

National Centre for Social Research., 2021. British Social Attitudes 2021. https://bsa.natcen.ac.uk/latest-report/british-social-attitudes-39/introduction.aspx [Accessed: 25.08.2023]

Needham, C., 2003. Citizen-consumers: New Labour's marketplace democracy. Catalyst.

Needham, C., 2007. The reform of public services under New Labour: narratives of consumerism. Springer.

Needham, C., 2008 (a). Realising the potential of co-production: Negotiating improvements in public services. Social policy and society, 7(2), pp.221-231.

Needham, C., 2008 (b). Choice in public services: 'no choice but to choose'. In Modernising the welfare state (pp. 179-198). Policy Press.

Needham, C., 2008 (c). In Powell, M.A. ed., 2008. Modernising the welfare state: The Blair legacy. Policy Press.

Needham, C. 2009. Editorial: Consumerism in public services. Public Money Management, 29 (2) pp. 79-81.

Newman, J. and Vidler, E., 2006. Discriminating customers, responsible patients, empowered users: consumerism and the modernisation of health care. Journal of Social policy, 35(2), pp.193-209.

NHS England., 2009 and 2012. The NHS Constitution: the NHS belongs to us all. https://www.gov.uk/government/publications/the-nhs-constitution-for-england [Accessed: 25.08.2023]

NHS England., 2014. NHS Five Year Forward View. https://www.england.nhs.uk/five-year-forward-view/ [Accessed: 25.08.2023]

NHS England., 2019. NHS Long Term Plan https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ [Accessed: 01/03/2023]

NHS England., 2022. Working in partnership with people and communities: statutory guidance. https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/ [Accessed: 29.08.2023]

NHS Gloucestershire., 2022. Working with people and communities Strategy. https://www.nhsglos.nhs.uk/wp-content/uploads/2022/06/NHS-Gloucestershire-

ICB-Working-With-People-And-Communities-Strategy-v1.0.pdf [Accessed: 16.08.2023]

NHS Gloucestershire., 2023. Equality and Diversity Strategy https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/our-strategy/ [Accessed: 08.06.2023]

NHS Gloucestershire., 2023. Equality and Engagement Impact Assessment. https://www.nhsglos.nhs.uk/about-us/how-we-meet-our-duties/equality-and-diversity/equality-impact-assessment/ [Accessed: 08.06.2023]

NHS Management Inquiry and Griffiths, S.R., 1983. NHS management inquiry. DHSS Leaflets Unit.

NHS Wales., 2001. Improving Health in Wales: A plan for the NHS with its partners. Cardiff: National Assembly for Wales.

NHS Wales., 2018. Prior Approval Policy. https://whssc.nhs.wales/commissioning/commissioned-services/commissioned-services-documents/prior-approval-policy/ [Accessed: 25.08.2023]

O'Donnell, M., O'Brien, J. and Junor, A. 2011. New public management and employment relations in the public services of Australia and New Zealand. The International Journal of Human Resource Management, 22(11), pp.2367-2383.

Ormston, R., Spencer, L., Barnard, M. and Snape, D., 2014. The foundations of qualitative research. Qualitative research practice: A guide for social science students and researchers, 2(7), pp.52-55.

Osborne, D., &T. Gaebler. 1992. Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector.

Oullier, O., Cialdini, R., Thaler, R.H. and Mullainathan, S., 2010. Improving public health prevention with a nudge. Economic Perspectives, 6(2), pp.117-36. http://oullier.free.fr/files/2010_Oullier-Cialdini-Thaler-Mullainathan_Neuroscience-Prevention-Public-Health_Nudge-Behavioral-Economics.pdf [Accessed 02.09.2018].

Paton, C., 1993. Devolution and centralism in the National Health Service. Social Policy & Administration, 27(2), pp.83-108.

Patton, M.Q., 1999. Enhancing the quality and credibility of qualitative analysis. Health services research, 34(5 Pt 2), p.1189.

Peckham, S., Mays, N., Hughes, D., Sanderson, M., Allen, P., Prior, L., Entwistle, V., Thompson, A. and Davies, H., 2012. Devolution and patient choice: policy rhetoric versus experience in practice. Social Policy & Administration, 46(2), pp.199-218.

Pettigrew, A., Ferlie, E. and McKee, L., 1992. Shaping strategic change-The case of the NHS in the 1980s. Public Money & Management, 12(3), pp.27-31.

Powell, M., 1996. Granny's footsteps, fractures and the principles of the NHS. Critical Social Policy, 16(47), pp.27-44.

Powell, M.A. ed., 2008. Modernising the welfare state: The Blair legacy. Bristol: Policy Press.

Rawlings, R., 2022. Wales and the United Kingdom: a territorial constitutional policy drive. Territory, Politics, Governance, 10(5), pp.714-732.

REACH, 19 November 2020. REACH launch their Fit for the Future Survey [Accessed 06.01,2023] https://www.reachnow.org.uk/reach-launch-their-fit-for-the-future-survey/

REACH, Jan 14, 2021. REACH publish results of their Fit for the Future Survey [Accessed 06.01.2023] REACH publish results of their Fit for the Future Survey - Reach Now

Roberts, A., Blunt, I. and Bardsley, M., 2014. Focus on: distance from home to emergency care. London: The Health Foundation and the Nuffield Trust.

Robertson, R. and Burge1, P., 2011. The impact of patient choice of provider on equity: analysis of a patient survey. Journal of health services research & policy, 16(1_suppl), pp.22-28.

Roderick, P. and Pollock, A.M., 2022. Dismantling the National Health Service in England. International Journal of Health Services, 52(4), pp.470-479.

Rowe, W.E., 2014. Positionality. The SAGE encyclopedia of action research, 628, pp.627-628.

Russell, J. and Greenhalgh, T., 2014. Being 'rational' and being 'human': How National Health Service rationing decisions are constructed as rational by resource allocation panels. Health:, 18(5), pp.441-457.

Safran, D.G., Montgomery, J.E., Chang, H., Murphy, J. and Rogers, W.H., 2001. Switching doctors: predictors of voluntary disenrollment from a primary physician's practice. Journal of Family Practice, 50(2), pp.130-130.

Saltman, R.B. and Vrangbæk, K., 2007. Drawing lessons for policy-making. Decentralization in health care: Strategies and outcomes, pp.77-78.

Samuelson, W. and Zeckhauser, R., 1988. Status quo bias in decision making. Journal of risk and uncertainty, 1, pp.7-59.

Savin-Baden, M. and Major, C., 2013. Personal stance, positionality and reflexivity in qualitative research. Qualitative research: The essential guide to theory and practice.

Schwartz, B., 2004. The paradox of choice: Why more is less. New York.

Scuffham, P.A., Ratcliffe, J., Kendall, E., Burton, P., Wilson, A., Chalkidou, K., Littlejohns, P. and Whitty, J.A. (2014). 'Engaging the public in healthcare decision-making: quantifying preferences for healthcare through citizens' juries'. British Medical Journal, 4(5), p.e005437.

Shannon-Baker, P., 2015. Making Paradigms Meaningful in Mixed Methods Research. Journal of Mixed Methods Research, 1, p.16.

Sheldon, C., 2012. Consultation: revisiting the basic principles. Judicial Review, 17(2), pp.152-160.

Simmons, R. and Birchall, J., 2009. The public service consumer as member. In The consumer in public services (pp. 235-254). Policy Press.

Simmons, R. and Powell, M. eds., 2009. The Consumer in Public Services: choice, values and difference. Policy Press.

Smee, C., 2005. Speaking Truth to Power: Two decades of analysis in the Department of Health. Harlow, England: Radcliffe Publishing.

Smith, A., 1776. The Wealth of Nations: Book IV: Chapter II. The Library of Economics and Liberty.

Socialist Health Association. The New National Health Service. Image of pamphlet distributed to all UK Households 24.02.1948. https://www.sochealth.co.uk/national-health-service/the-sma-and-the-foundation-of-the-national-health-service-dr-leslie-hilliard-1980/the-start-of-the-nhs-1948/ [Accessed: 07.06.2023]

Stepan, A., 2005. Federalism and democracy: Beyond the US model. In Theories of Federalism: A reader (pp. 255-268). New York: Palgrave Macmillan US.

Stevens, S., 2004. Reform strategies for the English NHS. Health Affairs, 23(3), pp.37-44.

Stewart, E., 2016. Publics and their health systems: rethinking participation. Springer.

Stewart, E., 2019. A sociology of public responses to hospital change and closure. Sociology of health & illness, 41(7), pp.1251-1269.

Stewart, E., Dodworth, K. and Ercia, A., 2022. The everyday work of hospital campaigns: Public knowledge and activism in the UK's national health services. In Posters, protests, and prescriptions (pp. 103-124). Manchester University Press.

Stewart, E., Greer, S.L., Ercia, A. and Donnelly, P.D., 2020. Transforming health care: the policy and politics of service reconfiguration in the UK's four health systems. Health Economics, Policy and Law, 15(3), pp.289-307.

Storey, J., Holti, R., Hartley, J. and Marshall, M., 2019. Devolving healthcare services redesign to local clinical leaders: does it work in practice?. Journal of Health Organization and Management, 33(2), pp.188-203.

Tanzi, V., 2008. The future of fiscal federalism. European Journal of Political Economy, 24(3), pp.705-712.

Thatcher, M., 1987. Interview for Woman's Own ("no such thing as society") https://www.margaretthatcher.org/document/106689 [Accessed 22.09.2019].

Thatcher, M., 1987. The Independent, 6 June. In: Needham in Powell, M.A. ed., 2008. Modernising the welfare state: The Blair legacy. Bristol: Policy Press. pp179-198

The Consultation Institute., 2018. The Gunning Principles - Implications. https://www.consultationinstitute.org/the-gunning-principles-implications/ [Accessed: 08.06.2023]

Timmins, N., 2005. The NHS revolution: health care in the market place: Challenges of private provision in the NHS. British Medical Journal, 331(7526), p.1193.

Tong, A., Sainsbury, P. and Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International journal for quality in health care, 19(6), pp.349-357. (Referred to in COREQ see Appendix 2)

Toulmin, S.E., 1958. The uses of argument. Cambridge university press.

Tully, M.P., Bozentko, K., Clement, S., Hunn, A., Hassan, L., Norris, R., Oswald, M. and Peek, N. (2018). 'Investigating the extent to which patients should control access to patient records for research: a deliberative process using citizens' juries'. Journal of Medical Internet Research, 20(3), p.e112.

Turnbull, J., Martin, D., Lattimer, V., Pope, C. and Culliford, D., 2008. Does distance matter? Geographical variation in GP out-of-hours service use: an observational study. British Journal of General Practice, 58(552), pp.471-477.

Valluvan, S., 2021. The clamour of nationalism: Race and nation in twenty-first-century Britain. In The clamour of nationalism. Manchester University Press.

Vaismoradi, M., Jones, J., Turunen, H. and Snelgrove, S., 2016. Theme development in qualitative content analysis and thematic analysis.

Vaughan, L. and Browne, J., 2023. Reconfiguring emergency and acute services: time to pause and reflect. BMJ Quality & Safety, 32(4), pp.185-188.

Veasey, K., Nethercut, D. (2004) Citizens Jury Handbook. St Paul, Minnesota: Jefferson Center. Available at: https://jefferson-center.org/wp-content/uploads/2018/03/Jefferson-Center-CJ-Handbook-2004.pdf (Accessed: 15 September 2019).

Victoor, A., Delnoij, D.M., Friele, R.D. and Rademakers, J.J., 2012. Determinants of patient choice of healthcare providers: a scoping review. BMC health services research, 12(1), p.272. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-272 [Accessed: 09.09.2018]

Victoor, A., Rademakers, J., Rooijen, M.R.V., Jong, J.D., Delnoij, D. and Friele, R., 2014. The effect of the proximity of patients' nearest alternative hospital on their intention to search for information on hospital quality. Journal of health services research & policy, 19(1), pp.4-11.

Vidler, E. and Clarke, J., 2005. Creating citizen-consumers: New Labour and the remaking of public services. Public policy and Administration, 20(2), pp.19-37.

Welsh Assembly Government., 2004. Making the Connections: Delivering Better Services for Wales. Cardiff: Welsh Assembly Government.

Welsh Assembly Government., 2022. Guidance for engagement and consultation on changes to health services 2022. https://www.gov.wales/sites/default/files/consultations/2022-12/guidance-for-engagement-and-consultation-on-changes-to-health-services-2022.pdf [Accessed: 29.08.2023]

Whitehead, M. and Dahlgren, G., 1991. What can be done about inequalities in health?. The lancet, 338(8774), pp.1059-1063.

Whitty, J.A., Burton, P., Kendall, E., Ratcliffe, J., Wilson, A., Littlejohns, P. and Scuffham, P.A. (2014). 'Harnessing the potential to quantify public preferences for healthcare priorities through citizens' juries'. International Journal of Health Policy and Management, 3(2), p.57.

Wynne, B., 1996. May the sheep safely graze? A reflexive view of the expert-lay knowledge divide. Risk, environment and modernity: Towards a new ecology, 40, p.44.

Zeckhauser, R. and Sommers, B., 2013. Consumerism in health care: challenges and opportunities. AMA Journal of Ethics, 15(11), pp.988-992.

7 Appendices

7.1 Case Studies References

All public documentation relating to the three case studies can be accessed via the following website: https://www.nhsglos.nhs.uk/have-your-say/working-with-you/you-said-we-listened-we-acted/

7.1.1 *Case Study 1: Developing Gloucestershire's Sustainability and Transformation Plan*

https://www.nhsglos.nhs.uk/news/developing-gloucestershires-sustainability-and-transformation-plan-stp/

7.1.2 *Case Study 2: Fit for the Future Engagement: Developing Potential Solutions*

https://www.nhsglos.nhs.uk/news/engagement-fit-for-the-future/

7.1.3 *Case Study 3: Fit for the Future Consultation:*

https://www.nhsglos.nhs.uk/news/consultation-fit-for-the-future/

7.2 Appendix 2: Consolidated Criteria for Reporting Qualitative Studies (COREQ) – 32-item checklist

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007. Volume 19, Number 6: pp. 349 – 357

YOU MUST PROVIDE A RESPONSE FOR ALL ITEMS. ENTER N/A IF NOT APPLICABLE

7.2.1 *Domain 1: Research Team and Reflexivity*

7.2.1.1 Personal Characteristics

1. Interviewer/facilitator: Which author/s conducted the interview or focus group?

Rebecca Parish completed the primary and secondary qualitative analysis of the data collected through a series of public surveys.

2. Credentials What were the researcher's credentials? E.g. PhD, MD

BA (Hons) Fine Art; Post Grad. Dipl. Visual Culture; MSc Health and Social Care Studies; Professional Doctorate Health Studies (Pending)

3. Occupation What was their occupation at the time of the study?

NHS Senior Manager in England.

4. Gender Was the researcher male or female?

Female.

5. What experience or training did the researcher have?

33 years working for the NHS, 22 years in a Public Engagement role.

8 years Professional Doctorate Study including Modules on Community Engagement, Research Design, Quantitative Research and Qualitative Research.

7.2.2 *Relationship with Participants*

6. Relationship established: Was a relationship established prior to study commencement?

There was no 1:1 relationship between the researcher and survey respondents.

7. Participant knowledge of the interviewer: What did the participants know about the researcher? e.g. personal goals, reasons for doing the research

Participants knew that the research was carried out on behalf of the NHS in Gloucestershire. Primary analysis was used to inform decisions about the configuration of specialist hospital services in Gloucestershire.

8. Interviewer characteristics: What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic

The researcher shared common characteristics with respondents being a resident of the same county as respondents, Gloucestershire.

7.2.3 *Domain 2: Study Design*

7.2.3.1 Theoretical Framework

9. Methodological orientation and theory: What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis

Qualitative Framework Analysis: Four models for providing health services: trust; command & control; voice; and choice & competition. Adapted from the book: The Other Invisible Hand (Le Grand, 2007).

7.2.3.2 Participant Selection

10. Sampling: How were participants selected? e.g. purposive, convenience, consecutive, snowball

Data was collected though random sampling or 'self-selection' participation in all population surveys. Most survey respondents had GL postcodes. The target group were users or potential future users of specialist hospital services at two Acute Hospitals in Gloucestershire.

Lewin, C., 2005. Elementary quantitative methods. Research methods in the social sciences, pp.215-225.

11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email

All population surveys open to 640,000 residents.

12. Sample size How many participants were in the study?

Across the three surveys between 1000 and 600 (approx.) participants took part in each survey.

13. Non-participation How many people refused to participate or

dropped out? Reasons?

Participants were self-selecting.

7.2.3.3 Setting

14. Setting of data collection: Where was the data collected? e.g. home, clinic, workplace

Online and Freepost Surveys.

15. Presence of non-participants: Was anyone else present besides the participants and researchers?

N/A

16. Description of sample: What are the important characteristics of the sample? e.g. demographic data, date

An all-residents sample with mixed demographics. Of particular importance to this research was the postcode of the respondent identifying whether they lived in the East or the West of the county and indicating any potential bias towards one acute hospital or the other.

7.2.3.4 Data Collection

17. Interview guide: Were questions, prompts, guides provided by the authors? Was it pilot tested?

N/A

18. Repeat interviews Were repeat interviews carried out? If yes, how many?

N/A Although the surveys analysed provide longitudinal data over four years on related subjects.

19. Audio/visual recording: Did the research use audio or visual recording to collect the data?

N/A all data was collected using paper /online surveys.

20. Field notes Were field notes made during and/or after the interview or focus group?

N/A

21. Duration What was the duration of the interviews or focus group?

N/A

22. Data saturation: Was data saturation discussed?

Yes. The sample size calculator Raosoft10 was used. With a 5% margin of error and a 95% Confidence Level and a population size of 640,000 a sample of 384 is the minimum recommended size of your survey. If you create a sample of this many people and get responses from everyone, you're more likely to get a correct answer than you would from a large sample where only a small percentage of the sample responds to your survey.

23. Transcripts returned Were transcripts returned to participants for comment and/or correction?

N/A

7.2.4 *Domain 3: Analysis and Findings*

7.2.4.1 Data Analysis

24. Number of data coders How many data coders coded the data?

One.

25. Description of the coding tree: Did authors provide a description of the coding tree?

Yes. Data was coded using the Analytical Framework (Le Grand, 2006) and by geography east/west of Gloucestershire.

Basit, T., 2003. Manual or electronic? The role of coding in qualitative data analysis. Educational research, 45(2), pp.143-154.

26. Derivation of themes: Were themes identified in advance or derived from the data?

The Analytical Framework was selected to undertake the coding of the data into categories or labels used for the analysis. Themes were identified which capture the nature, meaning, and essence of the data. These higher order themes are the claims presented and interpreted in the Results Chapter.

27. Software: What software, if applicable, was used to manage the data?

[10] http://www.raosoft.com/samplesize.html

SMART Survey software was used to develop the surveys and to collect the data11.

28. Participant checking: Did participants provide feedback on the findings?

N/A

7.2.4.2 Reporting

29. Quotations presented: Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number

Yes, quotations are used to illustrate themes. No participant numbers were not included. The only personal identified included was residency East / West

30. Data and findings consistent: Was there consistency between the data presented and the findings?

Yes.

31. Clarity of major themes: Were major themes clearly presented in the findings?

Yes, themes are presented in the findings.

32. Clarity of minor themes: Is there a description of diverse cases or discussion of minor themes?

Yes. The claim is the aspect of Le Grand's models for organising public services framework identified in the data, the warrant is the analysis that links the claim to the data, the data is the collection of qualitative survey responses or descriptive quotes.

[11] https://www.smartsurvey.co.uk/

7.3 Appendix 3: Trust Full Results and Analysis

In this Appendix, the data coded as 'trust' are presented using a series of chronological claim, warrant, data chains. The agency in 'trust', as conceived by Le Grand (2007), lies in the power of the professionals who commission and provide public services, whereas for this framework analysis I have chosen to shift the balance of power to the people and communities in receipt of those services (Department of Health, 2001). I consider their level of trust in the healthcare system, and their confidence in the rationale put forward for potential changes, based on their personal experiences of health care, and any other influences on their degree of trust within or external to the system. I will consider trust in this way in each of the three case studies, tracking any observable changes in the levels of participants' trust, and identifying any potential influences on their degree of confidence. Participation is highest when participants have the greatest opportunity to influence the policy which will ultimately lead to the development of potential changes which may affect them personally. It appears that participants judged their most powerful opportunity was to influence the development of local policy.

Key themes are identified and interpreted, illustrated by representative quotations selected from the data, from both east and west, or from one side of the county as required to reflect the response to the IDEAS, POLICY or PROPOSALS. Trust headline findings are briefly summarised below. These are explored in more detail at the end of the 'trust' section.

7.3.1.1 Trust Headline findings

Shifting Degrees of Trust amongst the Participating Population

The data, across the three case studies, show that trust in the system fluctuates, and can be influenced by nostalgia for earlier configurations of hospital based services.

Communicate to Increase Trust

Taking the opportunity to increase levels of trust amongst the population through honest communication is an emergent recommendation in the data.

Diminishing Trust as a Polarising Feature in the Later Data

At the PROPOSALS stage of the research period, case study 3, the FFtF consultation in 2021, the question of trust becomes more binary. The data suggest that support during this final stage is largely influenced by the postcode of the participant.

7.3.2 *Trust IDEAS – Case Study 1: STP*

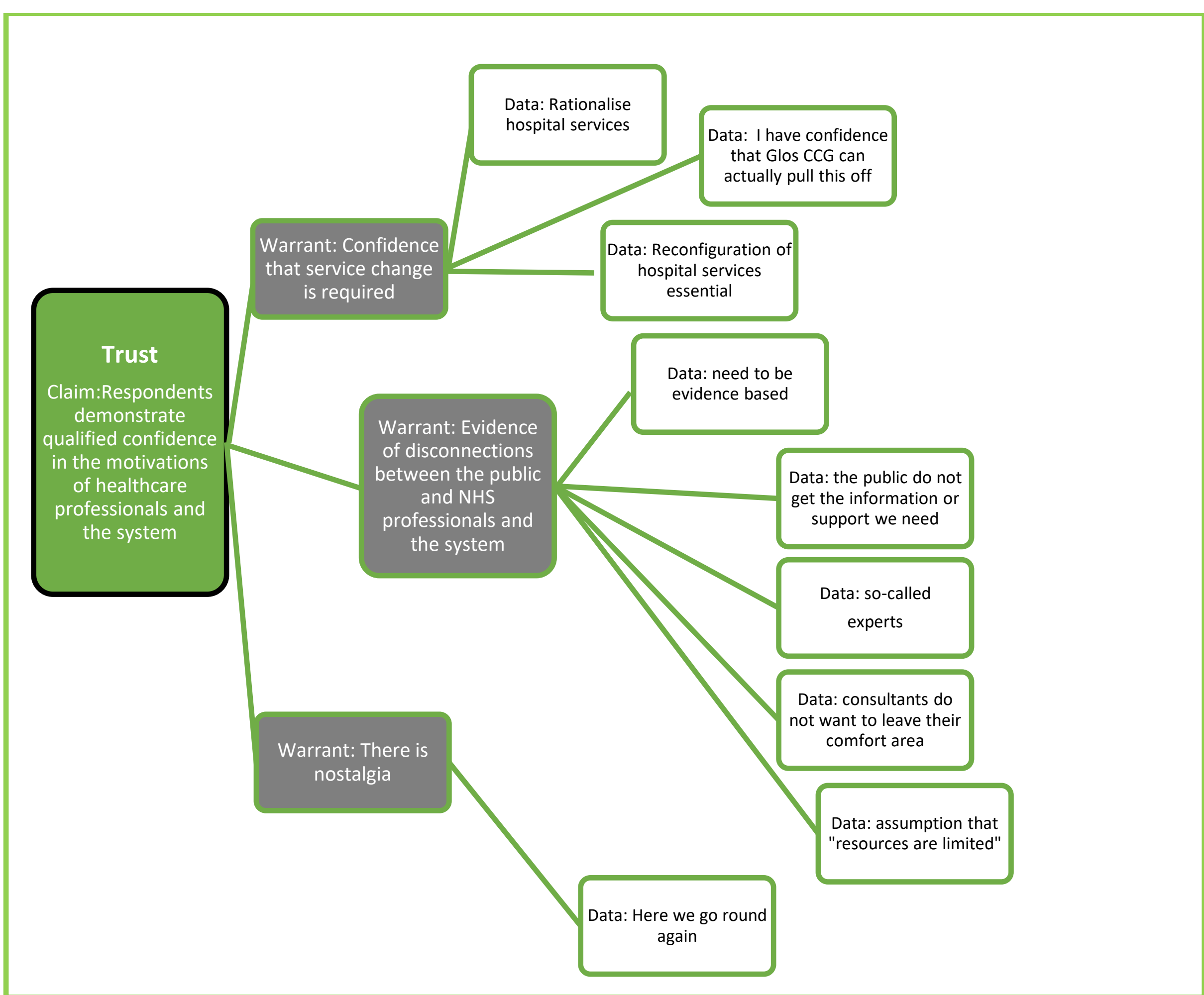
The 'trust claim' is that respondents demonstrate qualified confidence in the motivations of healthcare professionals and the system; this claim is supported by the three warrants and the data illustrated in Fig. A1 The first warrant in this chain is that there is confidence that service change is required, to meet the challenges and opportunities presented in the STP engagement. This includes reducing clinical variation and waste, developing a new sense of personal responsibility and improved independence for health, building community and voluntary sector capacity, and reorganising care pathways. The second warrant is that there is evidence of disconnections between the public and NHS professionals and the system; and the third warrant very specifically signals nostalgia.

In this analysis I have applied Le Grand's trust model to illustrate the degree of belief shown in the data, in the competence and motivation of the professionals working in the Gloucestershire NHS system, who are responsible for developing the STP. Given that the STP engagement asks the direct question whether respondents recognise in the draft plan what they have told us is important before, there are also degrees of trust in the accountability of current NHS professionals to have utilised the feedback received from earlier engagements.

Le Grand describes public service professionals as either altruistic 'knights' or egotistical 'knaves' (Le Grand, 2003). This is interesting in the context of the relationships between NHS managers, clinicians, and the people and communities they serve, referred to by Le Grand as either 'pawns' or 'queens', depending on their level of power over choices about the public services they access.

There is no explicit reference in the data to the concept of trusting or not trusting NHS professionals in Gloucestershire. However, there are degrees of confidence in the benefits of organising services differently, demonstrated in the data, and in degrees of concurrence with the proposed ways in which this could be done. This implicitly demonstrates levels of trust in the professionals who have identified the challenges and opportunities set out in the STP; a recognition of 'knightly' behaviour (Le Grand, 2003). However, there is also criticism of the priorities set out in the plan, demonstrating a lack of trust in the evidence presented by NHS professionals for consideration by the public.

Fig. A1 Trust Chain: IDEAS



With respect to trust, at the IDEAS stage, there is a difference in responses from people living in the east and west of the county. There is uniform support across the county for the direction of travel regarding centralising services to achieve efficiency. However, the data show that there is more scepticism in the west in the rationale for centralisation of services at one hospital site in the county; in particular, the NHS system contention that funding for services is limited. Data from both sides of the county have been selected to illustrate the analysis.

The data to corroborate this include these extracts from the survey response data.

> 'Rationalise hospital services to best meet needs of patients and allow clinicians to provide excellent services into the future'. [West]
>
> 'Duplicating services, for example A&E, on more than one site is wasteful and dilutes expertise'. [East]
>
> 'I suggest seeing the most experienced and a specialist around the presenting complaint will save further unnecessary costs'. [West]
>
> 'I have watched the CCG go down this route for a few years now and I am very pleased to see that the STP is building on the good work done

> already in the community, with things like the Frailty Service in the South Cotswolds, and not just chopping and changing and starting new for the sake of it. I have confidence that Glos CCG can actually pull this off to become one of the top STPs in the country'. [East]

The alternative position is demonstrated by a lack of trust amongst some respondents in the ideas proposed by the system to meet the challenges. These respondents focus less on the detail of proposed solutions, i.e. centralisation of services, and more on the validity of the challenges presented and those presenting them, i.e. the NHS or the industry. This suggests that the rationale to support changes needs to be shared, and that different ways of working need to be informed by evidence which is trusted by people and communities.

> 'Any initiatives need to be evidence-based rather than just well-intentioned and over-optimistic, especially with regard to the achievability of changing people's behaviour and attitude towards accessing services'. [West]

> 'We need the knowledge that the NHS has, and the expertise – and they aren't sharing. Whether it be red tape, or "big pharma", we the public do not get the information or support we need to make our own way'. [West]

In the illustrative quote below the suggestion is that it should be recognised that change decisions are likely to be unpopular in some quarters, but that sharing the evidence will contribute to public understanding and acceptance of change.

> 'Provides the opportunity to make some bold and difficult decisions that will ensure services are sustainable into the future. Some of these will be clearly unpopular with some members of the public, but if you are transparent in your approach and take the time to communicate the reasons behind your decisions, most people will understand'. [West]

There is evidence of lack of trust in the NHS professionals identifying challenges and ideas for change; they are referred to below as 'so-called experts', who lack empathy for the users of services.

> 'Have any of your so-called experts tried to get from one hospital to the other when they are feeling not well and short of funds? (I think not). Perhaps a bit of feeling for the community on behalf of the people you serve would be a great help'. [West]

One respondent, again from the west, shows no trust in the system or the STP engagement process, querying whether the plans are already agreed.

> 'Am I correct in thinking the county and yourselves have already submitted your plans to Government?' [West]

More unusual is a demonstration of lack of regard for clinicians, who rarely receive the level of criticism reserved for non-clinicians. This respondent demonstrates a lack of trust in the decisions made by 'knavish' (Le Grand, 2003) hospital consultants, whose preference for centralisation of services directly affects this respondent, due to limited access to transport to attend appointments.

> 'Get consultants to have to come to community hospitals for their clinics rather than being sent to hospitals further away when a particular consultant leaves because other consultants don't want to leave their comfort area. Living in Berkeley and being an OAP on my own it makes it difficult to get to Gloucester or even Stroud for routine consultant's appointments, whereas the Vale in Dursley is easy'. [West]

The data also question the veracity of wider system statements relating to stretched resources, resulting in the need to change the way services are currently provided. Such comments are occasionally accompanied by suggestions for alternative funding for services. Two respondents from the west of the county identify what they call 'elephants in the room' relating to the funding of public services.

> 'The elephant in the room is the assumption that "resources are limited" in one of the richest countries in the world?' [West]

> 'The "elephant in the room" of reducing demand by introducing an element of cost is not discussed at all – see how small 5p charge on plastic bags in supermarkets has worked wonders on reducing demand!' [West]

About the warrant that there is nostalgia, the 'East' quote below is specific to the configuration of NHS organisations from the 1980s and 1990s, when the county was split into two NHS administrative areas, East and West Gloucestershire. The 'West' quote is a more general point about cost savings achieved through the overall reduction the NHS bed base in the county, because of the closure of several community hospitals in Gloucestershire during the 2000s and 2010s. It is worth noting that at the same time as closing four community hospitals, three new hospitals were built during the same period, albeit with a significantly reduced bed-base.

The quotations below show there is frustration with the repetitive nature of the NHS discourse in Gloucestershire regarding the challenges facing the NHS and the need for future change. Some respondents suggest learning from the past instead.

> 'Here we go round again. We need to go back to ONE provider of health care – e.g. Cheltenham and district health authority – 30 years ago'. [East]

> 'One of the highest priorities has got to be recruitment, training and most importantly retention of staff. Staff are leaving because they feel

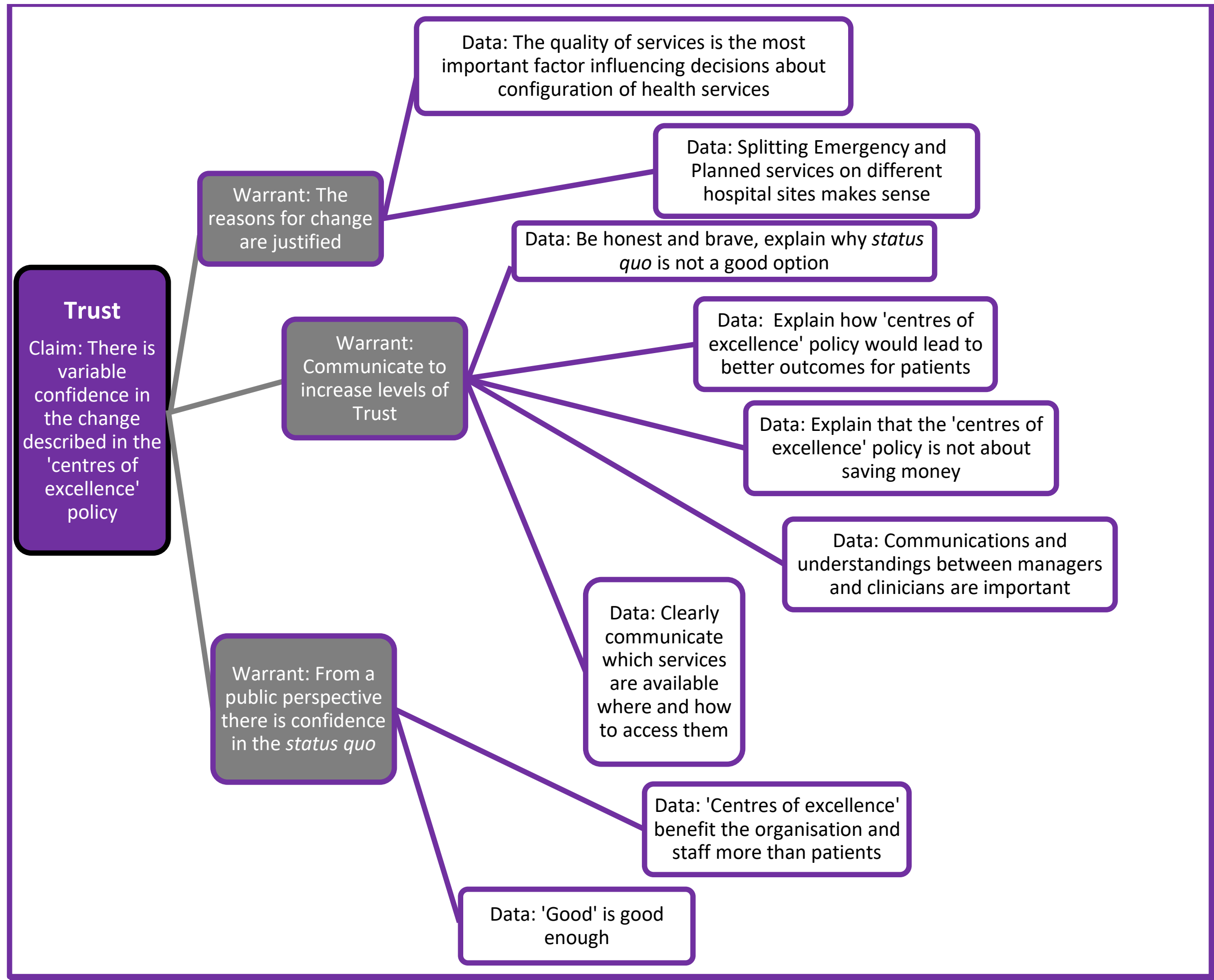
undervalued forever just tick boxing targets rather than delivering care. The reason we have such a problem with regard to "bed blocking" is without doubt previous policies which saw the closure of a number of local Community Hospitals with provided good stepdown/rehabilitation/respite care. This was done purely as a cost cutting exercise despite whatever we are told not for the benefit of patients or the Community at large'. [West]

It will be interesting to see how respondents respond to the continuing evolution of the conversation about rationalisation of services in Case Studies 2 and 3 later in this paper, and whether the nostalgic, more traditional stance is maintained or diminishes**.**

7.3.3 *Trust POLICY – Case Study 2: FFtF Engagement 2019/20*

The 'trust claim' is that there is variable qualified confidence in the change described in the CoE policy. This claim is supported by the three warrants, and the data illustrated in Fig. A2.

Fig. A2 Trust Chain: POLICY



The first warrant is that the reasons for change advanced by the CoE policy are justified. One of those reasons is that the quality of services will improve. Quality is

an element of what makes a good service in the trust model (see 1.3.3.1.). The data below confirm that quality is a more important factor, associated with specialist hospital services, for these respondents.

> 'If I had a serious car accident or stroke or whatever, and high-quality emergency treatment was centred at Gloucester, then (although I would personally prefer it otherwise) I would have to accept that that was the optimal approach from the point of view of the professionals concerned'. [East]
>
> 'Changes should result in a true improvement in the quality of care delivered. Improving the quality of the service is more important than the location'. [East]
>
> 'Please make careful quality measurements before planning a move and then publish before and after results'. [West]

The quotes above demonstrate a willingness (albeit reluctant in some cases – 'although I would personally prefer it otherwise') from participants from the east, to travel further to experience a higher quality service at a centralised specialist centre. This confirms findings from the IDEAS stage in 2016/17. Data confirm that the expertise of the specialist clinician is ranked as a more important factor than the distance to travel for a consultation with a specialist clinician. Once again there is a degree of scepticism from the participant from the west above, requesting proof that quality improvements are realised with results shared openly.

Secondly, the data show that some respondents express the view that 'splitting Emergency from Planned services on different hospital sites makes sense'. Incrementally there is evidence of growing confidence in the CoE policy, with suggestions coming from respondents for how to split specialist services between the two sites. As shown in the selected extracts below, these views are held amongst respondents from both east and west.

> 'CoEs can be built only if we concentrate fully on each of the two major types of services – emergency and elective. The best centres both nationally and internationally have dedicated emergency and elective services separated out and concentrated on'. [East]
>
> 'Getting to see the right doctor, having access to the best equipment etc. I support the centre of excellence for emergency care idea and it made a lot of sense for me. I see most people would continue to get most urgent care near where they live, so it was just critical life-saving care at a single unit, I think it should happen. Also I had two operations cancelled two years ago and I think that could have been avoided if planned and emergency was better separated'. [West]
>
> 'Agree with CoE as it is hard to argue with the logic. Need to hear everyone's views and get best ideas in the plan'. [West]

Again (and this is a theme that will feature in the consideration of Le Grand's second model command & control), a respondent from the west signals, not without some cynicism, the potential for FFtF to find itself in a political spotlight.

> 'The CoE idea is a good one and from a medical viewpoint it can't be argued with although politicians will'. [West]

The second warrant is that from the public perspective there is confidence in the *status quo*. Here the data divide into two areas. The first is that 'good' is good enough; and secondly, linked to this, is that CoEs benefit the organisation and staff more than patients.

In terms of the theme in the data that 'good' is good enough, many respondents express contentment with receiving what they perceive to be a good local service, rather than aspiring to an 'excellent' service. This aligns with the trust element – 'potential for lack of innovation' (see 1.3.3.1). In this instance, respondents show a lack of confidence in change, and the professionals promoting it, instead preferring to rely upon what they already know. There is another element associated with the trust model – selflessness or self-interest (see 1.3.3.1). It could be suggested that individuals who are prepared to support the CoE approach are acting not just for themselves but in the interest of the many; whereas those who favour what they know works well enough for them personally now are motivated by self-interest. The theme of lack of personal responsibility, or selfishness, as impacting on the efficiency of health service is also a feature of these data; this will be considered in more detail as part of the analysis of the data supporting the 'voice' model, where it occurs as a dominant theme. It is interesting that, when checking the quotes selected to illustrate this warrant, they all came from respondents from the east. Also of interest, in one of the quotes selected below, is the misunderstanding that FFtF proposes changes to local A&E or urgent services. This begins here and builds as a repeating theme.

> 'I'm fed up with the term "centre of excellence". Usually this just means a "cost-cutting" exercise and the reduction of services with people having to travel far further for care. Everywhere should be a centre of excellence at what it does anyway, not some sub-standard service run into the ground by spiralling costs caused to a large extent by people not looking after/taking responsibility for their own health-well-being'. [East]

> 'Your question pre-supposes that there are substantial problems with the current arrangements – that has still to be demonstrated sufficiently for me to see the need for change in A&E. I have no issues with the plan to have areas of specialism in each hospital to avoid duplication;

> that works and has the potential to be more efficient but not in urgent services where speed is of the essence'. [East]
>
> 'Forget CoEs. Just provide good medical treatment as has always been offered in the past'. [East]

The data to illustrate the warrant that 'CoEs benefit the organisation and staff more than patients' once again come from respondents from the east of the county. The views expressed are that the CoE policy was conceived to benefit staff in relation to several factors, such as convenience and status, or (using Le Grand's trust framework element) self-interest. Below are two representative examples from the east.

> 'There is little to be gained from attempting to pursue so-called CoEs. This is usually no more than an exercise in self-aggrandisement and self-publicity. It is far better to have a good general range of services required by the local population. No one really cares if their life is saved by a centre of excellence or a regular department'. [East]
>
> 'The implication is that CoEs will remove some excellence from other centres. This reveals that the focus of any potential changes is on the staff rather than on the patients'. [East]

The third warrant relates to the theme in the data that the local NHS should communicate to increase levels of trust. Here the data divide into five groups: be honest and brave and explain why *status quo* is not an option; explain how 'centres of excellence' policy would lead to better outcomes for patients; explain that the 'centres of excellence' policy is not about saving money; communications between managers and clinicians are important; and clearly communicating which services are available where and how to access them.

The data here clearly show that NHS professionals should not assume that people and communities will accept change without clear explanations of the potential benefits, with proactive communications advice offered by participants from both sides of the county.

> 'To defend "Centres of Excellence" you have to be more upfront about [the] inadequacies of two-site working. That takes courage and is open to the riposte "just get more money and people"'. [East]
>
> 'People will have different motivations, whether that be personal, emotional or political about any changes to either of the two sites... but this needs to be "background noise" and the focus should be on the hard facts around why these services do need to change. The case for change needs to be watertight with clear evidence of why retaining the "status quo" or to "do nothing" is not an option'. [West]

The data support the warrant that communication will increase trust in terms of the CoE policy leading to better outcomes for patients, with improvement in health being a ‘trust quality attribute’ as noted above.

> ‘People have to trust the hospital before they will trust the ‘Centres of Excellence’ contained therein. Generally, ordinary people are not aware of these (with notable exceptions such as Great Ormond Street for paediatrics, Frenchay [a former hospital in Bristol] – as was – for brain issues, etc.). In order to get people feeling that ‘Centres of Excellence’ is a good move, they need convincing that the medical service they receive will be better, not that it will be cheaper or more efficient (not typically what a patient focuses on!)’. [East]

The respondent from the east above literally spells it out in terms of the requirement for the system to earn the trust of the population by focusing on the argument that the CoE policy is about quality improvement rather than bureaucratic concerns, such as efficiency and cost saving; themes more associated with Le Grand’s next model – command & control.

In this chain, communications between clinicians and managers are specifically highlighted, suggesting there may be a lack of consensus amongst members of the NHS system across the county. This quote from a respondent from the East represents many similar views expressed by people from that side of the county.

> ‘Get clinicians totally onside for any change. You don’t want competing views from clinicians and management’. [East]

Responses show there is confusion amongst some respondents, not just about whether the A&E service is part of the FFtF programme, but a general lack of knowledge amongst the population about which services are currently provided in Cheltenham and which in Gloucester. A conclusion must be that this lack of knowledge about the current arrangements makes it more difficult for some people to participate fully in discussions about how services could be reconfigured differently in future.

> ‘We need to know what each hospital offers and how to access services. People need to understand the function of each one, the booklet gives a clear explanation of the intentions for each site’. [East]

It is not surprising there is confusion amongst the general population, given the number of changes to the configuration of services experienced in the previous 20 years, as described earlier in this paper. I can understand the way some respondents have described their desire to maintain the *status quo*; there is an assumption that both hospitals provide all services now (not least because this

historically was more likely to be the case) but also that they should continue to do so. However, programmes like FFtF have developed to meet the challenges of the increase in medical and surgical specialisation. This results, in the case studies considered in this paper, in the move towards creating CoEs in one location for each specialty service. Differences in opinion surface in the data when different visions for the future are expressed, some of which look back to the NHS of the past or are grounded in the *status quo* (Kahneman et al. 1991; Samuelson and Zeckhauser, 1988; Stewart et al., 2022).

7.3.4 *Trust POLICY – Fit for the Future Citizens Jury Number 1*

As explained earlier in this paper, NHSG commissioned an independently facilitated Citizens' Jury as part of the FFtF engagement. Jurors were selected to provide a more demographically representative sample of views. It is particularly applicable to this paper that jurors lived across all areas of Gloucestershire. However, the juror quotes cannot be attributed to east or west, as this information was not recorded in the independent Jurors' Report (Citizens' Juries c.i.c., 2020). In contrast to other participants to the engagement, jurors were given a significant amount of time, and access to experts and information, before reaching their conclusions. It is worth noting that amongst the expert witnesses invited to present to the jury – as well as NHS management (including myself), clinicians, academics, and voluntary organisations – were representatives from REACH. Given their level of exposure to information, and the luxury of time spent discussing the FFtF programme with expert witnesses, the trust claim for the Citizens' Jury Number 1 is that jurors supported the CoE policy because they trusted the evidence presented to them. Many jurors expressed the feeling that they had 'gained insight' during the jury process.

> 'We have a good understanding of what a Centres of Excellence approach is, why we need it, and how much it will benefit us. We discussed an important topic (not only for jurors but for everyone in Gloucestershire) and gained insight into the NHS in Gloucestershire.' (Citizens Juries CIC., 2020)

Fig. A3 Trust Chain: POLICY – Citizens' Jury

Trust

Claim: Jurors supported the 'centres of excellence' policy because they trusted the evidence presented to them

Warrant:Trust in clinical professionals

Data: The clinicians know what they are doing

Data: Clinicians frustrated with current arrangements

Warrant: Trust in model, doubts remain regarding delivery

Data: Centralisation could lead to bed blocking

Data: Need to get recruitment of staff right

Warrant: Acceptable trade-offs associated with centralisation of services

Data:Benefits worth the extra travel

There are three warrants supported by data (see Fig. A3). The first warrant is that there is trust in professionals. The quotes below, from jurors, suggest to me that they felt that clinicians were making the case for CoEs motivated by a desire to improve the quality of services, whilst acknowledging that the current configuration is frustrating this ambition.

> 'The clinicians know what they are doing, they have presented a clear case for their belief in this necessity, compelling as it is backed up by visible integrity and passion for delivering the best care'. [Juror 14. Very supportive]

> 'After listening to the frustrations of the dedicated staff who are currently trying their best and listening to why they believe CofE within their speciality is for the greater good to enable them to provide excellent care to all patients'. [Jury 6. Very supportive]

> 'This is a tried and tested method of service delivery which delivers better clinical outcomes which means highly skilled staff will be motivated to remain within the Trust. All patients want the best care and residents of the county need to be better informed on this approach'. [Juror 21. Very supportive]

The second warrant is that there is trust in the model, but some jurors' express doubts regarding its delivery; particularly in relation to having enough staff to create CoEs. Jurors' comments align themselves with Le Grand's attributes of trust, i.e.

‘quality’, which includes as one of its elements ‘inputs’, in terms of number and type of staff, their skills, and the size and condition of facilities.

> ‘Lots of positive information. Still some doubts about delivery’. [Juror 3. Fairly supportive]
>
> ‘I think it’s a no brainer really. The only reservations I have are if a CofE is going to result in more bed blocking and staffing issues going into the future’. [Juror 15. Fairly supportive]
>
> ‘If they can get the staffing right’. [Juror 11. Fairly supportive]
>
> ‘The experts seem supportive but my only concern is has enough consideration been given to doing nothing, and using the money which would be needed in making changes to invest in staff recruitment and retention?’ [Juror 10. Fairly supportive]

The third warrant is that there are acceptable trade-offs associated with centralisation of services. The juror quoted below echoes a comment made by a respondent from the east, highlighted earlier; that a key compromise some people would have to make, to access better quality specialist services, is travel to a location further away.

> ‘These benefits are worth the trade-off of potential journey time increase’. [Juror 6. Very supportive]

Analysis shows that levels of trust in the CoE policy are relative to the juror’s individual confidence that the policy can be implemented through specific proposals. Those who express doubts, for instance about the challenges regarding availability of specialist staff, are only ‘fairly supportive’ of the policy. Others, who identified themselves as being ‘very supportive’ of the policy, appear to trust the evidence presented to them, referring to the compelling presentations from clinicians. This is a characteristic of trust-based models for delivering services (Le Grand, 2007), and earlier observations regarding motivation and agency in public policy development and delivery; clinicians, or ‘knights’, are regarded as collaborating selflessly for the benefit of their patients, or ‘pawns’ (Le Grand, 2003), who in turn are content to relinquish autonomy in return for belief that the service they are being provided with is a quality service.

7.3.5 *Trust PROPOSALS – Case Study 3: FFtF Consultation, 2021*

There are three separate proposals to consider. The trust claim relating to the proposal to centralise Acute Medicine at GRH is that there is concern about the impact of the ‘centres of excellence’ policy on clinical outcomes (see Fig. 20). The claim for the Planned Lower GI proposal, where no preference is expressed for the

site of the CoE, is that the 'centres of excellence' is a positive policy, but some identify investment required at both hospitals (see Fig. 21). The outlier is the third claim, relating to the proposal for Planned Day Case: Upper and Lower Gastro-Intestinal surgery, where the claim focuses unequivocally on trust or 'support' for the proposal to create a CoE at CGH (see Fig. 22). Perhaps this is not surprising, given that the demographic data relating to residence shows that most participants to the FFtF consultation live in east Gloucestershire.

At this proposal stage, potential improvements in the quality of the service continue to show up in the data as an important factor in levels of confidence amongst respondents from both sides of the county. These data indicate trust that quality will be (and has been before, in one quote selected below) improved by creating CoEs.

> 'Anything that reduces risk, travelling time, being passed from pillar to post offers a quality service, with quality staff can only be excellent'. [West]
>
> 'The idea of creating centres of excellence at both of the two excellent large hospitals in Gloucestershire makes sense. It is worth remembering that the other specialist inpatient services, which have already centralised at either CGH or GRH e.g. cancer services at CGH and children's services at GRH, are working really well for patients'. [East]
>
> 'Centre of excellence as opposed to two try hards'. [East]

The final comment above about 'two try hards' suggests that without specialisation in one place the quality of the service provided in the county can never achieve an 'excellent' standard.

As illustrated in the previous case studies, there remains an acknowledgement from respondents from both sides of the county that, as the results of the STP engagement prioritisation process show, the necessity of travelling further is outweighed by the benefits of accessing a specialist hospital service in the county.

> 'It will ensure that specialist care is available at all times although it means I will have to travel from my home within walking distance of CGH'. [East]
>
> 'I would prefer to go to a site where the specialists are, rather than a hospital that is nearer but there are less staff available'. [West]

This respondent from the east acknowledges the logic in the CoE policy. These data are a response to the Acute Medicine proposal, to centralise the service at GRH. The reason for including this quotation here is to demonstrate confidence in the

assurances regarding the current and future status of the A&E Department at CGH. This is unusual amongst the overall data set.

> ‘With stretched specialised NHS resources concentrating particular but different specialists at each hospital makes sense. I am also reassured that A&E will remain at Cheltenham hospital as we live in Bourton-on-the-Water [in the east of the county] so need to be confident that the closeness of A&E in Cheltenham in an emergency provides a much better chance of survival rather than going all the way to far side of Gloucester from here’. [East]

The benefits of staff of working together in a centralised team, especially if this attracts and retains the right staff to work in the county, also continues to be acknowledged as a mark of quality; this is more strongly reflected in data from the west.

> ‘Will provide more focused training/learning opportunities for junior doctors and medical staff, with continuous supervision by senior doctors. This will contribute to attracting staff and improved retention rates’. [West]

> ‘Experienced qualified staff centralised… more opportunities for shared learning’. [East]

> ‘A centre of excellence in one location enables experience and expertise to be shared, high standards to be set and maintained, as long as its management is supportive and creates an environment where the organisation and the individual members can learn and develop, not compete’. [West]

I will concentrate now on trust themes that are particularly amplified or are unique to the FFtF consultation in 2021 (see Figs. A4, A5, A6).

For the first time, thematically the focus of trust has shifted towards trust in the consultation process itself, rather than the content of the activity. There are exceptions of course. that prove the rule, with a few examples of scepticism about the process of involvement from earlier in the research period. The following comment was received from a respondent from the west during the STP POLICY stage. It illustrates a fatalistic view of the way IDEAS, POLICY or PROPOSALS are developed in the county.

> ‘Secret plans made behind closed doors, a phoney consultation including the usual online survey and then the litany of “unavoidable” cuts rationalised as realignment, co-ordination, centres of excellence, blah, blah, blah. The fact is we need a massive injection of resources and a return to the principles the NHS was set up with. Anything else is rearranging the deckchairs on the Titanic. We’ve all had enough of “visions”. I await the list of services to close or be privatised’. [West]

As noted earlier, there are legal duties placed upon NHS organisations to undertake good quality consultation with the public about significant service changes, involving them from the start of the process – the IDEAS identification stage (STP) – through to the development of potential solutions, the POLICY creation stage (FFtF engagement) and onward to more formal public consultation in the PROPOSALS stage (FFtF consultation). A consultation process can be challenged and referred to the Secretary of State or a judge for a Judicial Review. There are no grounds to refer a consultation because the proposals for change are not popular; the only factors that can be considered are related to the process of involving people and communities. Consideration of the process of engaging and consulting with people and communities will take place later, when the paper concentrates on the analysis of Le Grand's 'voice' model; in particular, paying attention to the observations of the second FFtF Jury, which examined jurors' confidence in the FFtF consultation process. However, for completeness and consistency of reporting, it is worth noting here the following quotes from respondents living across the county to illustrate different levels of confidence in the consultation process. The first two quotes below demonstrate that there is trust in the competence of the staff involved in the development and presentation of the proposals.

> 'The report and its recommendations have been prepared by hugely professional, experienced, and competent personnel. Ninety-nine per cent of feedback from the public is likely to be simply based on how it affects their personal situation regarding treatment required and location, and not necessarily related to what is best for the community at large and indeed the NHS'. [East]

> 'The proposed innovation in the Consultation Document appears sound'. [West]

As a counterbalance to the confidence shown above, there is distrust from respondents on both sides of the county in the consultation process and the staff involved, specifically NHS commissioners, as illustrated by these data.

> 'Regarding this survey I find the information provided complex not concise. It is really time consuming for [the] general public to work out what is being decided and make their comment. There is also a feeling that whatever the public opinion is the NHS management will just do what they want'. [East]

> 'I think there should be a lot more work going into trust in our services and more specifically the paper pushers at CCG before trying to garner support for another master plan that will inevitably cost trillions, be done without consent and have frustrating outcomes for patients and staff'. [West]

Fig. A4 Trust Chain: Proposal – Acute Medicine at GRH

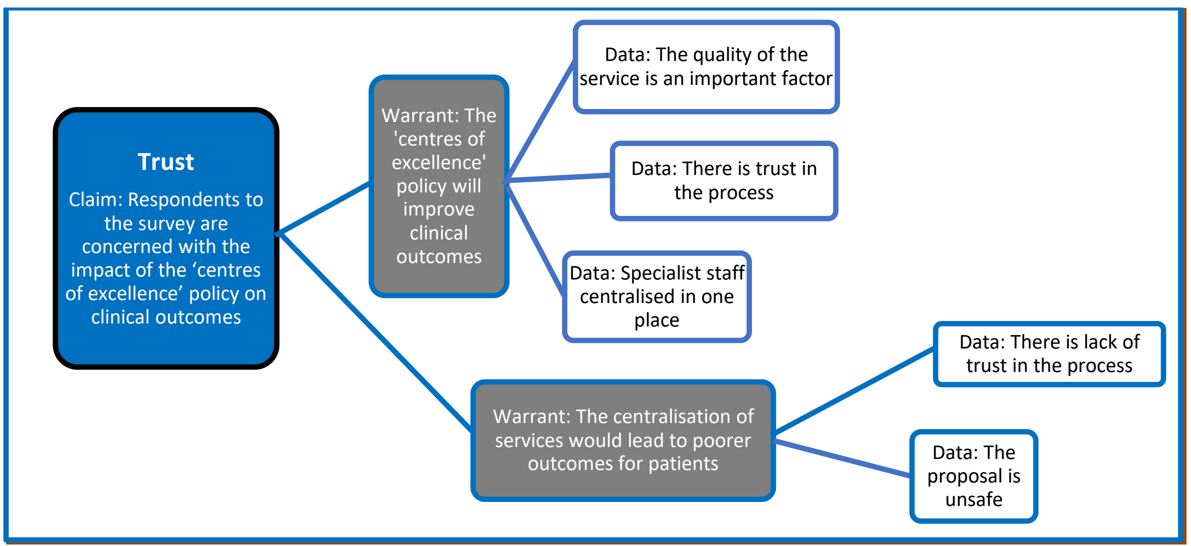


Fig. A5 Trust Chain: Proposal – Planned Lower GI Surgery at GRH or CGH

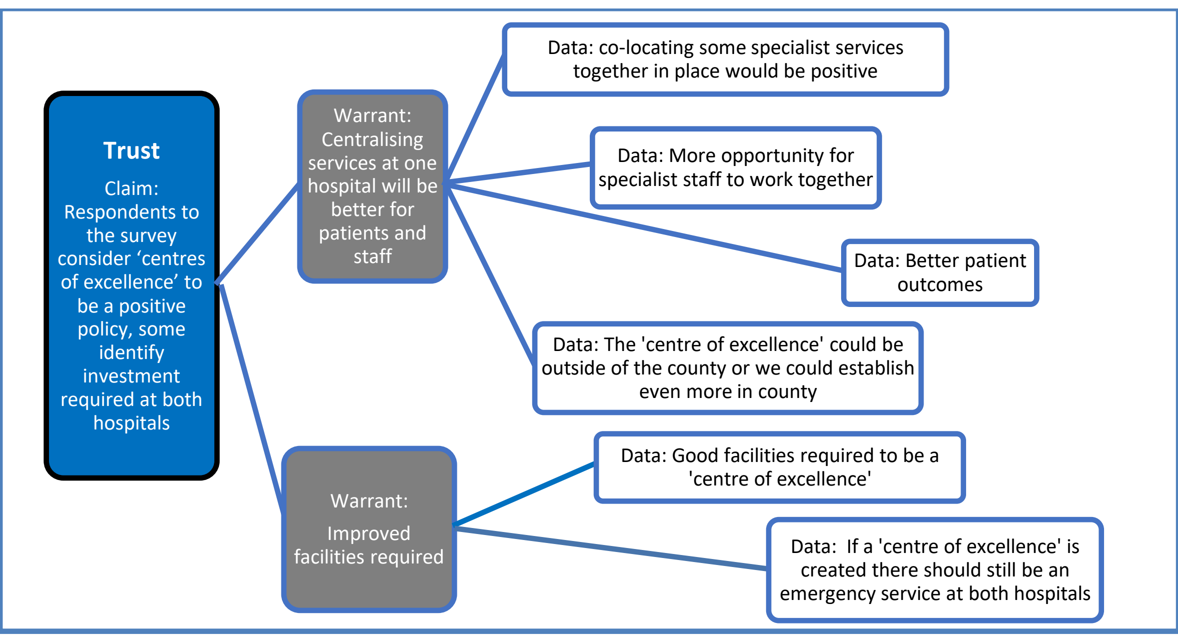
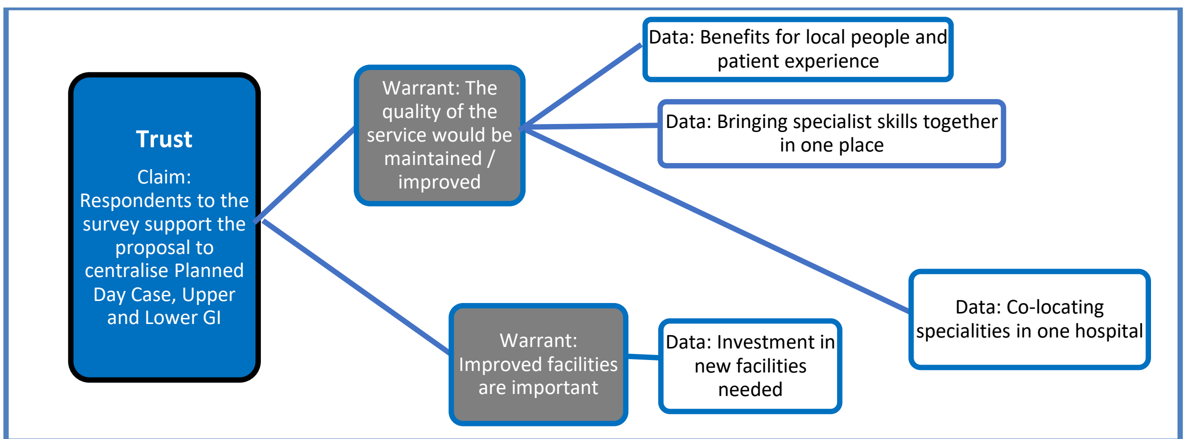


Fig. A6 Trust Chain: Proposal – Planned day case Upper and Lower GI (colorectal) surgery at CGH



A new theme in the data is the observation that a county border need not be a barrier to creating a CoE. This applies both to attending a CoE outside of Gloucestershire, and to encouraging incoming patients (non-Gloucestershire residents) to access specialist services at a CoE inside the county.

> 'If it's planned, why not just go to Oxford and build a bigger unit there?' [East]

> '…essential to attract good specialists and perhaps in time take on children's so we don't have to travel to Bristol'. [West]

This respondent is referring to the need to access specialist children's surgery outside of the county at a tertiary referral centre in Bristol. Specialist inpatient children's services remain at GRH following reconfiguration in 2005.

With the focus at the proposal stage being on existing services, of which patients may have experience, respondents are able to make real comparisons between aspects of the current services and potential future services. Comments about the quality of the current facilities are recorded for the first time in 2021. The data show that respondents from both the east and west have confidence in the facilities at GRH; others felt there is insufficient space at GRH, so the service should be centralised in Cheltenham. This element of comparison is of interest with this proposal, as no preference for a site for the CoE is indicated in the consultation.

> 'I believe in current medicine, centres of excellence are a "good thing". GRH has the space and I trust facilities for this so I am happy to proceed'. [East]

> 'Gloucestershire Royal already has good facilities and these could be improved if it was made a centre of excellence'. [West]

> ‘It is obvious that some services will have to remain in Cheltenham for the time being as Gloucester is not large enough to accommodate them all’. [East]

The response below, from the east, suggests that by centralising a service at CGH, there is opportunity to create more space for specialisation at the other hospital site. This respondent is happy to see the creation of a CoE at CGH, but feels it is important to comment on current capacity at GRH.

> ‘I have no objection to the siting of specialist services on one hospital site. If this allows the particular hospital to improve its services in that field so much the better and consider that GRH is already overloaded’. [East]

There is enthusiasm from the east for this service to be centralised in Cheltenham, but the current facilities would not be adequate. Respondents are not satisfied by the prospect of potentially securing the site for the centre; their expectation is that current facilities will be improved.

> ‘Planned surgery in a centre of excellence is nothing but good, but the site needs to be fit for this and to be able to accommodate patients staff and services alike’. [East]
>
> ‘Although I support the idea of a “centre of excellence”, I do think that CGH needs some significant investment in order to become this… if this is more readily available at CGH than GRH, then I am in support’. [East]

Respondents from across the county raise concerns about the safety of centralising Acute Medicine in the west of the county at GRH. The rationale for this belief is not explicitly made by respondents, but there is a suggestion from a response below that again there is a lack of confidence in GRH; this time, however, it is from respondents from the west. Also, the question as to whether acute/emergency services are maintained into the future at CGH as well as at GRH is raised by respondents from both sides of the county.

> ‘Gloucester Royal needs to improve’. [West]
>
> ‘This move is completely unsafe and a silly move. Cheltenham needs AMU [Acute Medical Unit] too’. [West]
>
> ‘It makes sense to consolidate planned care at either site, but does an emergency service need to remain at the other site?’ [East]

With respect to creating a CoE at CGH for Planned Day Case Upper and Lower Gastro-Intestinal Surgery, there is no dissent from respondents either side of the county; instead, benefits for local people and improved patient experience are cited.

It is interesting to note the respondent from the west below, an outlier from the normal partisan view, who appears to define 'local' as the whole county, rather than differentiating between east and west. It also interesting to note the use of the word 'deserve' in relation to CGH having a 'comprehensive GI surgery facility' due to the likely number of potential patients resulting from visitors coming to Cheltenham. This misses the definition of 'planned' surgery, which would only be available on referral from a patient's GP.

> 'Benefits local people'. [West]
>
> 'I think Cheltenham does deserve a comprehensive GI surgery facility as it is a reasonably large town which hosts national and international visitors every year'. [East]

Respondents from both sides of the county, but particularly the west, state that they accept the premise of splitting emergency and acute services from planned services. These views align with the CoE vision (see 1.9.5).

> '…centralising all day case GI work at CGH would reduce pressure on GRH to focus on emergency general surgery'. [West]
>
> 'I support the basis of 'Centres of Excellence' and would assume that the decision to base a particular function at each hospital is based on building up the core competency that already exists at the chosen hospital'. [East]

7.3.6 *Trust Findings*

7.3.7 *Shifting degrees of Trust amongst the Participating Population*

Some data suggest nostalgia for the way health and care services were organised in the past (up to and including the 1990s) in Gloucestershire was good, and that there should be no need to fix or change something today, if it had not been broken in the previous 20 years. Some respondents recollect about closures of community hospitals in the county during the 2010s, not believing in the policy care closer to home I. This view is expressed in data here more by respondents from the west, where decision to close two community hospitals in the Forest of Dean and replace them with one facility has been a subject for public consultation during the research period.

7.3.8 *Communicate to Increase Trust*

The data identify the opportunity to increase levels of Trust amongst the population through honest communication; specifically making it clearer what services are currently available where and that FFtF is not about saving money.

Jurors at the first FFtF Citizens' Jury, convened at the end of the FFtF engagement in 2020, benefitted from increased levels of understanding following a week of intensive information-sharing and discussion. An intended consequence is that jurors' comments demonstrate a high level of trust in the professionals who talked with them about the rationale for the CoE policy. Jurors demonstrate Trust in the justifications made for the trade-offs associated with the centralisation of specialist hospital services. However, some are less confident about the ability to deliver the benefits of the policy, namely improved quality, efficiency, and sustainability of specialist services in Gloucestershire.

7.3.9 *Diminishing Trust as a Polarising Feature in the Later Data*

The overall level of confidence amongst all respondents is specifically considered in relation to the extent of support or opposition to proposals for service reconfiguration. At the PROPOSALS stage of the research period, the FFtF consultation in 2021, the question of trust becomes more binary. The data suggest that support during this stage is largely influenced by the postcode of the participant. Respondents from the east generally demonstrate more trust in proposals to centralise services at CGH. They cite quality improvements as benefits of the proposed change. Respondents from the east generally express reservations about proposals to centralise any services at GRH. In the example where there is no preferred location indicated for the specialist service, the levels of trust focus on the CoE policy as a positive concept (so long as the centre is in Cheltenham), rather than the specific proposal presented.

7.3.10 *Trust Headline Conclusion*

The closer we came to decision making about actual service changes, the more the level of trust in the One Gloucestershire NHS system, with respect to the FFtF programme, became more partisan amongst individuals participating by sharing their qualitative views. Note that across all case studies the primary quantitative data showed high levels of confidence in the approaches promoted by the healthcare system (see 2.5.1). However, as I have also noted elsewhere, participation does diminish in the final stage of the research period, possibly indicating one of four things: increasing apathy; resignation; involvement overload; or acceptance amongst the population (see 2.4.6).

7.4 Appendix 4: Command & Control (Targets) Full Results and Analysis

In this Appendix the data coded as 'targets' are presented using a series of chronological claim, warrant, data chains.

Key themes are identified and interpreted and illustrated by representative quotations selected from the data from both east and west; or from one side of the county as required to reflect the response to the IDEAS, POLICY or PROPOSALS. Target headline findings are briefly summarised below.

7.4.1.1 Targets (1): Headline Findings

Efficiency

The relative efficiency of public services is a constant feature of targets data across the three case studies.

7.4.1.2 Targets (2) Headline Findings

Politics (with a big P) and Public Service Funding

Political influence emerges as a key differentiator of the views of participants from the east and west.

7.4.2 *Targets IDEAS – Case Study 1: STP Engagement 2016/17*

In considering the attributes of Le Grand's command & control model, I have identified in the STP response data an antipathy towards bureaucracy in public services, towards NHS management, the planning and commissioning cycle, targets and performance management, and the nature of NHS funding.

Therefore, the first command & control claim is that respondents to the survey do not support a bureaucratic model for organising local NHS specialist hospital services; this claim is supported by the three warrants and the data illustrated in Fig. A7.

The targets model attributes and elements (see 1.3.3.2) are exhibited in the STP data in several different ways. The first warrant is that the method of planning and commissioning in the NHS is inefficient. The following extracts illustrate the views of respondents from the east and west of the county. It is worth noting here that these two voices have experience of previous changes; the first identifies as a representative of confused communities across the county, and in the case of the second (as a former member of staff) the plea is for more involvement in planning by staff involved in providing services.

‘…it is important to allow the services that have been commissioned time to settle in and do their job. Four-year commissioning periods do not allow this… by changing the names of services every few years this disengages the community as they do not know who they are seeing for what and what each service does…’. [West]

Fig. A7 Targets (1) Chain: IDEAS

Targets 1
Claim: Respondents to the survey do not support a Bureaucratic Model for organising public services

Warrant: The method of planning and commissioining in the NHS is inefficient
Data: 4 year cycle - re-commissioing inefficient
Data: Lack of foresight... more planning after discussions with frontline staff

Warrant: There are too many managers in the NHS
Data: structure is top heavy
Data: cost of top management
Data: less money spent on management tiers...transfer to clinical areas
Data: checking on performance... poor commissioning
Data: cut the bureaucracy

Warrant: The method of funding NHS services needs changing
Data: stop peddling 'free at point of delivery' mantra
Data: jointly manage NHS and Social care funding

‘As a retired registered nurse I can appreciate the current problems with the NHS. However, a lot of these have been self-inflicted due to lack of foresight on the part of managers… Much more planning, after discussion with frontline staff… should take place’. [East]

The next warrant suggests there are too many managers in the NHS, and that money spent on salaries could be reallocated to frontline staff. This view is particularly strongly held in respondents from the west, but not exclusively.

‘NHS structure is top heavy – admin wasting valuable resources’. [West]

‘Employ more frontline staff. Reduce the number of managers. Cut the bureaucracy’. [West]

> 'I do think that a lot of money in the NHS is spent on staff who do not actually provide care but are checking on others' performance, and some fairly poor quality commissioning. Some money could be diverted from performance checkers and people from both commissioning and providers and diverted into frontline services'. [East]

The third warrant is that the method of funding NHS services needs changing. The data relate to how and what is funded, with two alternative funding models suggested: combining health and social care budgets, with a warning to keep the budget within the management of the NHS; and a protected ring-fenced budget for the NHS.

> 'The sooner everyone stops peddling the mantra that everything is free at the point of delivery the better. It is not free now for dentistry and optician services. If everyone paid for prescriptions there would be a reduction in waste. Life-threatening conditions should be treated free of charge. Other conditions should be financed in other ways e.g. insurance health care and social care will never work effectively while two systems operate'. [West]

> 'We need to organise our two big hospitals for efficiency and quality rather than duplicate services to save another 10-mile drive. Social care and NHS funding should be joint and managed together. It cannot be placed in the local a'thority's [sic] hands as history shows it will not be protected'. [East]

> 'We need a hypothecated NHS tax'. [West]

The second 'targets (2)' claim is that national and local politics influence local NHS services (see Fig. A8).

Many participants, when commenting about local challenges, refer to the influence of national government policies, political parties, and politicians. The first warrant in this chain is that respondents would welcome an increase in taxation to fund the NHS; this is different to the warrant in the chain above, which focuses on the method of funding as opposed to the amount of funding available.

> 'I recently spent 7 hrs in A&E. Everyone I spoke to would willingly pay another 1-2p on their income tax as an NHS tax only'. [East]

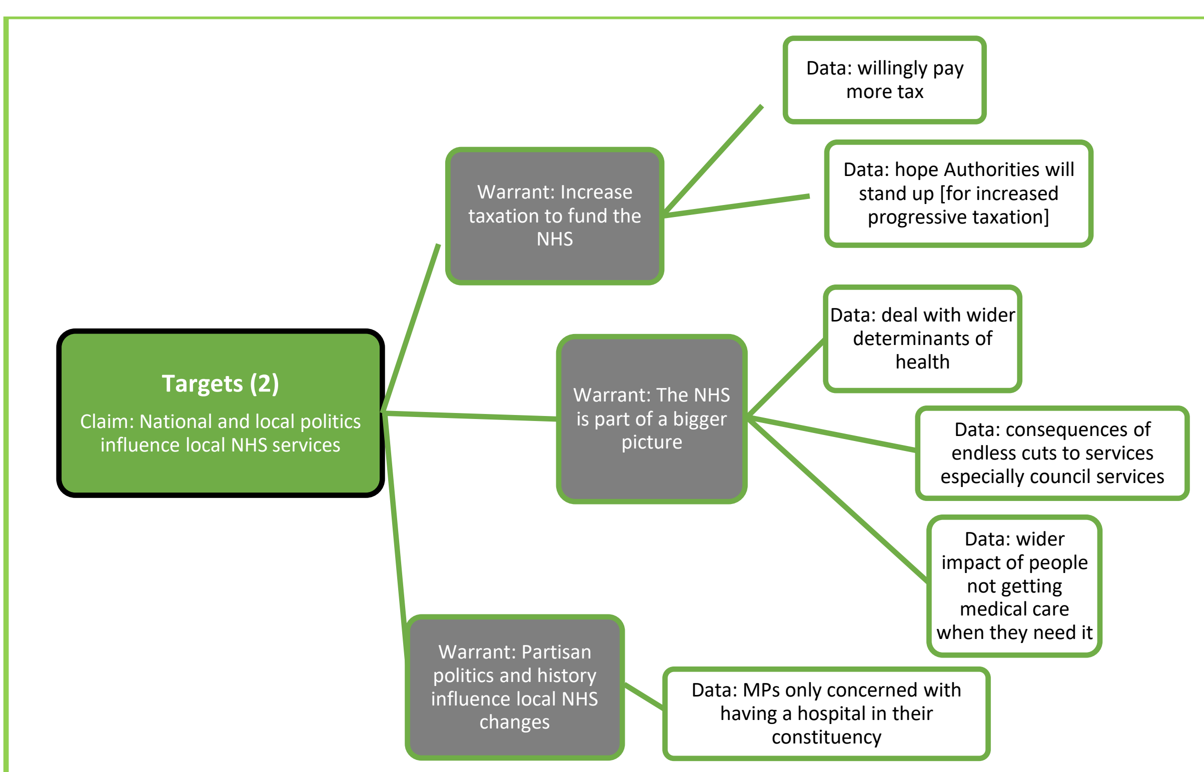
> 'You are asking questions based on the principle of the current budget. That is simply insufficient. We need to spend as the continent does. More per person. Anything else is tinkering around the edges'. [West]

The quotations below, from both sides of the county, urge the local NHS and social care leaders to be 'bold' and 'brave', to act more like altruistic 'knights' than self-interested 'knaves', and to challenge austere and regressive national policies (Le Grand, 2003).

> 'Feel that all the bodies involved in providing health care in Gloucestershire should campaign with others to persuade the government to inject further short-term funding into NHS and produce longer-term plan'. [East]

> 'Be brave Health Officials, and tell the political and senior civil servants that the cuts planned represent the biggest threat to the security of the nation. To fail to address that is little short of acquiescing to the political folly. I would have hoped for better from Gloucestershire'. [West]

Fig. A8 Targets (2) Chain: IDEAS



The second warrant recognises that the challenges facing the NHS are part of a bigger picture, with blame being directed at national policy. The two respondents from the west below focus their concerns on the causes of, rather than the responses to, ill health. Mention is made of the wider determinants of population health (Whitehead and Dhalgren, 1991). This is more strongly a feature of the approach described in Wales in the early years post-devolution (see 1.7); the impact on health and the wider economy of delays in accessing NHS treatment, as well as the perceived consequences of previous cuts to NHS beds and local authority social care provision.

> 'The present government seem reluctant to act on this for fear of any negative impact on the free-market economy or being accused of nanny stateism [sic]. Only if the cause of ill health is dealt with will

> health care become sustainable, savings will then just happen. Cutting beds, medication, staff etc will not make people better'. [West]

> '…the ineffective secretary of state for health needs to do the maths regarding his department's failure to recognise the knock-on cost of people not getting the medical care when they need it for things like mental health care, etc. When people cannot get the treatment they need quickly, it impacts on their ability to work, the family unit and therefore the overall productivity of the economy. Their employers also lose money, so that as a whole the country loses out. The Health Secretary needs to up his game and fully understand the effect of people not being able to work and contribute to the country, and the huge cost effect on our other public services and institutions. I have recently written to the PM on this very point.' [West]

The final warrant shifts focus from national political influence towards Gloucestershire's recent political history. Again the views come from the west of the county, suggesting local MPs favour a constituency partisan approach, rather than achieving a countywide party political consensus. At the time of the STP engagement in 2017 all but one of the six Parliamentary seats in Gloucestershire were held by Conservatives; the one exception being Stroud in the west, which changed to the Conservatives at the 2019 General Election.

> 'The NHS needs to be less risk-averse in its solutions to problems – I feel it is often constrained by history and local politics. It needs to be less tied to existing buildings and ways of working if you are truly going to achieve the change that is required'. [West]

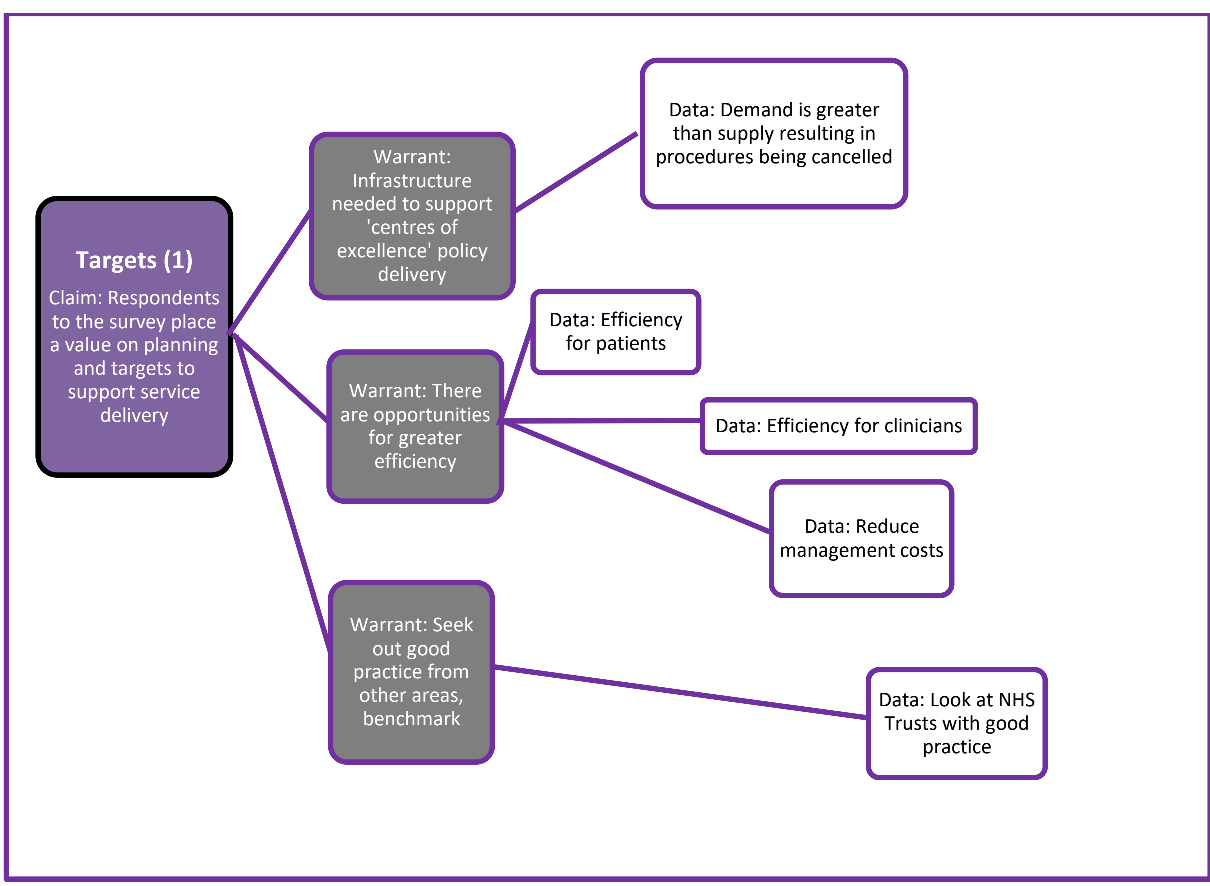
> 'More money is going in all the time but outcomes are worse than ever; MPs are only concerned with having a hospital in their constituency even if the greater good would be served by combining resources with a neighbouring town and consolidating health care'. [West]

7.4.3 *Targets POLICY – Case Study 2: FFtF Engagement 2019/20*

The number of responses to the FFtF engagement from the east of the county significantly outnumbers the responses from the west. Consequently there are more data to analyse from the east and this is reflected in the selection of quotations below. Where possible, and if relevant to the analysis and interpretation, data from both sides of the county have been included.

At the POLICY stage the 'targets (1)' claim is that respondents to the survey place a value on planning and targets to support service delivery (see Fig. A9).

Fig. A9 Targets (1) Chain: POLICY



The first warrant is that improved infrastructure would be needed to support the implementation of the CoE policy. The respondents from the east below are supportive of the policy in principle, but express doubts about the delivery, due to the level of planning and infrastructure required to deliver specialist hospital services at a time of high demand (outstripping supply) for NHS services in Gloucestershire.

> ‘Putting specialist centres for the different medical areas together in either Cheltenham or Gloucester for planned surgery is a great option… But this will not solve the under-capacity of the NHS against the over-demand of the public. We have an over-demand for treatment that will only be serviced by more capacity in the hospitals. Specialised centres should be more efficient so it’s a step forward, but it won’t solve the over-demand we have’. [East]

> ‘Centres of Excellence are important but the planning has to be first class. Services have moved backwards and forwards from Cheltenham to Gloucester but the infrastructure has not been able to support these moves. It comes down to bed occupancy; unless you can sort out your discharges especially for those with complex needs your plan will come to nothing. You already treat patients on a day-care basis as much as you can, but then you fill up the day units with inpatients so operations are cancelled. This is a classic example of the inadequacy of your infrastructure’. [East]

The second warrant has similarities to one seen in the IDEAS trust data, focusing on current inefficiency and opportunities to maximise future efficiency. However, the focus here is on policy practice rather than theory. The data suggest that the respondents below from the east are keen to identify efficiencies to save time and effort for patients, families, and staff. This appetite for suggesting improvements at this POLICY stage implies greater levels of support in the east for CoEs delivered through a targets model, than was evident earlier in the levels of trust in the CoE policy.

> ‘A service that joins the dots. My elderly father has to make numerous visits to hospital resulting in many letters from many departments arriving at various times. He is confused with who he is seeing, when he is seeing them, and often why. If there could be a joined-up approach with one visit to see either one person who can do all the conversations and then feedback, or one visit to see multiple clinics, it would save NHS money and time, and also my father, the patient’. [East]

And for clinicians -

> ‘Doctors should certainly not have to travel between sites, that is inefficiency. Even if doctors have to work at both, they should be able to be scheduled for a full day at each site’. [East]

Finally, the data here suggest again that the way to gain greater efficiencies is to reduce NHS management costs. This is a recurring theme across the targets data.

> ‘If you want to save money, remove some of the management layers and transfer those released by this back to medicine’. [East]
>
> ‘I'm sure by cutting down on unnecessary middle management you would be able to employ and train staff that are needed by the community. You must make a commitment to the people of Cheltenham!’ [East]

The third warrant is also a practical suggestion – to seek out good practice and apply established commercial business and industry practices.

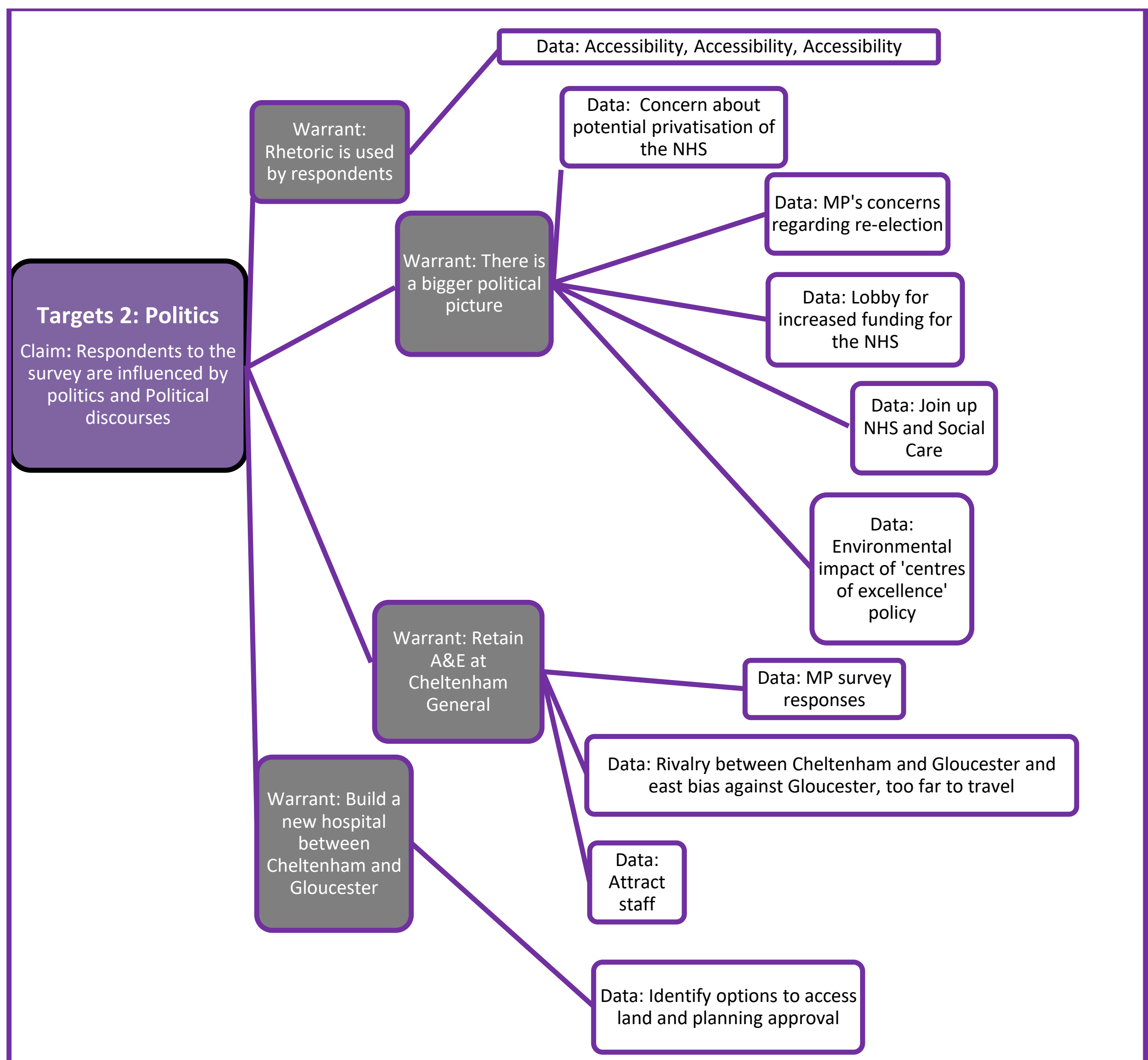
> ‘I would seek out those Trusts that are grading ‘excellent’ and look for transferable ideas’. [East]
>
> ‘Drive the hospital like a business, create positive customer experiences, and if staff are inefficient (trust me, from what I have seen, some are), manage them out of the organisation’. [East]

The Targets (2) (Politics) claim is that respondents to the survey are influenced by politics and political discourses (see Fig. A10).

‘You must make a commitment to the people of Cheltenham!’ is one of the quotes from the east which I selected to illustrate the claim above. This call to action is a

theme which also runs through the Targets (2) Politics Claim. In commenting on the CoE policy in the FFtF engagement, respondents exhibit a diverse set of political influences and perspectives. Almost all the selected quotes used to illustrate this claim originate from the east of the county.

Fig. A10 Targets (2): POLICY



The first warrant is that rhetoric is used by respondents. This is illustrated in the data from a respondent living in the east of the county.

> ‘Accessibility, Accessibility, Accessibility’. [East]

Repeating a triple priority for emphasis is an established political rhetorical device. One of the best known examples of this, from UK politics during the research period, is ‘Education, Education, Education’ (Blair, 1997; Blair and Adonis, 1996). From the response here it is difficult to tell how accessibility is measured by the individual. Is it used in relation to the CoE policy, in terms of distance from home to hospital, or in

terms of access to a service that might otherwise not be available in the county? Alternatively is it to do with equitable, physical, cultural, financial, or some other factors which might restrict access for an individual or group. My assumption, when undertaking the primary analysis of the data (NHSG, 2020), was that the respondent from the east meant this comment to refer to distance to travel, i.e. accessibility of specialist services; too far to travel to GRH from the east of the county, or conversely not too far to travel to CGH from the east of the county. I think it is reasonable to assume that the respondent is using a rhetorical device to highlight an important issue from their perspective, but without further context, its impact in terms of influencing decision makers is limited. There is learning, for people completing surveys to consider how the data is provided to maximise its impact on decision makers, and for survey designers to increase clarity of meaning in the data collected. In response to this challenge, at the FFtF consultation PROPOSALS stage the following qualifier question was added – ‘Please tell us why [emphasis added] you think this, e.g. the information you would like us to consider’ (see Appendix 1).

The second warrant is that there is a bigger political picture to consider. There are lots of connecting themes. Particularly noteworthy are the potential threat to re-election of the local MP if NHS services move outside of constituency, and again, the suggestion to be brave and petition elected representatives for increased funding for the NHS. Also, linked to this, and an earlier observation about joint funding, the suggestion that the NHS and social care should be more integrated. The data below, from both east and west, illustrate the variety within this warrant.

MP's concerns regarding re-election –

> ‘I believe that as long as any decision you make is not influenced by political fear over the loss of votes then I am comfortable with the outcomes. Allowing political intervention based on loss of voters is cowardly and puts people’s lives at risk’. [East]

> ‘Centres of Excellence approach sounds extremely sensible and clinically the right thing to do. Lots of politics and showboating when it comes to Cheltenham and Gloucester, but need to take a view about what is best for the patient’. [East]

> ‘The Centres of Excellence idea is a good one and from a medical viewpoint it can't be argued with although politicians will’. [West]

Lobby for increased funding for the NHS –

> ‘Unfortunately things needed to be put in place ages ago, and then by now we might already have Centres of Excellence, to allow this country to again lead the world in medicine and many other things too. We need politicians to be brave and increase taxes a little to allow this to happen’. [East]

Join up NHS and social care –

> ‘To allow a system where poor social care facilities block hospital beds with patients who cannot be released because of inadequate facilities is appalling and shows a deliberate paucity of thinking from the Government, Social care should be a part of the NHS’. [East]

The third warrant is the request to retain A&E at CGH. As noted, several times already, no proposals to change the A&E department at CGH feature in the STP or the FFtF programme. This warrant is strongly linked to the data above relating to the re-election of the local MP for Cheltenham, who promoted the FFtF engagement and provided sample survey responses which refer to the potential loss of the A&E at CGH. These responses were replicated by significant numbers of respondents. The first quote below from the data is a sample MP response and the second quote echoes the concern about CGH A&E but does provide a qualifier regarding the impact on accessibility.

> ‘Specialisms should not be pursued to the extent that CGI loses its A&E. Cheltenham General Hospital is exactly that – a general hospital – and no reconfiguration that might undermine that status should be considered’. [East: MP sample]
>
> ‘Keep A&E Cheltenham open. No point in providing a wonderful service (at Gloucester) if patients can’t get there’. [East]

There is also a set of data linking the attraction for clinicians to work in Gloucestershire to the misunderstanding of the current and future status of CGH A&E; this is a typical example.

> ‘The ongoing uncertainty about the future of the Cheltenham hospital must have an impact on recruitment. It is essential that A&E is retained in Cheltenham for reasons outlined above and that the Trust commits to it for the long term’. [East]

The rivalry between Cheltenham and Gloucester, and bias against GRH, also comes through in the data. The two respondents below cite incidences of choices made to delay accessing treatment in Gloucester, in order to wait for the A&E department at CGH to switch, from a nurse-led unit service overnight, to consultant-led from 8am in the morning.

> ‘The most important is to retain A&E at Cheltenham. Our 94-year-old relative has falls in the night but will not call for an ambulance because she knows it will take her to Gloucester, consequently she suffers’. [East]

> ‘I recently had to use 999 for a close family member; we delayed the call for five hours until 7am as we did not want to be taken to Gloucester. Had we been able we would have driven ourselves to CGH. The paramedics delayed taking them until 8am so they could go to Cheltenham. They died the following day and we thank God that we did not end up at GRH, where dealing with the situation for 18 hours would have added to an already distressing time. I know of other people who have also delayed a 999 call until after 8am to ensure they go to Cheltenham’. [East]

The final warrant is the suggestion to build a new hospital between Cheltenham and Gloucester. This suggestion is also seen in the ‘targets’ and ‘choice’ data. However, there is a particular piece of data, which relates to local politics in the form of planners, and so is selected for inclusion here.

> ‘When you take increase in population into account, how sustainable is the split-site scenario? Keep pressure on funders and planners to release land at Staverton/Elmbridge for a single site; modern hospital serving both towns’. [East]

This quote is particularly relevant to this thesis, as it pin-points an exact geographical position situated alongside the ‘Golden Valley’ bypass. This location is referred to earlier in this paper as the ‘hard grey tarmac’ creating a link between Cheltenham and Gloucester.

7.4.4 *Targets PROPOSALS – Case Study 3: FFtF Consultation, 2021*

As with the earlier analysis, the FFtF engagement data associated with the targets model shows potential efficiencies or inefficiencies, and value for tax-payer money. Principally, respondents from the east identify inefficiencies for patients in the Acute Medicine proposal to centralise services in Gloucester (see Fig. A11). The tension between the two hospital sites remains a feature in the data for the Planned Lower GI proposal, where no site preference is promoted (see Fig. A12). A new aspect emerges in the data at the PROPOSALS stage with respect to the proposal to create a CoE for Planned Day Case Upper and Lower GI Surgery at CGH. This proposal is seen as having the potential to ‘preserve’ CGH by retaining more specialist services on site (see Fig. A13). I will concentrate below on targets themes, particularly amplified by, or unique to, the FFtF consultation in 2021.

Fig. A11 Targets Chain: Proposal – Acute Medicine to GRH

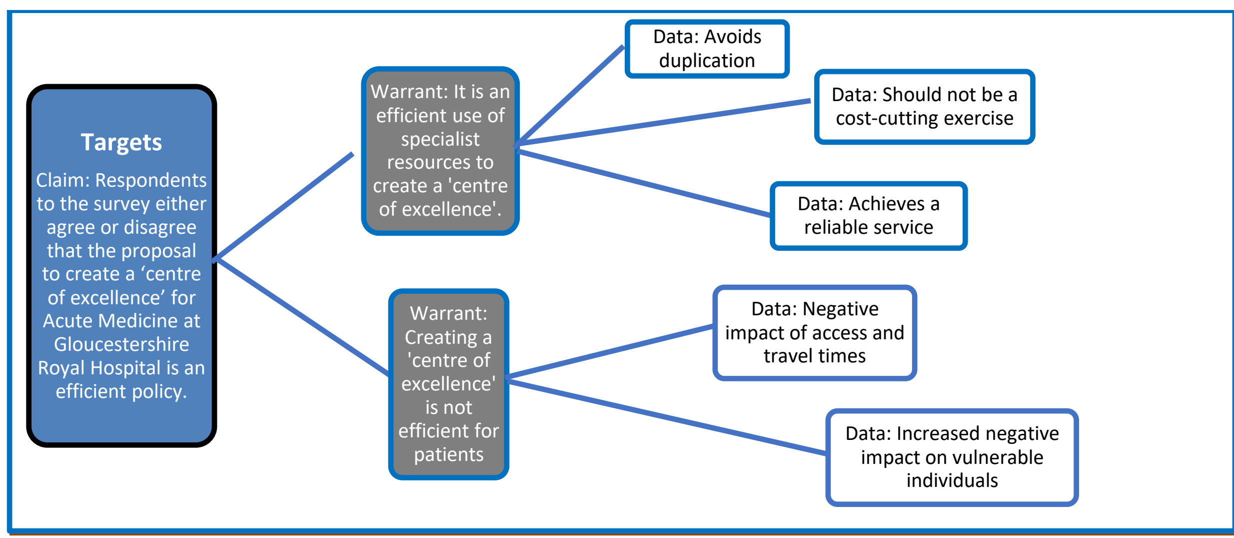


Fig. A12 Targets Chain: Proposal – Planned Lower GI Surgery at either CGH or GRH

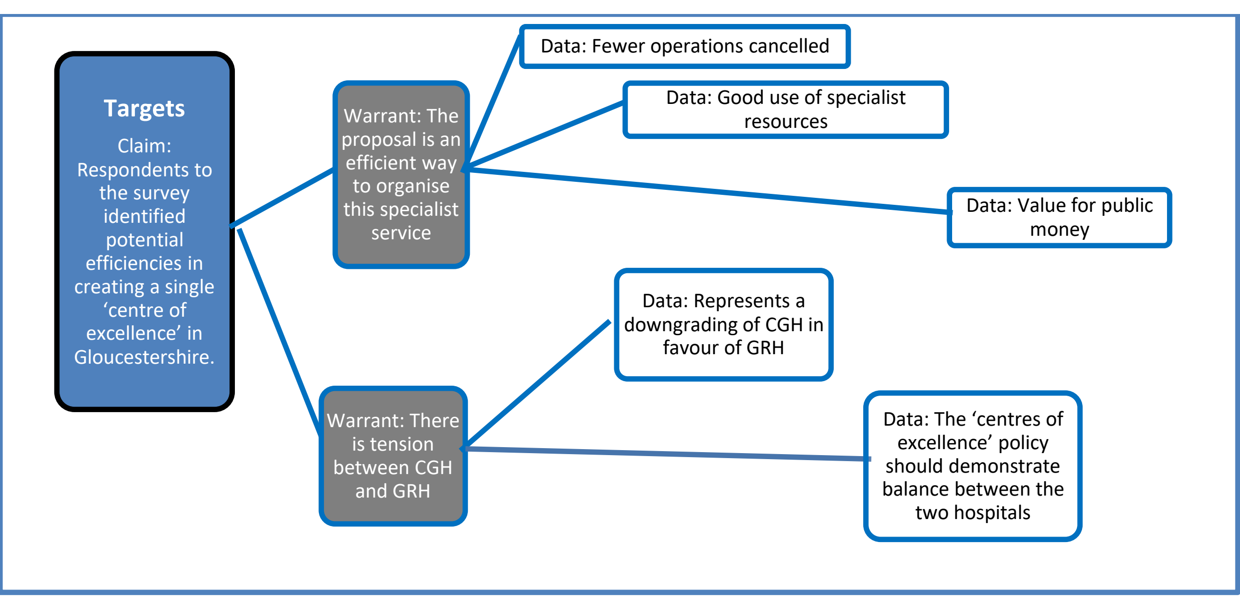
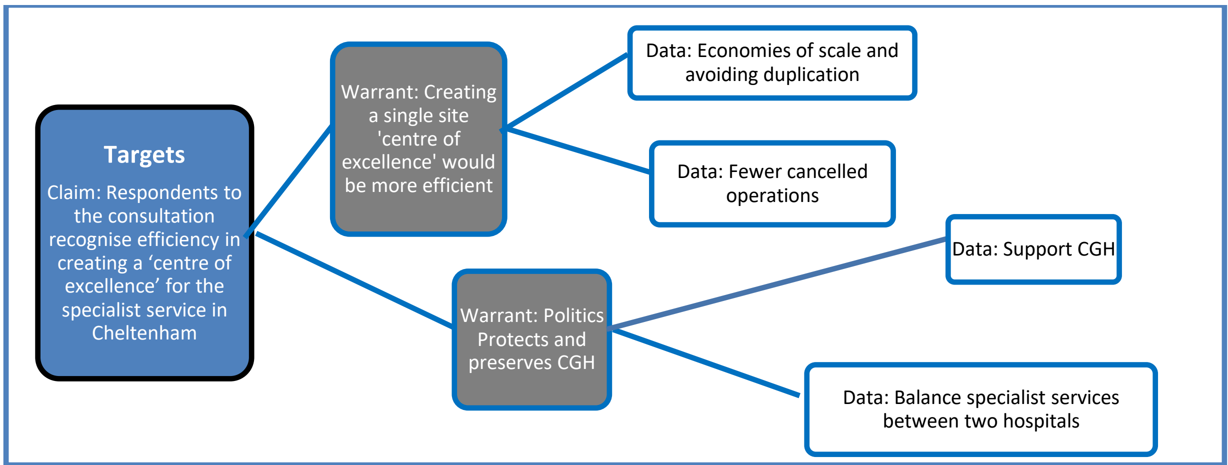


Fig. A13 Targets Chain: Proposal – Planned Day Case Surgery Upper and Lower GI at CGH



As seen in previous claims, there is evidence that respondents from both the east and the west felt that the proposals to create CoEs would be an efficient use of specialist resources.

Acute Medicine at GRH –

> 'If it means reliable and consistent access to specialists regardless of the day or night then it deserves full support'. [East]
>
> 'I wish to ensure that the best treatment is available as timely as possible and is not compromised by duplication of service across sites'. [West]

Planned Day Case Surgery Upper and Lower GI at CGH –

> 'It is easier to manage and better cost savings for the Trust, taxpayer'. [East]
>
> 'Specialist equipment in one place, more efficient use of resources and specialist staff'. [West]

Planned Lower GI Surgery at either CGH or GRH –

> 'Planned care still requires experts and equipment; it's unreasonable to expect the NHS to be able to fund this on two sites that are so close to each other'. [West]
>
> 'If it means fewer cancelled operations and less disruption in the busy winter months then it has to be a good thing'. [East]

Data from the Planned Day Case proposal, but applicable to all three, indicate respondents from across the county feel the centralisation of specialist services in one place represents value for public money.

> 'I accept it is no longer practical/affordable to have all specialisms at both sites'. [East]

> 'Focusing a specialism in one location makes the most sense, providing value for money'. [West]

However, this respondent from the west expressed the view that they support the policy of centralising Acute Medicine at one hospital, but that it must be adequately resourced and not be used as a cost-cutting exercise.

> 'With ever more complex equipment and specialist staff required it makes sense to centralise the service providing the infrastructure, beds, and staff are provided. Such a move must not be seen as part of a cost cutting exercise'. [West]

Introducing a political angle to this point of view, a respondent from the east suggests the FFtF proposals have been prescribed by central government as a way to save money.

> 'This will inevitably lead to cost savings (perhaps instructed by ministers, and not immediately) by reducing staff numbers to provide current levels of care, only now at one site'. [East]

As seen previously in the analysis of trust data, there is a degree of acceptance of the logic of centralising services, but there is also a degree of suspicion about the motivation guiding the evolution of the CoE policy as it moves closer towards a real change proposal.

As well as suspicion about ulterior motives, there is also concern that, if implemented, this proposal would have a negative impact on patients, firstly in terms of accessibility. Unlike the previous data, which only highlighted 'accessibility' as being a priority in and of itself, the data below offer a very specific example in relation to the proposal to centralise Acute Medicine in Gloucester.

> 'Concerns about a bottleneck – effect at GRH – if you double the amount of traffic, you need to double the width of the road, ALL roads, leading in and out'. [East]

The second Planned Day Case warrant is that the proposal to create a CoE at CGH will protect and preserve CGH for the future. However, the data from the east are influenced again by the misinformation about the status of A&E at CGH.

> 'Don't care as long as 24/7 type-1 consultant-led A&E services are restored to CGH'. [East]

The misunderstanding about the status of the CGH A&E is not exclusive to the east of the county. This respondent from the west is pragmatic about a service being centralised in Cheltenham as a mitigation for the A&E being in Gloucester.

> 'If the 24hr A&E is at GRH then to have this option at CGH would be good'. [West]

When I look at the data for Planned Lower GI Surgery, where no preferred site is indicated, the arguments made to locate the service in Cheltenham, to prevent its downgrading compared to GRH, are forcefully made from respondents from the East.

> 'The plan seems to be to downgrade Cheltenham GH despite the wide catchment area and substantially increased population in the rural parts of North Gloucestershire'. [East]

> 'I would not support the concentration of services on one hospital site if that led to, for example, a reduction in consultants at CGH which would eventually put the future of services at that site in question'. [East]

Finally, where there is no site preference indicated by the NHS system (Planned Lower GI Surgery), responses seem more inclined to suggest that the CoE policy should demonstrate balance between the two hospitals; the response below suggests a redressing of the balance in favour of Cheltenham is required.

> 'We need to establish strong bases in Cheltenham. Naive perhaps to suggest centres of excellence should be visible fairly equally in both hospitals, but there could be a tendency otherwise for one of the two (probably CGH) to have lesser standing, lesser research/funding potential'. [East]

7.5 Targets Findings

7.5.1 *Efficiency*

The relative efficiency of public services is a constant feature of targets data across the case studies. Views are expressed about the efficient use of public funds, with the suggestion at the IDEAS stage that too many managers in the NHS are associated with high management costs. Short-term planning, poor performance management and lack of involvement of frontline staff in developing services is also negatively reported. Some respondents suggest resources could be better joined up to support infrastructure across the wider health and social care system in the county. The opportunity to enhance efficiency through learning from best practice in other areas is also a feature of the data at the POLICY stage. At the PROPOSALS stage, responses to all three potential service reconfigurations described in the FFtF consultation refer to the opportunity for specialist hospital services to be organised more efficiently at single CoEs.

7.5.2 *Politics (with a big P) and Public Service Funding*

Political influence emerges as a key differentiator of the views of participants from the east and west. This is despite the Parliamentary elected representative make-up of the county during the research period being exclusively Conservative. The data suggest that those participants who express more welfarist associated with the conception of public ownership of public services views appear more likely to express opinions at the IDEAS and POLICY stages rather than at the PROPOSALS stage. This may be associated with the drivers for the proposals not being about reducing staff, public service funding, or the characteristics of the services providers (NHS not private hospitals); rather, focusing on locations of services provided by a single NHS Foundation Trust. Under the heading of Politics, at the POLICY stage, needing to find new ways to fund NHS services, and increasing general taxation to increase the NHS budget, is a recurring response; and this is added to by a stated willingness to pay an extra 1-2p on income tax to support the NHS. These views are more prevalent amongst participants from the west.

During the POLICY stage there is a stronger political discourse in the east relating to the retention of the A&E department at CGH. An alternative idea put forward by several respondents, to resolve the longstanding competition between Cheltenham and Gloucester, is to build a single hospital for the county situated half-way between the two conurbations. This would be somewhere along the axis of the 'hard grey tarmac' (see 1.13.1). This is not a new idea; it has been a recurring topic of discussion between the Trust provider, the Commissioner, the local population, and locally elected representatives for over twenty years. The concept has been tested by the NHS system on several occasions during the period but has been ruled out as being unaffordable on every occasion. It remains an option for consideration by the system in future, should new enhanced NHS capital funding schemes become available. It also features as one of the potential amenities in Gloucestershire County Council's 2050 Vision for a 'Super City'.

> 'Super City – Gloucestershire's two main urban centres – Gloucester with its cathedral city status and heritage, and Cheltenham with its spa town elegance – could grow and regenerate by developing a third centre connecting the two to create a "super city". This would create a vibrant heart in the centre of the county, offering integrated, creative communities to live and work. The benefits of the "super city" would ripple out to the rest of the county through varied transport links; changing perceptions of Gloucestershire as a group of separate districts (Gloucestershire County Council, 2018)

The ‘Super City’ idea has echoes of the CoE discourse, in that its purpose is to promote the benefits of the two parts of the county working together and to neutralise the negativity created by the distance (physical and historical) between Cheltenham and Gloucester; in the case of 2050 Vision by literally filling in the geographical space between with development.

Back in 2020, at the FFtF PROPOSALS stage, the tension between locating services at either GRH or CGH is a key feature in the data, especially where there is no preference expressed by the NHS system for the location for Planned Lower GI Surgery, and there is a real competition between the two hospitals to provide the service. In relation to the proposal to create a CoE at CGH, there is a sense that this reconfiguration will ‘preserve’ CGH, indicating that respondents feel that the hospital has been, and continues to be, under threat of downgrading.

7.6 Appendix 5: Impact of COVID-19 on this research

The initial spark of inspiration for this research was the idea to investigate an unintended consequence of devolution in the United Kingdom (UK); one of its most significant constitutional change programmes (Brown Swan, 2022). My attention was drawn to this subject through my professional role in Gloucestershire, handling the impact on patients' experiences of national differences in relation to patient choice post-devolution. I had observed an underserved group living on the Wales/England border, who had established a campaign group, Action 4 Our Care (A4OC) and used their collective voices to raise their concerns locally and nationally about the impact of divergent policy ten years post-devolution. With the publication of the NHS Constitution in England, as English residents registered with Welsh GP practices, they were unable to exercise their constitutional right to patient choice of secondary care hospital (Costa-Font and Greer, 2013; Department of Health, 2009).

Their community action resulted in changes to national policy implementation, to the signing of a cross-border protocol in 2013, and the introduction of the Referral Access Service in 2016, thereby enabling them to achieve their NHS Constitutional rights as English residents (NHS England, 2009; NHS Gloucestershire, 2023).

My original research plan had been to explore the justifications and implications of England/Wales policy divergence through analysis of healthcare policy development in England and Wales and a series of structured interviews with key individuals from the A4OC Group and representatives of the NHS Cross-border Network. However, due to COVID 19 pandemic restrictions and my associated temporary redeployment; with support of my Supervisory team, I shifted focus towards micro-level 'small d' devolution at local system level within England. During my redeployment I did retain an interest in the different approaches to the emergency response to the COVID-19 pandemic, collecting an archive of over 200 online BBC News articles illustrating the divergence during 2020 and 2021. A useful archive for potential future research. The following references may be an interesting starting point for such research.

- Department of Health. 2015. The UK Government's Response to the House of Commons Welsh Affairs Committee Report: Cross-border health arrangements between England and Wales. Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office.
- Department for Health, Social Services of the Welsh Government and the NHS Commissioning Board. 2013. NHS Commissioning Board. 2013. Protocol for Cross-Border Healthcare Services. https://www.england.nhs.uk/wp-content/uploads/2013/03/england-wales-protocol.pdf
- House of Commons Welsh Affairs Committee (2015) Cross-border health arrangements between England and Wales. London.
- House of Commons Welsh Affairs Committee Third Report of Session 2014-15: Cross-border health arrangements between England and Wales. http://www.publications.parliament.uk/pa/cm201415/cmselect/cmwelaf/404/404.pdf [Accessed 09.09.2018]
- House of Commons Welsh Affairs Committee. 2015. Cross-border health arrangements between England and Wales. The Stationery Office Limited.
- NHS England; and NHS Wales., 2018. England / Wales NHS Cross-border Healthcare Services: Statement of values and principles. https://gov.wales/sites/default/files/publications/2019-04/england-wales-nhs-Cross-border-healthcare-services.pdf [Accessed: 26.09.2019]
- NHS Gloucestershire, 2023. Cross border healthcare. https://www.nhsglos.nhs.uk/about-us/how-we-work/cross-border-healthcare/ [Accessed: 08.07.2023]
- Forest of Dean and Wye Valley Review, 19 March 2014: New promise to border patients http://www.theforestreview.co.uk/article.cfm?id=339&headline=New%20%promise2%...&searchyear=2014 [Accessed 19.10.2019] and Forest of Dean and Wye Valley Review, 26 November 2014: 'Put patients first'. http://www.theforestreview.co.uk/article.cfm?id=1207&headline=%E2%80%98Put%20patients%20first%E2%80%99&searchyear=2014 [Accessed 19.10.2019]
- ITV News, 18 November, 2014: Interview with Pam Plummer of Action4OurCare. https://www.itv.com/news/westcountry/update/2014-11-18/forest-of-dean-residents-treated-unlawfully-by-nhs/ [Accessed 19.10.2019]
- West Country ITV News, 13 April 2016: 9000 Gloucestershire patients caught in NHS no man's land. https://www.itv.com/news/west/2016-04-13/gloucester-patients-caught-in-nhs-no-mans-land/ [Accessed 19.10.2019]
- Monmouthshire Beacon, 20 April 2016: Cross-border health care victory for campaigners. http://www.monmouthshirebeacon.co.uk/article.cfm?id=104966&headline=Cross-border%20health%20care%20victory%20for%20campaigners§ionIs=news&searchyear=2016 [Accessed 19.10.2019]