

The sham of NHS consultation on service provision

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1. Introduction

Across the whole of England there has been a wave of consultations on NHS services over the last five years involving what is euphemistically called the reconfiguration of services. Although the focus in NHS consultation documents has tended to be on improving health care, bringing care closer to home, making care safer and so on,¹ in all cases closure of one or more valued services has been the intended outcome.

In this brief paper based on our experience in advising local government overview and scrutiny committees across the south of England – including in Gloucestershire, Hertfordshire, Sussex and London – on their responses to NHS consultations on major service reconfigurations, we review the general lessons to be learnt from current consultation practice in the NHS, and suggest that it must improve in the future if the Government is genuinely interested in taking account of what the public wants from its health services.

We start by examining what the consultation process is supposed to look like.

2. The consultation process

When presenting proposals for major expenditure of public resources or for changes in service provision, health organisations are obliged to comply with guidance issued by various government bodies charged with ensuring best practice and best value for money in the planning and implementation of healthcare schemes. Any failure to comply with guidance can delay approval and elongate the process between conception and execution of plans.

¹ The Health Minister, Ara Darzi, for example in his interim report on the NHS (Darzi, 2007b) identifies a vision of the NHS that is 'fair, personalised, effective and safe', the implication being that today's NHS is unfair, depersonalised, ineffective and unsafe. But such platitudes are designed to mask the real intent which is to impose on local populations solutions that centralise services.

Guidance has been prompted by a history of problems with large-scale public planning, procurement and implementation which has resulted at times in judicial review, lengthy and costly public inquiries, planning blight, construction of the wrong facilities in the wrong place, and excessive costs. There is therefore a strong presumption that guidance should be followed wherever possible to help avoid potential pitfalls and risks associated with complex and controversial schemes.

Most consultations take place under the statutory duty to involve and consult under section 11 of the Health and Social Care Act 2001 (HMSO, 2001). This was since reconfirmed in section 242 of the National Health Service Act 2006 (TSO, 2006) and amended in the Local Government and Public Involvement in Health Act 2007 (TSO, 2007) which places a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change. In theory – though not often in effect – this should mean consulting and involving not just when a major change is proposed, but in ongoing service planning; not just in the consideration of a proposal, but in the development of that proposal; and, in decisions about general service delivery, not just major changes.

The duty to involve and consult commenced on 1 January 2003 and guidance was issued in February 2003 – *Strengthening accountability - involving patients and the public: practice guidance* (Department of Health, 2003a). Further guidance was issued in *Substantial variations and developments of health services: a guide* (Centre for Public Scrutiny, 2005).

There are four requirements for lawful consultation:

1. at the formative stage the consulting body must have an open mind on the outcome;
2. there must be sufficient reasons for the proposals and requests for further information should be supported;
3. adequate time should be allowed for consultation with all key stakeholders ie NHS bodies should not delay consultation until a situation is urgent; and,
4. there should be evidence of ‘conscientious consideration’ of responses by the consulting body.

In a letter to the NHS of 10 May 2006 introducing *The NHS in England: the Operating Framework for 2006/7* (Carruthers, 2006), the then NHS Chief Executive, Sir Ian Carruthers, stated succinctly in paragraph 12,

Service or organisational reconfiguration in the NHS has too often in the past failed to deliver the required quality and cost improvements. Proposals must have rigorous business cases with integration and benefits plans and clear accountability so that quality and financial improvements are realised.

However problems already encountered had led to requests from overview and scrutiny committees for referral of decisions to ministers and requests for judicial review. In October 2006 as a result of the controversy building around proposed reconfigurations in the NHS, Carruthers was asked by David Nicholson, the current NHS Chief Executive, to review existing proposals for changes in services throughout the country. His findings were issued in the form of further guidance to health organisations (Carruthers, 2007). One of the key recommendations was that a full business case setting out the clinical and patient benefits of service change should be produced for all proposals, and should be reviewed by the SHA before consultation begins. It was also recommended that the SHA must ensure the framework for testing proposals is in place, so that the proposals for service improvement are sufficiently robust and fit for purpose before formal consultation proceeds. The guidance recommended that SHAs should ensure that each scheme in its work programme complies with consultation legislation and guidance in an accurate, effective and timely fashion.

So it would seem that NHS organisations have before them a pretty comprehensive set of guidelines and instructions on how to consult. However on the whole we have found that consultations have fallen far short of these standards. The key question perhaps is why this should be the case.

One possibility is that many organisations have found themselves in dire financial straits so that often the timetable for consultation was driven by the need to make cuts rather than any real desire to understand the wishes of the population being served.

3. The financial state of the NHS

It is no coincidence that plans to reconfigure acute services were introduced in many areas of England at a time when there had been major concerns about deficits in NHS finances. This may seem strange given recent headlines that the NHS in 2007/08 (excluding Foundation Trusts) will have a surplus of at least £1.8 billion (Department of Health, 2007). However, less than two years ago the NHS appeared to be out of financial control with estimates of overspending reaching around £1 billion total in 2005/06. Moreover the current overall financial surplus masks real difficulties in some areas of the country.

In many cases this has resulted in major reconfigurations of health services being presented for consultation and approval. Hospital beds are seen to be the most expensive element of healthcare and if these can be reduced and rationalised onto fewer sites then there would seem to be a major financial advantage.

Despite attempts by the current Chief Executive of the NHS, David Nicholson, to distance the financial backdrop from the reconfiguration issue it remains the case that this has been a major driver nationally and locally for reconfiguration.

The House of Commons Health Committee in its report, *NHS Deficits* (House of Commons Health Committee, 2006), highlighted the role of poor central and local management as causes of the deficits,

Poor central management has contributed to the deficits. The Government's estimates of the cost of Agenda for Change and the new GP and consultant contracts proved to be hopelessly unrealistic. Government targets, such as the 4-hour A&E target, have been expensive to meet and have had unintended consequences which have imposed additional costs.

Poor local management is also to blame. For all the added costs imposed by the Department of Health, it is undeniable that the NHS has had a lot more money to spend. Surpluses can be found in PCTs and trusts with a low per capita funding. Deficits exist in trusts with a high per capita funding. We had a good deal of evidence of poor financial management; for example of a hospital trust which hired staff without knowing whether it could afford to pay their salaries, and of PCTs which failed to recruit vital members of the financial management team. Nevertheless, poor financial management is not just

caused by local managers and boards. The Government has also contributed, for example by repeated changes and the emphasis on meeting targets at short notice.

There was no suggestion that the deficits were due to the current configuration of services, yet there seems to have been undue urgency to reconfigure services as a result of financial pressures.

In these circumstances there is an even greater need to ensure proper public scrutiny of NHS proposals that may result in at best the waste of considerable public resources and at worst the removal of essential health services for local communities with little or no substitution of accessible services to take their place. In the next section we discuss some of the issues around the national reconfiguration of services.

4. The national debate on reconfiguration

The NHS Chief Executive, David Nicholson, identified in September 2006 up to 60 reconfigurations of NHS services affecting every SHA in the land. He said that although some changes will try to squeeze out the overcapacity that contributed to the NHS's deficit in the last financial year, most will be aimed at redesigning the NHS to improve care by concentrating key services in fewer hospitals.

He identified A&E departments, paediatrics and maternity services as areas where provision would have to be overhauled (see John Carvel in the Guardian, *Plan for wave of closures of NHS Services*, 13 September 2006). Such an overhaul was supported in the Institute of Public Policy Research report of January 2007, *The Future Hospital: The Progressive Case for Change* (Farrington-Douglas and Brooks, 2007).

In a response to this report, Byrne and Ruane identified that the best way to reconcile the interests of emergency and non-emergency patients is the rapid triage of the relatively few patients who require tertiary care (specialist care) (Byrne and Ruane, 2007). They argued,

This would be achieved through training ambulance paramedics to recognise them and take affected patients to the appropriate regional centre which will have a clinical network of cardiologists, neurologists, vascular surgeons and other

specialists plus the appropriate support resources. This means that the District General Hospital can have the best of both worlds by treating the majority of patients near its catchment area and ensuring the minority who require the services of more specialised facilities access these in time.

Byrne and Ruane summed up as follows,

Regional Specialist Centres are certainly required for the relatively few people who need very rapid emergency care. District General Hospitals are the best means of dealing with the great majority of cases...In relation to training, these are easily managed by rotation of doctors in training through specialist and general units in a planned way. A lot of the staffing problems are asserted to derive from the impact of the European Working Time Directive (EWTD) on the availability of both junior doctors and consultants given the shorter working times required under that legislation. However, appropriate rotas for smaller hospitals, increased medical staffing of small to medium sized hospitals or shared rotas among hospitals should address this, along with an examination of roles which can be transferred to other clinical personnel.

The European Working Time Directive (EWTD) was announced in 1998 and was one of the reasons why the NHS required additional funding. However bearing in mind that the UK continues to have relatively few doctors per head of population compared to other developed countries, there is no imperative to rationalise clinical services beyond those specialist services where a conclusive link between volumes and outcomes has been established (perhaps cancer services, paediatric surgery, neurosurgery and a set of relatively rare but life-threatening conditions). To do so would result in reduced access to services, and also reduced choice and competition when current government policy is to encourage these.

In the next section we consider the general criteria that should be used in considering the way in which health services are organised.

5. The criteria for determining the configuration of services

There is no simple answer to the question of what criteria should be used to evaluate a range of options for the reconfiguration of

health services. Practice varies from region to region in England. But perhaps the key characteristic should be that the criteria are seen to be fair by the stakeholders involved.

In considering the suitability of any options put forward for change in the way NHS services are provided, we suggest that the likely impact of each option on the following key factors should be considered:

1. accessibility for the public, including issues around equity of provision;
2. clinical considerations – clinical quality and safety;
3. financial considerations –affordability and efficiency of the system; and,
4. deliverability.

These are in fact the criteria most frequently used in such decisions; the last, deliverability, is a kind of technical criterion, ensuring that what is proposed is possible within existing real resource constraints. Key issues to consider when setting criteria are:

- do they concur with common practice?
- is there clarity and measurability of criteria? and,
- are they acceptable to local stakeholders?

We would argue that these criteria meet these considerations. However the key issue is how they are implemented: the answer is ‘not very well’ in most consultations we have observed.

Accessibility

Perhaps the key consideration for the local population is the impact that changes to the configuration of hospital provision will have on their ability to access services. Most often this will be assessed in terms of the impact on travel times for patients and for relatives. Thus travel times should be a key factor for the determination of where a hospital should be sited.

Although accessibility is often one of the public’s main concerns, it is also an issue that concerns staff and it will impact on staff recruitment and retention. Often consultations take little account of the transport needs of staff, who may be required to work unsocial hours, particularly when the reduced availability of public

transport at night is considered. Adequate car parking provision is also therefore an important consideration.

Travel times should be considered for a whole range of services from A&E to emergency surgery, maternity services and elective care. Clearly there will be different considerations depending on which services are reviewed. Although a key issue is the safety of patients in need of care, accessibility in terms of convenience of provision must also be a consideration. Often there will be a trade-off between accessibility, cost, and clinical quality.

It is also important that any analysis of accessibility considers the impact of site location on those using public transport and on the most disadvantaged groups in the population. The Government is clear that there should be particular attention paid to the impact of reconfiguration of services on disadvantaged groups. The Treasury's Green Book (HM Treasury, 2003) which provides guidance for capital projects has a section on distributional impacts. This states '*At a minimum appraisers [should] identify how the costs and benefits accrue to different groups in society*' and goes on to argue that '*a rigorous analysis of how the costs and benefits of a proposal are spread across different socio-economic groups is recommended* (page 42).

The Department of Health, in its response to the distributional aspects raised in the Green Book, summarised the requirements as follows (Department of Health, 2004a),

For NHS and DH business cases, on distributional effects, the Green Book requires that:

- *Cases identify how the costs and benefits of a proposal accrue to different groups in society. They should be explicitly stated and quantified as far as possible;*
- *Differences in the distributional effects between options for a project should be clearly stated, or where appropriate, it is explained in the case how the options have exactly the same distributional effects;*
- *Where the distributional effects between options differ significantly, either the costs and benefits by income group should be quantified and scaling factors by income group applied, or where this is not feasible or practical, distributional effects should be included as one of the criteria in the standard benefits weighting and scoring methodology;*

- *Cases state why quantification in monetary terms of benefits and costs by income group, and adjusting these by scaling factors, has not been undertaken (where it has not). Reasons may include the difficulties of putting monetary values on benefits, and the necessary income or socio-economic information not being available at an acceptable cost given the importance of the proposal, and the likely scale of the impact of the distributional analysis to the proposal under consideration.*

It has been argued that the distance that people have to travel to a facility is a barrier to access (Haynes *et al.*, 1999). Moreover a recent study by Jon Nicholls (Nicholls *et al.*, 2007) has shown a clear positive correlation between distance travelled by ambulance for certain conditions and mortality. The importance of the issues highlighted by the Department of Health and the Treasury are confirmed by a review of the literature, *Is the NHS equitable? A Review of the Evidence* (Dixon *et al.*, 2003). In this, Dixon and her colleagues have found strong evidence that lower socio-economic groups use services less in relation to need than higher ones, and they observe,

The reasons for this inequity include lack of suitable transport and restrictions on available time, limiting access to services.

Although in many consultations some measures of access have been used in assessing changes in service provision, too often they have appeared as secondary considerations to those reflecting clinical or financial issues, even to the extent that at the stage where decisions on which options should be presented for consultation, accessibility is not included as a criterion. Moreover although the Treasury and the Department of Health have both stated quite clearly a requirement to consider the equity issues and particularly the impact on disadvantaged groups when consulting on changes in service provision, in our experience this has rarely been done properly.

Clinical considerations

A second key consideration in determining what changes there should be to the configuration of hospital provision is the impact such changes will have on the quality of provision, and in particular clinical outcomes. Often this is the factor that the NHS focuses its attention on.

There are two elements to this consideration.

- First there is some evidence – though limited – that increased specialisation in the provision of services leads to better outcomes for patients, and this tends to be an argument in favour of reducing the number of hospital sites providing the same service. This may be particularly true of planned services where delay in getting to a hospital is unlikely to have any detrimental effect on the outcome for the patient. It is more problematic in situations where a patient is in urgent need of care – sometimes in life-threatening situations – where delays in getting to hospital may be the main determinant of the outcome.
- Second it may not be physically possible to offer a full range of services on a large number of sites due to shortages of clinicians, nurses or other specialist staff, or of expensive equipment. Being able to staff facilities is an issue that has been brought to the fore with the introduction and gradual implementation of the European Working Time Directive (EWTD) which restricts the number of hours that clinical staff can work, and hence increases the numbers required. However, in our view this usually comes down to a matter of cost, as equipment and human resources can often be made available if required but perhaps at a cost that the health economy is unwilling or unable – due to political constraints – to bear.

The Government has published a number of reports almost invariably authored by a clinician (Boyle 2006, Alberti 2006, Philp 2007, Colin-Thome 2007, Shribman 2007a, 2007b, Darzi 2007a, Richards 2007) on a range of service areas including emergency care, maternity and paediatric care, cancer and heart services, and surgical services. These have all tended to focus on the clinical argument for rationalisation of service provision to fewer hospital sites. However having examined much of the evidence we believe that for most services there is not a prima facie clinical argument for the reduction of the number of hospital sites offering a range of services and specialties, although we accept there may well be additional costs involved in continuing with current levels of access.

Perhaps the most definitive recent report on this matter, and one that is independent of Government, was that of a working party of

the Academy of Medical Royal Colleges in September 2007 (Academy of Royal Medical Colleges, 2007). This report found,

There is a lack of evidence of outcome for the large majority of patients using acute health care services, but there is evidence that the best possible care is not provided at present for some conditions.

The report went on to say,

Plans to redesign services which involve moving services from one site must be evidence based and not be fully implemented until replacement services are established and their safety audited.

There may well be extra resources and hence costs involved in retaining current patterns of service provision, but these costs should be spelt out rather than simply assuming existing patterns are not sustainable. It is similarly true that the costs of changing how services are provided should also be made clear.

Much of the argument has centred on the EWTD which has been cited in several consultations as a key issue relating to the sustainability of services across several sites and has been influential in determining views taken on clinical sustainability of service provision. Guidance issued by the Department of Health in January 2003 (Department of Health, 2003b) on implementing the EWTD offered several ways forward that allow less centralised, more local solutions.

These included:

1. reduction in the number of rotas – there was seen to be a need for fewer but more intensive resident rotas, which could be achieved by cross-cover and fewer tiers of cover;
2. new working patterns for consultants and specialist registrars;
3. expansion of staff numbers;
4. different forms of team working; and
5. new service models.

A Compendium of Solutions to implementing the Working Time Directive for Doctors in Training was published by the Department of Health in May 2004 (Department of Health, 2004b). This gave more detailed advice on measures available to cope with EWTD beyond centralisation of services. These included: hospital-at-night; rota

redesign; more effective use of doctors in training, consultants and other staff; and creating networks of care.

In our view too often the clinical argument is presented with an unwarranted level of certainty, and seems to be given precedence over all other considerations. The reality is that the clinical grounds for rationalisation are balanced by clinical risks and costs associated with the changes; often other options involving modest additional investment and changes to working practices may represent a better choice for the local population.

Financial considerations

Financial affordability needs to be considered in the short, medium and long term; often in NHS consultations it is very much a short-term consideration. The question usually addressed is whether a particular option for configuration of services results in a solution that is affordable for the health economy as a whole over perhaps a 3 – 5 year period. However consideration also must be given to efficiency issues around the various options. These would come out of an economic appraisal. An option might be financially affordable but not efficient; likewise an efficient solution may not always be affordable.

So efficiency is a key consideration when looking at the long-term sustainability of a particular solution, particularly in the more competitive market environment that has been encouraged within the NHS.

Similarly there must also be consideration of system-wide sustainability, ie. the impact of particular options on the whole health economy, including, for example, the pattern of services and finances of social service provision. Equally there should be some consideration of the impact on service providers outside of the immediate health economy, who also may provide key services to some local residents of the health economy concerned.

There should also be consideration as to whether the options proposed represent value for money. Although affordability is a major consideration, a full business case would present economic analysis that identified whether the benefits of the proposed investments were positive and would help in ranking the options being considered.

An analysis of value for money would take into account all the costs (and benefits) to the health economy, including costs to ambulance, social services and the voluntary sector. It should also take into account the adverse economic impact on the population in terms of additional travel times and care available for patients, as outlined in *The Green Book: Appraisal and Evaluation in Central Government Treasury Guidance* (HM Treasury, 2003).

In many NHS consultations, the financial case for reconfiguration is often weak, and may rest on highly debatable assumptions: for example that large investment is required in centralised facilities or that very large financial savings are achievable from reducing patient activity, largely in non-elective services. A proper consultation must always include business cases supporting the key assumptions, and an economic analysis should be presented. However in our experience large categories of costs associated with developing alternative community services are often omitted; externalities are not fully considered; financial savings plans justifying large and risky capital developments are weakly substantiated; and the commercial risks associated with investing large sums in relatively inflexible PFI-financed new central facilities are not mentioned, let alone analysed in any depth.

Deliverability

Deliverability is often defined in consultations quite narrowly, for example in terms of the possibility of capital funding. Evidence of deliverability is very important in any business case supporting change. For example in business cases to support significant capital investment, plans should provide a range of information including: milestones for the project, including any procurement and bidding timescales, with justification; arrangements for staff and clinician consultation and input to design stages; clearly set out details to show resources to manage the process to project commencement; evidence that an internal risk register is established, risks assessed and management arrangements reviewed and regularly updated; and an outline benefits-realisation plan, covering all benefits – strategic, savings or efficiencies.

In the absence of the business plan and the supporting information it becomes difficult to comment on the deliverability of different options. Too often local populations have faced consultations where

the eventual outcome is not the option chosen because this turns out to be undeliverable within the current timescales and circumstances.

Decisions on reconfigurations are finely balanced. Complex decisions of this nature should only be made after a careful consideration of all the facts and issues in a fully worked-out and robust business case where a range of options are considered. We regard as premature and alarmist the policy in many areas to go to early formal consultation. The process is managed better by use of informal consultation with overview and scrutiny committees at an early stage and then formal consultation once a business case and 'full' options appraisal is available. This ensures that there is a readable, digestible and firm basis to decide between options. The result otherwise is too many unanswered questions to enable local people to make a considered judgement. In these circumstances it is not surprising that the local population respond defensively.

Finally on the question of whether the resources will be available to deliver any plan there must be confirmation that there is a robust business plan which will secure the finances from public funds or through the PFI route within the timetable assumed. Delays in this can lead to further bouts of financial crisis as the very ambitious targets to stem demand for healthcare prove difficult to achieve. There are several examples in England of approvals from local consultations to ambitious plans which have not been realised because of the difficulties of securing funds. This can blight other developments for a considerable time.

6. Concluding remarks

Major changes have been introduced to the NHS over the last few years designed to provide more patient choice, competition and contestability, and an expanded role for the independent sector. Financing of health services is increasingly to be distributed according to Payment by Results (a system of national tariffs) with PCTs concentrating on commissioning services and ensuring demand for services is managed appropriately. Providers are increasingly semi-autonomous, free to develop according to decisions made at a local level. In these circumstances caution is advised in committing strongly to major centrally-planned changes

in service provision when the direction of travel of the NHS remains uncertain.

Decisions on the configuration of services most suitable to local needs and preferences are often finely balanced. In asking the public to support a particular solution or set of solutions, proper consideration should be given to what the population feels is important. Often there may be a fine balance between access, cost and clinical quality or safety, but choices are rarely presented to the public in this way. Instead, in our experience, consultations are largely public relations exercises: the choice is often almost pre-determined; uncertainty is presented as fact; and there is a dearth of evidence made available which local people can consider in expressing their views. It is not surprising that the public often feel that NHS consultation is a sham.

Nature of public consultation

It remains controversial as to whether public consultation can play a constructive part in decisions on reconfiguring clinical services. Some politicians, managers and clinicians would argue – at least privately – the issues are complex and ill-suited to the public forum where local vested interests always dominate if care is not taken. However given that services are funded by the tax payer, that there is little alternative voice allowed for consumers in the NHS and that there is a risk of provider capture (where the service is run for the benefit of those working in it) we argue strongly that there is a good case for public consultation around major service change.

But if there is consultation it should not be pseudo-consultation with no proper regard for evidence or justification; or a full evaluation of the options. The public are right to react against spin and should be treated like adults – able to balance clinical and financial arguments, and able to say no.

The importance of due process and the cost of ignoring it

There have been numerous examples of poor planning in the NHS and other parts of the public sector where the risks of underestimating the costs of change have been ignored and undue priority given to (prime) ministerial whim or ill-informed and self-serving advisers. Much attention has been given to the NHS IT project which is several years late and will cost far more than stated. Even now no one knows what it will deliver.

There is a danger that a culture of top-down dictation percolates to other levels of the NHS and the public sector. Closing local A&E departments may not seem a big issue to NHS managers under extreme pressure but for people without ready access to private transport or without a good local GP service (which often does not exist in poorer areas) the local A&E is often a lifeline. Decisions on the future of these services and other key local services eg maternity services should be carefully evaluated in a proper options appraisal and all the evidence justifying change well presented together with the business case showing how change has been costed, afforded and can be delivered.

Without this, local populations and their representatives are fully entitled to resist and obstruct change. And without this, NHS management will lose respect and independence.

Independent assessment

In our role as advisers on healthcare issues it is clear that it is very difficult for local managers and staff to stand out against the prevailing winds of change blowing through the NHS. Managers appear under extreme pressure to deliver short-term objectives without there being a clear long-term strategy. This leads to short-termism, opportunism, and cynicism.

The NHS must recover more scope for independent management, respect for due process and respect for the local population – or their customers, in new NHS-speak. And there have to be independent checks and balances to ensure this occurs. This means a role for local government and community scrutiny and representation; a role for independent advisers with access to information; respect for compliance with guidance; and independent audit and the real fear of penalty if in breach.

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