Are trusts trying to differentiate themselves on quality grounds? A review of 26 London trust websites

The promotion of competition between healthcare providers has provoked a great deal of debate. What both sides of the argument have in common is an assumption that this reform is having a significant impact on the way providers behave.

Many would assert that their organisations are making major efforts to promote their services and gain additional custom. This article examines how that is translated into what the average ’customer’ can readily see – namely NHS trust websites. By the end of the article some of those readers may have cause to re-examine the effectiveness and sincerity of those efforts.

Promoting competition between providers, empowering patients to make informed choices and increasing choice of service provider are meant to be complementary forces for beneficial change. Competition is supposed to take place on quality issues, as price-based competition has in theory been ruled out. In reality, that prohibition is overstated as there remain significant areas of NHS service provision that are not governed by national tariffs. However generally speaking, for payment by results services price plays a relatively insignificant part in contract discussions - certainly compared to what one would expect if price competition was formally allowed.

The conventional wisdom is that providers wish to increase market share. It is understood that to do so they must make inroads into the market share of others rather than create new demand, and that they must compete on quality grounds because of the restriction referred to above. The target audience for the promotion of those services is sometimes disputed. Is it primarily the referring GP or the patient? However, these marketing approaches need not be mutually exclusive.

Importantly, there are grounds for questioning that conventional wisdom. First, do providers always want to increase their activity or market share? They probably will not want to if commissioners are unwilling to pay for that activity, or the marginal price of the work is less than the cost of delivering it. This is a very real issue, especially for non-elective cases, but also more generally where commissioners consider themselves financially overstretched. For providers, ‘trading out’ of their financial problems tends to be an attractive option. But this is increasingly regarded as unrealistic in a system that is no longer enjoying real funding growth.

The key question is, are providers making much effort to promote themselves to ‘customers’ and if so how are they trying to differentiate themselves from their competitors? An analysis of trust websites is revealing.

Methodology

The content of the public websites of 27 trusts in London were examined for a period of approximately 15 minutes per trust. This was considered a proxy for what a reasonably well motivated consumer might do. The idea was to establish to what degree the trust in question was actively promoting the following:

* Performance against particular quality indicators, for example wait times, infection control, patient satisfaction, national awards, health outcomes, staffing ratios, Patient Recorded Outcome Measures, sub-speciality interests.
* Explanations of quality issues in healthcare provision, for example health indices like hospital standard mortality rates, what a PROMs score means, what MRSA is, and how these are measured.
* Usability - how easy it is to find items, and whether GPs have their own section.

This does not claim to be a scientific study. It is necessarily subjective because the author made the assessments. But a standard format was followed in terms of searching for each item and the same searches were undertaken for each trust. This included looking for information on ‘PROMs’ and ‘patient satisfaction’ using the search facility on trust websites. The results of the study should at least provide an insight into the London market place. The 27 trusts are:

Barking Havering and Redbridge

Barnet and Chase Farm

Barts Health

Chelsea and Westminster FT

Croydon Health Services

Ealing Hospital

Epsom and St Helier

Great Ormond Street FT

Guys and St Thomas FT

Kings College Hospital FT

Hillingdon Hospital FT

Homerton University Hospital FT

Imperial College Healthcare

Kingston Hospital

Lewisham Healthcare

Moorfields Eye FT

North Middlesex

North West London Hospitals

Royal Brompton and Harefield FT

Royal Free FT

Royal Marsden FT

Royal National Orthopaedic Hospital

West Middlesex Hospital

South London Healthcare

St George’s Healthcare

University College London Hospitals FT

The Whittington Hospital

The purpose is not to identify the best and worst trusts in terms of their ability to promote themselves. It is rather to assess the degree to which NHS trusts have responded to the supposed incentives to gain extra income by attracting additional activity. To what extent have they differentiated themselves on quality grounds to seize this opportunity?

One might expect to find some of the most intense competition in the UK amongst these providers, not least because it is often claimed that London has too many hospitals.

The answer is that their efforts, in so far as they manifest themselves in public information on websites, are singularly underwhelming. In some cases, multi-million pound organisations have websites that might be characterised as amateurish - links that do not work, no search field, constant crashes – and with minimal content on healthcare quality. If these organisations want to attract additional customers they are doing a good job of disguising their intentions.

The following results are particularly noteworthy:

* Only two trusts, both FTs, provided waiting time information on their site. No trust showed this information as part of their speciality or consultant profiles.
* One trust website had no search field.
* The websites for three trusts repeatedly crashed. On another, the ‘why choose us’ link did not work. The website for a newly merged trust did not work at all - and access was attempted on three separate days. The results for that organisation have been taken from the website of one of its constituent trusts, otherwise that organisation would have had zero return.
* Only 19 trusts had information on sub-speciality interests by consultant, with eight failing to provide this.
* 24 trusts had web pages targeted at GPs, while three appeared to have nothing.
* 20 trusts carried eye-catching patient testimonials or stories highlighting innovation or excellence on their home page.
* Searches for ‘PROMs’ brought nothing back from fifteen trusts.
* Searches for ‘patient satisfaction’ brought nothing back from four trusts. The others had a range from three to 1,517 results.

The study erred on the side of generosity. For example trusts were marked with a ‘yes’ for sub-speciality information although they may have had this level of information for only selected specialties. Likewise, on the issue of a specific tab for quality I have marked ‘yes’ if a trust has a tab for infection control, cleanliness or ‘why choose this hospital’. If the criteria had been for an area of the website where all quality indicators could be viewed and interrogated, then no trust would have received a ‘yes’.

Even with the bar set low, the results of this survey are less than impressive. There was no discernable difference in the website content between FTs and non-FTs. However, overall there was a noteworthy lack of consistency. For example one academic health science centre had detailed consultant profiles including their publications, while another did not even have sub-speciality interests, just a list of consultants for the specialty concerned.

No trust had a specific tab that linked to PROMS or patient satisfaction. Not one trust had set out its PROMS score in relation to a specific service, for example hip replacements. Moreover, trusts did not detail outcome measures, volumes, length of stay, or patient satisfaction result for any specific procedure, consultant or specialty. The exceptions were some specialist areas such as paediatric cardiac surgery, infertility and in one case hip replacement. This might be characterised as isolated pockets of useful information on the quality of a specific service produced by a minority of trusts.

Interestingly, one trust managed to combine the extremes. It had some specific quality and outcome measures for one of its specialties - less than 1 per cent of patients had complications, average length of stay for 2010 was 14 days compared to the national average of 22 days - with no sub-speciality information for the consultants.

Most trusts have a specific section for infection control, and some incorporate general quality measures into this area, such as PEAT scores. They are the most uniformly developed aspect of ‘quality’ on trust websites, but even this is not universal. Instead trusts have a tendency to use the ‘news’ section to highlight their quality portfolio. The problem with this approach is that would-be customers have to search the index of news stories to obtain this information.

Trusts have their quality accounts on their websites, mostly on web pages relating to board publications. Some - but far from all - searches linked PROMs or patient satisfaction to the quality account, but these documents are far too large and unwieldy to be of much use as a marketing tool.

How many staff are aware of what a trust’s quality account is, or what is in it? How many board members can honestly say they have read it from cover to cover? In any case would-be patients are most unlikely to read it. This illustrates a general weakness of the approach to promoting trusts on quality grounds. The efforts to do so are mostly clumsy, rather like watching a bear dance.

Those organisations might respond by pointing out that they do not have a dedicated marketing function. However, this does not explain why these tasks are given relatively low priority and so few resources. If trusts are serious about differentiation and this is seen as important in gaining customers, why is more attention not being paid to promoting that differentiation?

Perhaps the answer simply is that trusts do not truly believe the promotion of a quality service is important, or they do not believe it strongly enough to make an investment in this resource at the expense of something else.

Given that London contains a number of trusts which consider themselves among the best in the country for clinical quality this apparent lack of differentiation is somewhat puzzling. So, too, is the relative absence of publicity about where individual trusts are placed on the various NHS league tables. Websites were generally uninformative in establishing where a trust sat were compared to other trusts on such matters as A&E access targets, the 18 weeks target, length of stay, mortality rates, complaints, re-admissions, and nurse and medical staffing ratios. While it is understandable that those trusts which were doing badly might not wish to advertise their position, the reticence of those doing well is frankly puzzling.

Perhaps it is explained by organisational nervousness about what the future might hold. Do we want to say we are doing well now if next month we do less well?

Perhaps trusts are spending little time on differentiating themselves via their websites because they don’t think this is an effective medium for influencing the public. If so, then what do they regard as an effective medium for influencing would-be patients? Or perhaps they think influencing GPs is more important. In that case, why do three trusts have no GP-specific web pages?

Perhaps the answer lies more in providers’ and commissioners’ ambivalence towards extra activity. Certainly it is difficult to find a provider promoting short wait times in A&E, and this will surprise few. The failure to publicise shorter wait time for elective care is more difficult to explain. The suspicion is that commissioners are trying to make the eighteen-week wait time effectively guarantee the minimum wait time as well. At least one acute trust in London has a contract agreement with their host PCTs that closely resemble the block contracts of twenty years ago. Quite how such arrangements square with either the spirit of a system based on PbR or indeed the entire thrust of the government’s health reforms is of interest. Practically, it makes little sense for any organisation covered by such a contractual arrangement to promote itself to patients in the hope that more people choose that provider.

All of the above conspires to undermine a key objective of the reforms - greater responsiveness to consumers with the aim of driving up quality and efficiency. It also raises a question about the commitment to another key element of government health reforms, the promotion of informed, empowered consumers. Trust boards may think they are serious about differentiation, letting patients know about the quality of services, and thus gaining market share. But evidence from the content of their trust websites begs to differ.

Finally readers may find it ironic that the one trust which put a set of key quality indicators on its front page and explained what these meant has just become subject to a special administrator. One wonders to what degree their problem was not enough demand from patients for their services.

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