

The Future Hospital

The politics of change

Joe Farrington-Douglas with Richard Brooks

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List of abbreviations

A&E	Accident and Emergency
EWTD	European Working Time Directive
IRP	Independent Reconfiguration Panel
LINKs	Local Improvement Networks
OSC	Overview and Scrutiny Committee
PCT	Primary Care Trust
PFI	Private Finance Initiative
PPIF	Patient and Public Involvement Forum
SHA	Strategic Health Authority
VCS	Voluntary and Community Sector

Executive summary

Background

Health care needs to adapt as health needs change and as the technologies and techniques of delivering modern care develop. As our previous report *The Future Hospital: The progressive case for change* (Farrington-Douglas with Brooks 2007) explained, the model of health care provision needs to change, with wide-ranging effects on the location and functions of district hospitals. We argued that changes to health services should be driven by progressive objectives. In particular, changes should aim to:

- Improve safety
- Improve access
- Increase efficiency
- Prevent ill health
- Raise responsiveness
- Reduce inequity and inequalities

However, the progressive changes that ippr advocates are hampered by a damaging and dysfunctional politics associated with changes to hospitals. At present, we are not achieving the best outcomes from our health system, nor are we achieving public engagement and confidence in the NHS. The public do not trust the process of hospital change.

The Future Hospital project at ippr aims to develop a new process and politics of change through which changes to the health system provide safe, equitable, efficient and accessible care, while engaging the public and maintaining confidence in the NHS.

Methodology

The focus of this report is on the politics and process of hospital change at a local level. This is based on a year-long project that began with desk-based research, a research seminar and meetings with stakeholders and experts. A theoretical framework was developed to explore the local politics of hospital change, generating a series of hypotheses about the preferences of different stakeholders. These hypotheses were then tested and explored in two case studies of recent hospital reconfigurations, where 28 local stakeholders were interviewed. These included: managers and clinicians working in the hospitals, Primary Care Trusts and Strategic Health Authorities involved in change; local patients; public groups including hospital campaigners; and local politicians, including councillors and MPs.

The findings and recommendations are based on a combination of case studies, desk-based research, meetings and theoretical work.

Ten key findings

Further details about the results for each group of stakeholders are set out in Section 2 of this report. This summary outlines ten key findings from the research of most relevance to policy.

1. Reconfiguration was aiming to redesign services, rather than just cutting or centralising hospital departments.

Managers and senior clinicians interviewed explained that reconfiguration was driven primarily by clinical concerns. Reconfigurations involved some centralisation but also aimed to extend the provision of traditionally hospital-based services in the community. There was therefore a two-way process of centralising some services and devolving others. In neither case study were district general hospitals threatened with closure, with many services continuing to be provided in existing locations or closer to home.

2. Engagement and settlement on the principles of change is possible, but is undermined by the perception of financial cuts.

Although there was significant opposition to changes in the location of services in both case studies, interviews suggested that there was scope for agreement between local stakeholders on the principles of

change. The new model of care aimed to satisfy a range of objectives, including access and safety. Evidence from these case studies suggests that when stakeholders engage with each other then they can move towards a settlement that satisfies a range of interests.

However widespread, reporting of financial difficulties, both nationally and locally, undermined the capacity to engage in change. The perception that changes were driven only by financial concerns led potentially sympathetic stakeholders to distrust the process of change and provided an opportunity for opponents to question the motives of change.

3. There was debate about the interpretation of objectives, including a ‘conspiracy of safety’.

While there was some agreement on the principles of change, there was disagreement about what those principles meant. Clinicians and managers used technical measures of access and safety whereas local patients, public and politicians used these concepts more informally.

In particular, there was a lack of public understanding of technical patient safety arguments. While the public and patients were concerned about travel times to A&E (accident and emergency), they were not informed of the quality of service currently provided there. Managers and clinicians failed to publicise the risks to patients of being treated in existing hospitals where the staffing and patient volumes were not reaching safe levels.

4. While there was good involvement of senior clinicians in developing and leading change, there was less effort to engage with politicians and frontline staff.

Much effort had been made by health trusts locally to engage the local population, with varying success. Senior clinicians often led the public debate. However, engagement of local councillors and MPs was not so good; they were not kept informed of local developments. Non-management frontline staff, unlike senior clinicians, often opposed changes affecting their hospital.

5. Strong opposition came from ‘HIMBYs’ opposing the ‘tough choice’ of hospital, but the engagement and consultation process had concentrated on the principles of change.

While patients, public and politicians often agreed with the need to change services, they opposed changes to their own local hospital. This is similar to the ‘Not in my back yard’ (NIMBY) position held by local populations opposing the location of necessary but unpopular public facilities, such as wind farms or social housing. We call this position ‘Hospital in my back yard’ – HIMBY, and hence HIMBYism.

HIMBYism is partly the product of the way local consultations were constructed. The emphasis of the local consultation was on the principles of change, with less emphasis on which potential hospital site should be chosen for locating particular services.

6. The consultation and site choice process was perceived as procedurally unfair and there was a ‘paradox of consultation’.

The process of deciding the new configuration of hospital services was not very transparent, leading to widespread distrust by local stakeholders in the fairness of the outcome.

There was a ‘paradox of consultation.’ Local stakeholders expected to influence the outcome of consultations. Several options, including ‘doing nothing’, were presented for public feedback. Yet in practice change was unavoidable, even if it was unpopular with consultees. This led to a perception that consultation was a ‘sham’.

7. Local authority overview and scrutiny committees were engaged in the principles of change, but not in the choice of site.

Local councillors who scrutinised the consultation process as part of joint overview and scrutiny committees were successfully engaged in the case for change. However, they avoided making potentially controversial recommendations about the choice of site. One local authority reneged on the joint committee’s approval of reconfiguration and referred the hospital site decision to the Secretary of State for Health.

8. MPs were in a difficult position, often accepting the principles of change privately but opposing change locally.

MPs were the most inconsistent interviewees. They often understood the provision of local health services and the need for change but faced electoral pressure to ‘defend’ local hospitals. Again, the financial

problems faced by the NHS made it harder for them to lead the debate rather than follow public opinion. Where MPs opposed the proposed changes to hospital provision, they were able to undermine the process of change by claiming it was driven by cuts rather than the goal of service improvement.

9. Local politicians had a political opportunity, ambiguous power and no responsibility.

Politicians were in an unclear position in the process. They had an opportunity to make local political capital out of difficult decisions, by defending current configurations. Councillors were only able to influence decisions through scrutiny, and MPs had an unclear role in the process, depending on whether they were in a good position to lobby the Secretary of State. But no local politicians had any responsibility or accountability for delivering services as a result of the reconfiguration process.

10. There was an accountability gap at a local level, with centralised decision-making and regulation.

Although local consultation and scrutiny processes were in place, they were undermined by the fact that the only official recourse for local populations was to refer decisions upwards to the Secretary of the State, who would then make a final decision. The external regulation provided by the Independent Reconfiguration Panel was hampered by the Secretary of State's veto on referrals and the fact that it reported to her. Local stakeholders did not feel that the local or national decision-making process was transparent or procedurally fair, and distrusted the process and consequently rejected its outcome.

Policy implications

The issues identified in the research summarised above require a range of actions by the NHS, local and central government in order to improve the process and politics of hospital change. These are set out in detail in section 3.

National hospital change strategy

While it is right that the process and decisions on hospital change are devolved to the local NHS and communities, there is a need for a national strategy for reconfiguration. The current approach of central government is to incentivise change locally through financial incentives which in fact often present themselves as deficits in the budgets. This fails on technical (or strategic) and political (or tactical) counts. Deficits in themselves do not necessarily indicate a need for hospital reconfiguration and the publicity about financial deficits undermines a more progressive case for change.

A national strategy should set out the progressive case for hospital change, based on values and evidence. It should also answer the criticisms and concerns that stakeholders have expressed. The process of consulting on a national strategy would be an opportunity to engage stakeholders, in particular working in partnership with professional organisations to establish the clinical case for change. The national strategy could set minimum standards or parameters for hospital configuration. This could include good practice guidance on the throughput of patients needed for the safe delivery of particular specialities. It should also allow for and encourage more innovative solutions for local service configuration.

Communication, engagement and consultation

The 'black box' of hospital safety needs to be opened in order to allow local stakeholders to judge the performance of existing hospitals. This would also have wider benefits for encouraging improvements in safety and quality, and informing patient choice.

Politicians and frontline staff need to be better involved in discussions about hospital change. Not only is it important that the concerns of frontline staff are addressed in order to help bring about the changes, but they are also influential communicators in the local community.

The consultation process needs to be based on three stages. The engagement phase is important to improve information and understanding, as well as to develop options in deliberation with the public. The consultation phase should provide a formal process to gather preferences for the decision-making criteria to decide between a limited range of feasible options. The third stage is the fair and transparent appraisal of options based on the decision criteria. This process needs to be made procedurally fair, so that the outcome of the decision is more acceptable and less open to criticism.

The current regulations for consultation may need to be reviewed in order to implement this change of approach.

Regulation and accountability

The local processes, and the bodies responsible for local decision-making, lack the necessary transparency and accountability to make them trustworthy in the perceptions of local stakeholders. The fact that the only recourse for local communities, via local authority scrutiny, is to refer a decision upwards to the Secretary of State undermines the credibility and the perceived fairness of local decisions.

Similarly, the involvement of the Secretary of State in the decision to invite the Independent Reconfiguration Panel to review a local decision, and the fact that the panel reports to her, also undermine the independence of the regulatory function.

While reducing the role of the Secretary of State in local decisions will not 'depoliticise' hospital change, it would give the local process more credibility and trust. Therefore the ministerial veto on referrals by local communities to the Independent Reconfiguration Panel (or equivalent advisory body) should be removed. This would improve perceived fairness of the procedure for consultation and decision-making.

In return for giving local authority scrutiny committees increased power to call in the regulator, they should have to ensure that they do not simply pursue a HIMBY position on difficult site choices. Local authorities scrutinising hospital change proposals that affect a wider area would delegate their referral powers to a joint scrutiny committee, pooled with representatives of other areas.

We do not recommend that local authorities have the final say on reconfiguration proposals. The NHS needs to be able to make decisions based on clinical factors and effective stewardship of resources. Our proposals would make the local NHS more locally accountable through stronger local scrutiny and regulation.

Conclusion

ippr has made the progressive case for hospital change. The process and politics of reconfiguration, however, are currently dysfunctional.

This report sets out the steps towards a more functional process and politics of hospital change. Local changes associated with financial deficits can be divisive and may not achieve the best outcomes. A hospital change strategy developed in partnership with clinical organisations would develop a consensus on the principles and parameters of change. Greater transparency about safety in hospitals and a fairer process of weighing up options would improve engagement and real consultation on feasible alternatives. Greater local accountability, rather than centralised decision-making, would improve trust in the process and reduce the opportunity for political points-scoring.

Hospital change will remain controversial and requires healthy, well-informed debate. Improving the process and politics of change should ensure that local health services can achieve better outcomes and efficiency, improved services for patients and public engagement and confidence in the NHS.

Introduction

As technology and health needs change, health care needs to adapt. In particular, the traditional district general hospital model that characterises much acute care in the UK needs to change to improve safety and access. Some acute services requiring high-tech equipment and specialist teams need to be concentrated in fewer centres in order to improve outcomes for patients. Other traditionally hospital-based services could be provided more locally by suitably skilled professionals in community hospitals, GP surgeries or at home.

The Institute for Public Policy Research's (ippr) first report for this project, *The future hospital: The progressive case for change* (Farrington-Douglas with Brooks 2007), summarised these pressures and the six positive reasons for changing hospitals:

The progressive reasons for hospital change

- Improving safety
- Improving access
- Increasing efficiency
- Preventing ill health
- Raising responsiveness
- Reducing inequity and inequalities

Hospitals are expected to serve a range of functions in public policy. These can be:

- clinical – concentrating specialist health needs to enable the performance of high-tech surgery and the advancement of skills and research
- economic – providing employment and achieving economies of scale
- social – providing accessible health care and other community services
- cultural – generating civic pride and symbolising a strong welfare state.

(Healy and McKee 2002)

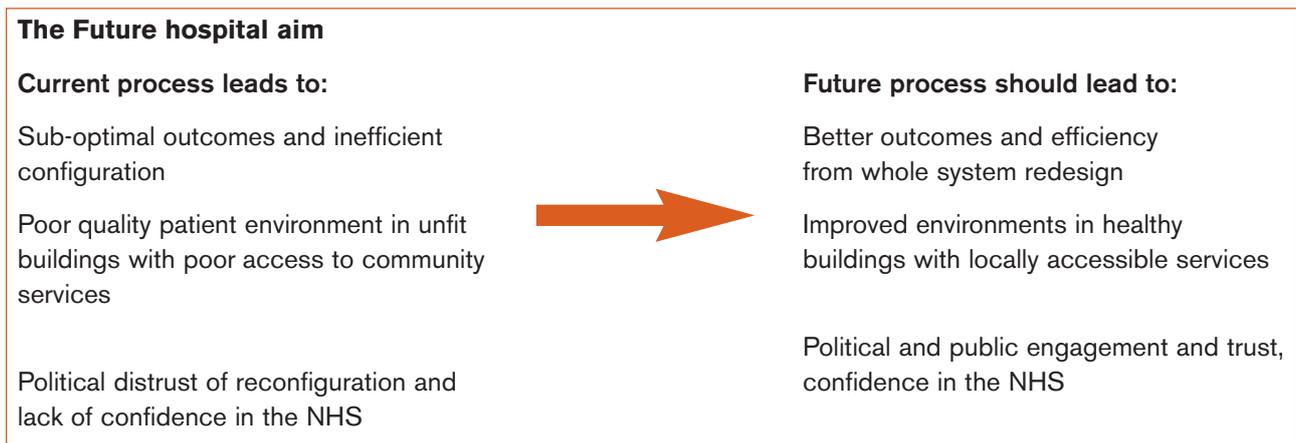
Social policy analysts and policymakers, managers, health care professionals, patients, voters and politicians may place different emphases on these different goals. Our previous paper emphasised the public value of hospitals as places that provide a feeling of security and trust, as well as services and improved health outcomes. Therefore decision-making about hospital change is not just a technical process. In collectivised health systems like the NHS, 'reconfiguration politics is a fully political process, and understanding it requires a political account of the structure of local conflicts over what hospitals are and are for' (6 *et al* 2005).

The political difficulties of hospital reconfiguration have attracted the attention of policymakers. New structures for consultation and decision-making have been introduced to make reconfiguration more acceptable to the public, aiming to 'help the NHS to work in a new stronger partnership with the public and staff to find high-quality, sustainable solutions for local services' (Department of Health (DH), 2003: 3) and emphasising stronger roles for smaller hospitals, in recognition of the fact that they are popular.

The continuing political conflicts undermine the achievement of health and social policy goals. Partly due to reluctance by local managers and politicians to engage in controversial reconfiguration until recently, the need for reconfiguration remains strong. The National Leadership Network warned in strong terms that delay in tackling local reconfiguration would lead to 'service failure' (National Leadership Network 2006: 18). As our previous paper explained, not reconfiguring hospitals costs lives, as patients miss out on treatment in well-staffed specialist centres. Financial deficits are blamed in part on unsustainable configurations of services, for example in Surrey and Sussex, and in Hertfordshire and Bedfordshire (Moore 2006). Meanwhile, hospital reconfigurations remain politically controversial, with 'save our hospital' candidates continuing to win seats in local elections (*Health Service Journal* 2006).

The need to change hospitals is real, but at present the process and politics of reconfiguration are dysfunctional. Failure to evolve the way health care is delivered would lead to worse outcomes. In short, preserving hospitals in their current configuration would mean more people living in pain or dying unnecessarily with unsafe care. Resources wasted on unsustainable services would be better spent on improving health and wellbeing.

However, at present the barriers to hospital change mean that we are not achieving the outcomes we should be from the health system. Neither are politicians, public, patients or professionals well engaged in change. Public confidence in the NHS is declining (although statistics on patient satisfaction, access and outcomes are improving). This project therefore aims to explore how these negative outcomes and distrust could be transformed into better health services and public confidence.



The previous paper provided the theoretical framework for the project, exploring what hospitals are for and setting out the arguments for reconfiguring health care systems. This paper looks in more detail at the process and politics of reconfiguration. At present, these are characterised by conflict and polarisation of positions. This makes hospital change less likely to achieve good outcomes, and undermines the political sustainability of the whole health system. But the overall aims of hospital change, as set out in our previous paper, should not be unacceptable to any party if there is genuine discussion and willingness to understand. This paper aims to get behind the conflicts and understand the viewpoints of the different stakeholders, to identify the points of conflict and to allow the development of a more constructive process and politics of hospital change.

Section 1 summarises previous research and sets out a framework for analysing hospital politics. Using new data from interviews with people involved in recent reconfigurations, section 2 analyses the different roles and preferences of stakeholders in hospital reconfiguration. Section 3 draws on these case studies, backed up by wider policy research and theory to explore how the politics and process of hospital change could be improved to achieve the transformation to improved outcomes, services and trust.

1. Previous research and theoretical framework

Through two case studies of recent reconfigurations this section explores the roles and preferences of different stakeholders in local hospital change politics. Twenty-eight stakeholders were interviewed in the summer of 2006 to discuss their views and opinions of actual hospital reconfigurations in their area. The aim was to compare their viewpoints and to identify potential improvements to the reconfiguration and consultation process.

Hospital reconfiguration politics: previous research

Academic debate about hospital configuration is dominated by technical research and analysis, whereas less attention has been paid to the actual dynamics of local decision-making (6 *et al*, 2005).

However, there have been some studies in this area. The case that has attracted most attention is the reconfiguration in Kidderminster where an independent anti-reconfiguration candidate defeated a Labour minister in the 2001 general election. The Kidderminster case attracted national and specialist media attention (Lock 2001, BBC 2001) as well as academic research.

An independent evaluation of the impact of reconfiguration was commissioned from a university research centre by CHART, an organisation linked to the Health Concern campaign. The study's main focus was on the health care and health impact of the reconfiguration, concluding that, 'overall the reconfiguration had relatively little impact on the level of use of NHS acute hospital facilities by local populations' (Raftery and Harris 2005: 85). The study also commented on the process of consultation and the politics of the decision-making process, concluding that the consultation process was 'universally considered to have been poor' and that campaign groups 'lost trust in Worcestershire Health Authority at an early stage' (ibid: 86, 90). The poor leadership of the NHS was contrasted with that of the campaigners; the socio-cultural factors of Kidderminster's local history and socially cohesive population, it was suggested, created ideal circumstances for strong campaigning (ibid).

Another examination of the Kidderminster example emphasised the symbolic power of hospitals – 'the sense of ownership that surrounds these facilities is bound up with ideas about local identity and "sense of place"' (Brown 2003: 490). Brown contrasts these with the emphasis on economic and clinical factors summarised by Edwards and McKee (2002). Brown notes the rhetoric of localism and community participation in NHS policy through different governments since the 1980s, in contrast to the centralisation of governmental control over the NHS in that period. He sets local configuration disputes in this context: communities' attempts to influence NHS decisions are frustrated by a centrally controlled structure over which they have little power, save by the ballot box in a general election.

Brown also highlights the importance of socio-cultural factors in Kidderminster creating fertile ground for popular protest, with a settled, affluent population with a strong local identity. In conclusion, therefore, 'it was apparent that the hospital was of vital importance to the community... it was equally clear that the campaign sought to counter the lack of political voice given to people within the NHS' (Brown 2003: 503).

Another study of hospital reconfiguration politics was conducted in Leicester, primarily as a study into new forms of citizenship involvement in decision-making, significantly citizens' juries. The case study has particular salience as it was cited by the current Secretary of State for Health as an example of good practice in involving the public and overcoming Kidderminster-like problems in her own constituency (Hewitt 2005). In the study of Leicester, Parkinson (2004) focuses on the representation claims of different groups, finding not only that decisions about and by the NHS suffer from being perceived as less than legitimate because administrators lack a local democratic mandate, but also that campaigners' claims to represent local feeling are questionable. Parkinson's critique concludes that the citizens' jury method cannot neutralise the local battle for legitimacy in hospital reconfiguration decisions (ibid).

6 *et al* (2005) draw on these studies in developing their framework for analysing the positions of stakeholders in reconfiguration politics. No studies were identified that conducted primary research at more than one site. Our study adds to the literature by using in-depth interviews with stakeholders in reconfiguration debates to test the framework developed from existing research.

Case studies

Two cases of recent reconfigurations were studied to provide real examples of local hospital change politics.

Our case studies aimed to investigate the roles of stakeholders in reconfiguration debates, in particular comparing them to a set of ideal typical public interest claims. They explored the reasons and values behind their attitudes to hospital change and how their position may have moved during the process. It was asked whether the process led towards a general consensus, or if positions polarised during the debate.

Beyond these formal questions, the study aimed to explore the politics and process of hospital change more generally, and the perceptions of different stakeholders of the problems and solutions.

In order to identify whom to interview and to provide a system for analysing their perspectives, we adapted a framework of four types of public interest claims developed by 6 *et al* (2005).

Public interest claim types ¹		
	Informal/popular goals	Technical/expert goals
Less institutionalised imperative	<u>CONSUMER public interest type</u> Prioritises ease of access, cheap access for relatives, convenience in moving along pathways of care	<u>PATIENT public interest type</u> Prioritises absolute and relative health gains, health melioration, improved treatment outcomes, survival rates, hygiene
↓		
More institutionalised imperative	<u>VOTER public interest type</u> Prioritises community base, loyalty to an institution, civic pride, preservation of status quo, local political accountability	<u>TAXPAYER public interest type</u> Prioritises cost effectiveness, cost-benefit efficiency, crude productivity, cheap administration, cheap, auditability, controllability

Source: 6 *et al* 2005: 22

6 *et al* (2005) hypothesise that local² stakeholders make competing claims to these types of public interest, trading off interests differently in reconfiguration debates. It should be noted that the framework addresses the claims that groups make, rather than their underlying motive. We do not therefore directly address conflicts between producer and consumer interests as part of the framework. Our focus is on the arena of public politics, rather than the politics of change inside the NHS, although the latter is also important in managing change and we did uncover issues that will be discussed.

Adapting these hypotheses, this study therefore aimed to test the following:

H1: NHS managers will prioritise cost-effectiveness, crude productivity and controllability (TAXPAYER) and will support the proposals for reconfiguration³.

H2: Clinicians will prioritise clinical quality, particularly prioritising concentration to increase volumes of specialist procedures (PATIENT) and will support the proposals for reconfiguration⁴.

H3: Local patients will prioritise ease of access and localness of services (CONSUMER), as well as loyalty, civic pride and the status quo (VOTER) objectives, and therefore prefer solutions that keep their local hospital running as a provider of full acute services.

1. Note that the types do not refer to the groups that might prioritise them, but to a set of public interest claims that could be made by any group. The public interest types refer to the claims to public interest made by different stakeholders, rather than the source of the claim. VOTER has been adapted slightly from the original to reflect that as a local case study we were interested in local voter rather than national voter priorities. We have increased the emphasis on loyalty and civic pride and added a path dependency tendency for local VOTER, hypothesising that local politics tends towards negative campaigns against change. We would include accountability and amenability, included by 6 *et al* under VOTER, in the TAXPAYER type.
2. 6 *et al* (2005) make hypotheses about national interests and their roles and preferences, but our study concentrated on the local interests. The influence of national regulators and government policy came into play in some cases, as will be discussed. 6 *et al*'s hypothesis for the preferences of national clinical professional organisations has been transferred to clinicians.
3. 6 *et al* (op cit) hypothesise that senior managers at affected hospitals would prioritise preservation of as many services as possible. In these case studies the recently merged trusts managed both the 'upgraded' and the 'downgraded' hospitals, thus reducing the motivation to preserve the services at the latter site. This will be elaborated in the discussion section.
4. 6 *et al* (op cit) tentatively hypothesise that local clinicians will express consumer (or producer) interests. However for the purpose of the study we hypothesised that they would prioritise PATIENT type claims. Further hypotheses for staff interests are developed in the discussion section of this paper.

H4: Local public including campaigners and voluntary and community sector (VCS) representatives will prioritise loyalty, civic pride and the status quo (VOTER), as well as ease of access and localness of services (CONSUMER), and therefore prefer solutions that keep their local hospital running as a provider of full acute services.

H5: Local politicians will prioritise VOTER and CONSUMER interests.

This would place stakeholders at the following positions on the quadrant:

CONSUMER: Patients, public, politicians	PATIENT: Clinicians
VOTER: Public, politicians, patients	TAXPAYER: Managers

These are of course simplified hypotheses to provide a framework of analysis, rather than a realist prediction of local hospital politics. The original developers of the model expected there to be a mixture of public interest claims by each stakeholder group, but we have simplified this picture to create our hypotheses. Part of the aim of the study was to refine them and develop new hypotheses to explain any deviations.

2. Case studies of hospital politics

In order to protect the anonymity of the interviewees, the case studies will be referred to as South Redcity NHS Trust (SRT) and St Mary's and Blueburb NHS Trust (SMBT).

The aim of the study was to draw general conclusions about hospital reconfiguration politics rather than to make judgments about the individual examples. Scope for drawing wider conclusions from two case studies is obviously limited. The lessons from these case studies provide a useful evidence base, combined with our wider desk-based research and theoretical work, policy seminar and expert and stakeholder meetings to back up the discussion in the final section.

The following summaries set out the context of the case studies against the local background.

South Redcity

South Redcity's reconfiguration focused on two neighbouring hospitals. The city as a whole had three acute hospitals, including a university hospital in the centre, one in the south of the city and one just over the city border three miles away in North Yellowshire. A review of acute services led by senior consultants in the late 1990s had proposed closing the three hospitals and building a new super-hospital but this plan was abandoned.

The two South Redcity hospital trusts merged administration in the late 1990s. When they were established, the local primary care trusts (PCTs) and acute trusts worked together on a discussion document that took a more of a whole-system view of health service provision for the city. This included developing new community hospitals and moving some outpatients and elective surgery out of the acute hospitals. The acute part of the proposals included options to close both the hospitals in South Redcity and North Yellowshire and to build a new hospital on a greenfield site. In the pre-consultation 'engagement' or 'discussion' phase, when the principles for change were debated, this was ruled out and the options that were formally consulted on related to moving most acute services, including A&E, into one of the hospitals while keeping the other site open as a community or locality hospital with a minor injuries unit, as well as an option to 'do nothing – keep things as they are'. The consultation did not state a preference of site.

After the consultation the site in South Redcity was selected to be built up. A campaign to save the North Yellowshire hospital was then launched, with the support of a local MP, and the decision was referred to the Secretary of State by Yellowshire County Council. The reconfiguration had been approved but was under review by the private finance unit at the time of the interviews.

St Mary's and Blueburb

St Mary's and Blueburb's reconfiguration also revolved around two sites run by one trust that came out of a two-trust merger in the late 1990s. An earlier attempt to close Blueburb hospital and another hospital in neighbouring Brownborough and build a new hospital in between had foundered, since health authority boundary changes had placed Blueburb in the same health authority as St Mary's in Greenshire.

St Mary's had built up its services in the 1990s. Blueburb had gone against Government advice and sold part of its land to a supermarket in order to build itself up as well. Since merging with St Mary's, Blueburb hospital's acute services had been gradually moved to St Mary's. The discussion document had proposed changing Blueburb's A&E department to a walk-in centre and moving emergency surgery to St Mary's – eight miles away. Outpatient and elective surgery would be increased at Blueburb hospital and at nearby community hospitals. Following consultation, this was approved and had not been referred to the Secretary of State, although there had been a petition led by the local MP.

Further details of the methodology behind our study are available in a technical Annex published separately on the ippr website, in the 'health & social care' team pages:
www.ippr.org/research/teams/project.asp?id=2142&pid=2142.

Interviews

In summer 2006 we conducted interviews with the following people, from two areas that had recently experienced hospital reconfiguration.

Stakeholder	South Redcity NHS Trust (SRT)	St Mary's and Blueburb NHS Trust (SMBT)
Managers	SRT: Director of strategic development	SMBT: Project director, service reconfiguration
	South Redcity and North Yellowshire Strategic Health Authority (SHA): Director of health policy and strategy	Greenshire SHA: head of capital development
	North Yellowshire PCT: Director of planning	East Greenshire PCT: Director of planning
		Brownborough PCT: Head of modernisation and capacity
Clinicians	Medical director, SRT	Medical director, SMBT
	Chair, Joint Union Committee, SRT	Deputy Director, Nursing, SMBT
		Nurse, member Joint Union Committee, SMBT
Patients	Chair, SRT Patient and Public Involvement Forum (PPIF)	Member, Brownborough PCT PPIF
		Chair SMBT PPIF
Public	Chair, Save North Yellowshire Hospital	Blueburb Residents Forum
		Blueburb League of Friends
Voluntary and community sector (VCS)	Council for Voluntary Services	Council for Voluntary Services
Overview and Scrutiny Comm'ees (OSC)	Chair, Joint Redcity and Yellowshire Overview and Scrutiny Committee (OSC)	Chair Joint Brownborough and Greenshire OSC
	Member, Yellowshire OSC	
MP	MP for Redburb	MP for Brownborough
	MP for North Yellowshire	MP for Blueburb
	MP for Redcity South West	
Total: 28	13	15

Results

The 28 interviews were recorded and transcribed. We analysed the transcripts to assess stakeholder preferences and public interest values against the hypotheses.

The technical Annex on the project pages of the ippr website summarises:

- what each interviewee perceived as the reasons for reconfiguration
- initial preferences and reasons
- how their preference changed during the process
- what different criteria they would prioritise for reconfiguration decisions
- how they traded off quality and convenience.

This data, backed up by the rest of the interview, allows interviewees to be categorised according to their public interest type, that is, as either CONSUMER, VOTER, PATIENT or TAXPAYER.

Most interviewees expressed a mixture of different views. For example, they may have expressed and supported the clinical case for rationalising hospital services, within the PATIENT type; but may have also expressed a preference for a particular site on the basis of accessibility, within the CONSUMER type. Therefore interviewees were placed within more than one category where appropriate.

The following tables summarise the public interest claim types as expressed by interviewees in the two case studies. This allows a general view of interviewees' interests⁵.

Table 1 summarises the positions held by all the interviewees in both case studies. As predicted there were a range of public interest types expressed by interviewees. Tables 2 and 3 split the interviews according to the two case studies.

Tables 4 to 8 show the results for the stakeholder groups: managers, clinicians, patients, public/VCS and politicians.

Table 1: Combined (n=28)	
CONSUMER 50% (14)	PATIENT 64% (18)
VOTER 25% (7)	TAXPAYER 43% (12)

Table 2: Redcity and Yellowshire (n=13)	
CONSUMER 46% (6)	PATIENT 77% (10)
VOTER 31% (4)	TAXPAYER 46% (6)

Table 3: St Mary's and Blueburb (n=15)	
CONSUMER 53% (8)	PATIENT 53% (8)
VOTER 27% (4)	TAXPAYER 40% (6)

Table 4: Managers (n=7)	
CONSUMER 57% (4)	PATIENT 100% (7)
VOTER 0% (0)	TAXPAYER 86% (6)

Table 5: Clinicians (n=5)	
CONSUMER 0% (0)	PATIENT 100% (5)
VOTER 40% (2)	TAXPAYER 20% (1)

Table 6: Patients (n=3)	
CONSUMER 100% (3)	PATIENT 0% (0)
VOTER 0% (0)	TAXPAYER 33% (1)

5. Numbers and percentages are provided for comparative purposes, although the methodology was qualitative and the findings presented here are not intended for complex statistical analysis, for which larger samples would be required. Percentages sum to over 100 across the four categories because interviewees could make claims to more than one category.

Table 7: Public/ VCS (n=5)	
CONSUMER 80% (4)	PATIENT 25% (1)
VOTER 25% (1)	TAXPAYER 0% (0)

Table 8: Politicians (n=8)	
CONSUMER 38% (3)	PATIENT 63% (5)
VOTER 50% (4)	TAXPAYER 50% (4)

Question 1: Did stakeholders take the positions predicted in the hypotheses?

As Table 1 shows, there was representation of various stakeholders in each interest type. Interviewees did not typically express a single interest above all others and all interest groups were represented in CONSUMER and PATIENT categories. Only managers were not represented in the VOTER category, and only public/VCS were not represented in the TAXPAYER category. So overall there was more diversity and cross-over of interests than we had hypothesised.

Hypotheses H1 to H5 predicted the positions that would be taken by different stakeholders.

H1: NHS managers will prioritise cost-effectiveness, crude productivity and controllability (TAXPAYER).

Table 4 shows that all NHS managers expressed PATIENT values, in particular that reconfiguration was necessary for clinical reasons so that hospitals can provide safe specialist services to higher volumes of patients. All but one manager did, however, also emphasise the importance of financial reasons for reconfiguration (TAXPAYER). More than half of managers also acknowledged the importance of accessibility (CONSUMER), both to justify the choice of site and to argue for more services to be moved out of the hospitals into community settings.

H2: Clinicians will prioritise clinical quality, particularly prioritising concentration to increase volumes (PATIENT).

Table 5 shows that all the clinicians interviewed did, as predicted, make arguments for concentration of acute services to improve safety and quality, and to improve health outcomes (PATIENT). In particular, clinicians argued against CONSUMER interests. Although the trades union representatives interviewed both supported the reconfiguration decision, their members on the site which they perceived as being downgraded did not agree with the site choice decision due to loyalty to the hospital (possibly linked to fear of loss of jobs). This has been recorded as a VOTER-type preference⁶. One medical director also emphasised the importance of financial viability, since in his view it was unrealistic not to include TAXPAYER-type interests as criteria for decision-making.

H3: Local patients will prioritise ease of access and localness of services (CONSUMER), as well as loyalty, civic pride and the status quo (VOTER) objectives, and therefore prefer solutions that keep their local hospital running as a full acute provider.

All the patient representatives (Table 6) emphasised CONSUMER interests, prioritising convenience and locality, in line with the hypothesis. However, they did not express VOTER interests such as loyalty or civic pride. One emphasised the importance of being pragmatic rather than campaigning for two hospitals, since there was not enough money to sustain both (TAXPAYER).

H4: Local public including campaigners and voluntary and community sector (VCS) representatives will prioritise loyalty, civic pride and the status quo (VOTER), as well as ease of access and localness of services (CONSUMER), and therefore prefer solutions that keep their local hospital running as a full acute provider.

All the public, campaigner and VCS interviewees (Table 7) that expressed a preference favoured a

6. Although the tables otherwise record only stakeholders' personal expressed preferences, in this case the preferences of clinical staff represented by the unions have been included because they were significantly different and interviews with staff on each site had not been scheduled. This allocation to a public interest claim may be misleading if the actual claim was to a private employment interest.

CONSUMER viewpoint, stressing the importance of access, partially confirming the hypothesis. However, only one made arguments for loyalty and civic pride, while the most high-profile campaigner also emphasised the PATIENT interest type.

H5: Local politicians will prioritise VOTER and CONSUMER interests.

Politicians (Table 8) expressed the widest range of viewpoints, being represented in high numbers in each of the four categories, reflecting the paradox of their position and conflicting with the hypothesis. This may represent conflicts between different party interests. Politicians' highest representation is in the PATIENT category, which was not predicted. They did not express VOTER themselves, but argued that they were obliged to express their local loyalty in order to meet electoral demands. There were differences between MPs and OSC councillors, of whom the latter were more likely to favour PATIENT arguments and did not express VOTER interests.

We did not make distinctions between members of different parties in the hypotheses. More in-depth research of the impact of party-political circumstances on hospital change politics is required.

Question 2: How did stakeholders' positions change in the course of the discussion? Did the process resolve conflicts, or did positions polarise during the debate?

Table 9 (and Annex 1) show whether and how interviewees said that their position changed during the process of discussion, consultation and reconfiguration. The snapshot interview methodology was not the best way of establishing this, as most people said that their opinion did not change.

Stakeholder	Change to position	Reason for position change
Manager, SRT	Ruled out closing either site after discussion phase	Political acceptability
	Preference changed from N Yellowshire to S Redcity	Planning and traffic constraints on N Yellowshire site
Medical director, SRT	Ruled out moving to one hospital for whole of Redcity	Political acceptability
Patient member, Redcity Public Involvement Group	From keeping both open to supporting S Redcity option	Clinical and financial sustainability
Chair, Redcity and Yellowshire Joint OSC	Saw more clearly the case for concentration and more community facilities	Clinical and financial sustainability
Member, N Yellowshire OSC	Initially preferred N Yellowshire; trusted professionals' decision	Clinical case
MP for Redburb	Preferred N Yellowshire, but accepted decision once made	Political compromise
Manager, SMBT	Made some minor changes to plans	Response to feedback from consultation
Chair, Greenshire and Brownborough OSC	Realised Blueburb people had E Brownborough Hospital; learnt a lot and was convinced	Clinical case
MP for Brownborough	Initially fought changes but explained it to people when it became inevitable	Political compromise
MP for Blueburb	Backed reconfiguration to new site in 1990s; now trying to frustrate change although inevitable	Political unacceptability

Ten interviewees (36 per cent of the total) expressed a change in position during the process. All but one (the MP for Blueburb) suggested that they had adjusted their initial preference to reach a compromise. This suggests that a pattern of convergence rather than a polarisation of positions is at least possible to some extent. In particular, all the overview and scrutiny committee members interviewed revised their initial opposition as they were exposed to all the arguments. More Redcity case study interviewees (six out of 13, or 46 per cent) compromised their positions during the process, compared to three out of 15, or 20 per cent of St Mary's and Blueburb interviewees. This was due to the extremism of the initial Redcity reconfiguration proposals, and also may indicate an effective discussion and consultation process, as will be discussed.

However, those who did not say that their preference changed may have actually polarised or hardened their position during the process. For example, the campaign against the downgrading of N Yellowshire Hospital was only started after the consultation, when the decision was announced, and some had not taken part in the consultation. So although they said that their opinion did not change, their expressed position polarised during the debate. Interviewees who said their position remained the same may have started out with a vague instinct that hardened. Some may also have softened, saying that they always supported the case for change although they may have initially opposed it.

Imperfect memories and interviewer effects (including retrospective rationalisation of personal positions) may have led people to claim that they had always held such a view, whereas if we had interviewed them earlier in the process then they might have stated their real position. In order to investigate the extent of convergence and polarisation, a longitudinal methodology may be more appropriate, that is, interviewing stakeholders at various points during the process.

Discussion

The hypotheses set out in the introduction provided a useful framework for exploring the roles and preferences of stakeholders in hospital reconfigurations. For some stakeholders the hypotheses provided a fairly accurate prediction of the main positions held. For example, clinicians did prioritise the importance of concentrating acute services in order to improve quality, safety and health outcomes (PATIENT); managers did not see loyalty and civic pride (VOTER) as valid criteria for reconfiguration decisions; local public representatives did not see cost-efficiency (TAXPAYER) as being important.

However, there were substantial deviations from the hypothesised positions. Frontline clinical staff were presented as being loyal to their hospital (VOTER), rather than to achieving clinical quality through rationalisation (PATIENT); managers argued more strongly for PATIENT outcomes than for TAXPAYER efficiency; politicians held the full spectrum of positions, prioritising PATIENT and TAXPAYER positions as much as more populist CONSUMER preferences, although neither our framework nor the research fully explored the role of party politics. These deviations from the framework reflect in part our simplification of the original hypotheses and framework.

The role of managers

As discussed, managers did not just expound the need for cost-efficiency, although most of them did emphasise that finances were a consideration for reconfiguration. Conspicuously, all the managers interviewed prioritised the clinical case for reconfiguration and said that safety and quality were their main motivators (PATIENT). Reconfiguration had in both cases been initially promoted by clinicians and prompted by concerns expressed by medical royal colleges, who regulate professional training in hospitals (now overseen by the Postgraduate Medical Education and Training Board).

'Actually it was much more of clinical issue than a management issue.' Manager, South Redcity NHS Trust

'I think the reasons that the royal colleges didn't approve of it, I'm guessing, is because of what is best practice.... So the drivers weren't primarily financial, they were service driven.' Manager, Greenshire SHA

Five of the seven managers directly linked their concerns about clinical quality with staffing issues. The reduction of doctors' working hours by European Working Time Directive (EWTD) regulations was frequently mentioned as a significant short-term pressure. For managers in these case studies the perception was that the effective reduction in available staff time had practical, non-negotiable implications for maintaining safe services in smaller hospitals.

'There's a lot of new legislation, the EWTD etc and junior doctors' hours regulation. Basically, you need to have a lot more doctors to provide 24-hour, seven-day services, just the sheer maths of it if doctors

are working 40 hours a week rather than a few years ago close to 100, you just need a lot more doctors.’
Manager, South Redcity NHS Trust

‘The other key driver that was important was the working time directive around junior doctors, which made it very hard to see how a two-site trust like St Mary’s and Blueburb could cope with running two full hospitals in terms of providing junior doctors.’ Manager, Brownborough PCT

It was not clear when coding the interviews whether claims based on working-time issues should be classified as PATIENT interest – as more staff are needed to sustain a safe service – or as a TAXPAYER interest – as costs of staffing are increased, leading to different economies of scale:

‘So I would say this was a financial thing, as the rotas weren’t tenable, and also a safety thing which we were aware of, that some services were shaky.’ Manager, St Mary’s and Blueburb NHS Trust

‘The trust couldn’t carry on working as they were, as doctors were spread thin over two sites. The royal colleges could withdraw approval for training. But I think it would be narrow-minded to say it was only because of medical training. I think the reasons that the royal colleges didn’t approve of it, I’m guessing, is because of what is best practice.’ Manager, Greenshire SHA

The managers placed greater emphasis on staffing issues related to quality. They acknowledged that historic staffing levels had only been achieved by clinicians working excessively long hours, putting safety at risk. They saw the new working regulations as making it impossible to ignore any longer pressures for reconfiguration that had existed for some time. While theoretically there are workforce reorganisations that can improve utilisation of support staff, generalists and partial rotas – emphasised by 6 (2004) – the perception by managers was that the effective 40 per cent reduction in available staff time had practical, non-negotiable implications for maintaining safe services in smaller hospitals. For managers in these case studies it was inaccurate to describe working time regulations as a public interest ‘claim’, competing with CONSUMER or VOTER claims. Managers linked staffing issues to quality (PATIENT), arguing that previous staffing levels were only clinically ‘sustainable’ by clinicians working unsafe hours.

Similarly, the clinical drivers for concentration to improve clinical quality and patient safety were not perceived by managers as being a political claim. 6 (2004) and 6 *et al* (2005) are sceptical about the evidence for the relationship between quality of healthcare and volumes of specialist procedures. Department of Health (2003) and Posnett (2002) also present the evidence against concentration for quality but managers saw the clinical safety issues as a practical fact. A more recent review of the evidence by Murray and Teasdale (2005) and our previous paper (Farrington-Douglas with Brooks 2007) present new evidence of the relationship between quality and volume in specialist services, and against maintaining the status quo.

Despite their prioritisation of PATIENT and TAXPAYER claims – linked to prioritisation of mergers – managers also prioritised the importance of access (CONSUMER), for example as a factor in the choice of site.

‘South Redcity Hospital is located in one of the most deprived communities in Redcity and so in terms of accessibility to more deprived communities, accessibility in terms of walking and non-car forms of transport, it scored better.’ Manager, South Redcity NHS Trust

The managers’ range of positions reflected how much they felt that the proposed reconfigurations did not represent one dominant interest, but were carefully worked solutions that balanced PATIENT, CONSUMER, VOTER and TAXPAYER interests. They represented what 6 *et al* (2005) anticipate as a potentially politically robust settlement (although this may also reflect people rationalising their final position and their initial preferences may have been more biased).

Managers presented the proposals as a new model of care, rather than just a reconfiguration of acute services. The proposals included the development of more community facilities where services previously provided in acute settings could safely be provided there, as well as a concentration of the most complex acute care.

‘Given that the overall package was more than just the acute hospital change, it was a big shift of services. In practice that means 300,000 people a year being able to get their outpatient or similar appointments in a local centre – big, big numbers. So we weren’t just offering an increase in travel time, we were reducing travel time.’ Manager, South Redcity NHS Trust

‘One of the key things the reform depended on was having enough alternatives to admission and having GPs who could think strategically about what to do when confronted with a patient who needs

some kind of intervention. We put a modest amount of money into opening up some additional intermediate care beds in the area.’ Manager, Greenshire SHA

For managers and other interviewees, therefore, the trade-off between clinical quality and local convenience did not lead simplistically towards either concentration or decentralisation. Managers emphasised that the model of care aimed to balance convenience and quality at appropriate levels for different specialities. They argued that routine outpatients and day surgery would be more accessible, and that the increase in travel times would be limited to specialist and major emergency treatment, which are much less frequently used and supported by better equipped ambulances that can resuscitate at the roadside.

‘For different specialities and different treatments... access means different things so that’s why the model of care was important because what it was saying was for things like minor injuries, diagnostics and outpatients we will increase accessibility by shifting where you can get those... The concept of footfall matters because actually hundreds of thousands of people use those facilities compared to acute positions, particularly blue light provision which is ‘nee nor’ to the nearest hospital anyway.’ Manager, Redcity and Yellowshire SHA

The managerial concept of access was different to the narrower claim of distance to hospital, described by the framework, or in particular to distance to A&E which was used by patients, public and politicians. For managers access was a technical goal, measured by consultants’ reports, rather than a popularly measured idea. In these case studies the contest for defining what constitutes a public interest goal was as significant as the contest between claims for different goals.

The managers’ reasons for prioritising access were not only to satisfy CONSUMER demands. Both hospitals that were being ‘downgraded’ were going to be kept open for political and local loyalty (VOTER) reasons as well as CONSUMER convenience – original plans to close one or both sites had been rejected previously, after adverse feedback from politicians and the public.

‘Basically, from the public engagement phase we had two clear messages. One was that people strongly supported the development of these new community facilities to provide the routine services and secondly, people wanted to see some ongoing hospital presence at both S Redcity and N Yellowshire. That was the feedback from public engagement, and as a consequence of that we narrowed down the options.’ Manager, South Redcity NHS Trust

‘I genuinely believe there would not have been the political will [to close Blueburb Hospital]. And even if the MPs had been fantastically in favour privately, they would never have said it publicly. In my opinion, the Department of Health would never have supported it.’ Manager, St Mary’s and Blueburb NHS Trust

Similarly, managers’ appeals to TAXPAYER interests, in particular the need to develop local services that are financially sustainable within resource allocations, did not simply pull in the direction of centralisation for perceived economies of scale. The financial arguments employed by managers included a desire to reduce the dominance of acute hospitals, which in both cases were perceived to be over-provided, and rebalance the local health economy in favour of primary and community services. Providing many non-specialist services in smaller community settings was seen to be more efficient, and better able to meet increasing chronic health needs. Therefore, argued the managers, the balance of resources should shift from acute to primary and community care.

‘Redcity is trying to get some resolution to the overprovision of hospital services which it obviously has. There is too much resource tied up in acute services and not enough potentially out in the community and some of the acute provision [is] in the wrong place.’ Manager, Redcity and Yellowshire SHA

‘We are awash with estate, and we are all broke. So the obvious solution is that you close down a piece of estate.’ Manager, St Mary’s and Blueburb NHS Trust

For managers, therefore, the reconfiguration debate was not a question of centralisation versus the status quo. Their argument for a new model of care was to an extent meeting all categories rather than going for one in particular. They aimed to settle the conflicts that 6 *et al* anticipate with proposals that ‘articulate the widest possible range of both public and private interests’ (6 *et al* 2005: 22). Where the managers were arguing for remodelling rather than just merging and centralising health services it is difficult to characterise them as prioritising ideal type TAXPAYER (or any other) interests.

The role of clinicians

Clinicians confirmed the view of managers that the reconfigurations had been initiated by clinical considerations. Clinical leaders – medical directors and a deputy nursing director – were strong advocates of change and had played an active role in promoting the reconfiguration plan internally and externally. Their main priority was clinical quality, and they argued strongly for concentration as being necessary to improve standards of care.

‘I don’t think you can sacrifice good-quality health care purely on what actually is seen as the altar of access.’ Medical director, South Redcity NHS Trust

Foremost in the minds of the clinicians, as well as those of the managers, were the regulation of working times and changes to trainee doctor roles. The clinicians distinguished between arguments for concentrating services to increase the volume of specialist procedures, and ensuring that the staffing levels were viable. Like managers they also saw working time regulations as a new and practical challenge, rather than a contestable claim. This does not easily fit within the theoretical framework described in section 1, which characterises hospital politics as a process of trading off different claims.

‘Apart from the financial drivers and being viable and having the volume... also the drivers around the changes in the medical training.... you weren’t going to be viable for the royal colleges.... You could sit back and say well hold on a minute if you had the political will you could make it work but on the other hand there just aren’t the bodies around.’ Deputy nursing director, St Mary’s and Blueburb NHS Trust

However, clinicians were not simplistic in their desire for concentration. Like managers, clinicians also emphasised the other benefits of reconfiguration, whereby concentration of acute services would be matched by devolution of more routine services in a new model of care.

‘You said “downgrading” ... – we carefully did not use that phrase, it was about re-providing services in a different way.... Everybody thinks of emergency admission as the most important thing but in fact in many ways it’s the smallest amount of work we do... In fact what we would wish to provide is more extensive and better outpatients locally at Blueburb so that the population didn’t [have to] travel.’ Medical director, St Mary’s and Blueburb NHS Trust

‘Looking at what can be done at home and what you have to stay in hospital for, over the years that has changed and you haven’t got the need for so many inpatient beds.’ Deputy nursing director, St Mary’s and Blueburb NHS Trust

‘I am convinced it will be a lot better, there will be a lot easier access because they won’t have to travel so far, they will have the four or five community hospitals in their own district, and access to the facilities should be a lot easier for people.’ Chair, Joint Union Committee, South Redcity and North Yellowshire Trust

Although early plans drawn up by consultants in Redcity and E Greenshire had proposed closure of existing hospitals to be replaced by a new-build super-hospital, they had revised their objectives in the face of competing TAXPAYER, CONSUMER and VOTER claims.

‘But I think everybody realised that both politically and cost-wise that was perhaps never going to be a runner but I think everybody would agree that that was their preferred option.’ Medical director, St Mary’s and Blueburb NHS Trust

Clinicians were more likely than managers to emphasise the importance of local politicians in obstructing change to hospital patterns in their constituencies. The populist approach of politicians was a source of frustration to clinicians who worked within a rationalist framework.

‘But that is my major concern. The politicisation of the whole situation, rather than this willingness of MPs to say, yes I’ve looked at this logically, it does make sense, obviously there are concerns, let me go and explain it in those terms to my constituents and see what we can do to come to a favourable solution.’ Medical director, South Redcity and North Yellowshire Trust

A campaign to save North Yellowshire Hospital led by the MP for North Yellowshire was particularly criticised, and is well characterised as a clash of PATIENT and VOTER paradigms:

‘I think the politicians rode the wave.... I think health service professionals generally tend to be fairly logical, caring people, who do not like to see their carefully thought-out ways of best giving patient care

rubbished as being inappropriate and uncaring by an unscientifically planned view.’ Medical director, South Redcity NHS Trust

‘I saw him [MP for North Yellowshire] on television again last night, spouting away again on matters he doesn’t understand – no sorry.’ Chair, Joint Union Committee, South Redcity and North Yellowshire Trust

However, while the clinicians whom we interviewed supported reconfiguration for clinical reasons, they also confirmed that other frontline staff at the ‘downgraded’ hospital site opposed change. They interpreted these views as being about local VOTER concerns, rather than as clinical concerns.

‘They very much wanted to continue what they had at Blueburb, they felt it was a good standard, wards worked well and local to their homes, they wanted to stay there.’ Nursing union steward, St Mary’s and Blueburb NHS Trust

‘Both patients and staff have a loyalty to what they know and support.... They are very tribal here, that’s what you need to know really.’ Chair, Joint Union Committee, South Redcity NHS Trust

This viewpoint contradicts Hypothesis 2 namely, ‘clinicians will prioritise clinical quality, particularly prioritising concentration to increase volumes (PATIENT) and will support the proposals for reconfiguration’. However, it does meet one of 6 *et al*’s predictions that individual clinicians in affected hospitals will try to preserve their jobs (as in their personal interest – while making claims under VOTER or CONSUMER public interests) (2005: 9). In this study we were only able to interview a small sample of staff and selected senior clinicians and union representatives. Further research on the attitudes of staff to hospital reconfiguration would be able to explore internal politics of hospital change in more detail.

It would be inaccurate to suggest, however, that frontline staff were opposed to reconfiguration in principle. Even those who were involved in ‘Save our hospital’ campaigns supported the clinical case for reconfiguration. They just wanted to concentrate services at their hospital.

‘They just wanted North Yellowshire to be the main hospital and not South Redcity. So they agreed with the principles behind it all, they agreed that it was an improvement, but they would have preferred it was North Yellowshire was the main hospital unit rather than South Redcity was the main hospital unit.’ Chair, Joint Union Committee, South Redcity NHS Trust

The aim for frontline staff, therefore, was not to oppose concentration but to concentrate services at their hospital.

‘They probably thought the site might have been Blueburb, but in reality when so many of the basic services... at St Mary’s it wasn’t a viable option really.’ Nursing union steward, St Mary’s and Blueburb NHS Trust

This position diverged from the framework in that frontline staff held both VOTER and PATIENT viewpoints – which 6 *et al* (2005: 14) suggest is one of the pairs of interests most difficult to align. The trades unions, representing staff on both sites, supported the model of care and the criteria for selecting the site. They did not, however, express a preference of site because each set of staff supported its own hospital. They presented themselves as remaining neutral, but in fact the choice of which site would be downgraded was devolved to local site unions that campaigned for their own side.

‘The decision not to have a preference was completely pragmatic really because we’ve got equal numbers of staff on each side and the views of each group of staff were equally strong.’ Chair, Joint Union Committee, South Redcity NHS Trust

The chair of the Joint Union Committee was pessimistic about local staff, patients, public and politicians in a hospital being downgraded ever supporting change for the benefit of health outcomes.

‘When you put two into one, sides will split no matter what the constituency is, on loyalty to what they know. I don’t think you turn that around.’ Chair, Joint Union Committee, South Redcity NHS Trust

In both case studies, the crux of the local debate was not between pro-concentration PATIENT/TAXPAYER and pro-locality CONSUMER/VOTER interests. For staff – and for other groups – the argument for change was largely won. The main battleground was between different hospitals. The two-into-one debate requires a different framework for examining different interests, how they make claims and settle or polarise positions.

Guidance for consulting on change recommends putting clinicians at the front of the campaign for change (Department of Health 2003). But winning the support of frontline staff in hospitals may be more important, and more difficult to achieve, than is perceived. Interviewees pointed out that clinicians doubted that they would be involved in decisions, or distrusted managers' commitment to implementing the changes set out in the commitments. There were also difficulties in communicating change to non-management frontline staff.

'Whenever we get consulted we quite often come across information by accident, for example we came across plans by accident. The plans for rebuilding were submitted to us well after they were submitted to the council, so they was little chance of altering them.' Nursing union steward, St Mary's and Blueburb NHS Trust

'I think the argument is, if they [frontline staff] see something closing down and are not convinced that what's replacing it will be as good or equally as good, then there will be opposition.' Chair, Joint Union Committee, South Redcity NHS Trust

'I guess you just have to keep communicating to people because what you're saying is not what's being heard.... All those opportunities had been there and people have been sat down and told things but it just seems like it wasn't reality to them. It is difficult but then that's change isn't it?' Deputy director of nursing, St Mary's and Blueburb NHS Trust

An important area for further research would therefore be to explore the opinions and motives for non-management frontline staff, including nurses and junior doctors, who were not interviewed directly in this study because of time constraints.

The role of patients

There were some methodological problems in selecting patient interviewees. We interviewed members of official patient involvement committees, so there was a degree of self-selection. While appropriate for a study of key stakeholders, these interviewees were volunteer 'principal-agent' representatives (individuals formally representing the interests of a diverse group), rather than 'descriptively' representative (that is, a sample of patients selected to represent the characteristics of the wider patient population) (Parkinson 2004: 372). As Parkinson predicts, the legitimacy of patient representatives was challenged by other stakeholders and their close involvement may have meant they were more likely to be informed and engaged than the wider patient population. We were aware that one interviewee was an existing patient, but it was not appropriate to ask interviewees about their personal health care. Other interviewees, including clinicians and public, also claimed to be speaking on behalf of patients.

Nevertheless, the patients interviewed complied with the hypothesis that they would prioritise CONSUMER interests over PATIENT.

'I think I would have gone the other way and gone for localising services where they were needed even if that meant a certain lack of expertise in the people dealing with the patients.' Vice-chair, Brownborough PCT Patient and Public Involvement Forum (PPIF)

Again, like frontline staff, patients were prepared to accept the case for reconfiguration but were loyal to their local hospital, with forums divided on the site decision and therefore not engaging in the tough choice of which site to downgrade.

Neither patient representative in St Mary's and Blueburb had been well-informed about the clinical case for reconfiguration, although one went along with the principles because the PPIF had been established late on and his perception was that the reconfiguration could not be affected.

'It is sometimes difficult to know what is the real driving force. If you don't know what is driving, and I can't say intellectually I was totally clear of the reasoning. Which is a poor position, not for want of wanting to know.' Chair, St Mary's and Blueburb NHS Trust PPIF

The patient representative in Redcity also expressed uncertainty about the case for change, accepting the TAXPAYER case rather than the clinical arguments. This was linked to problems of cynicism and lack of trust in local communities where hospitals were being changed.

'It's a "patient-led NHS" although I think they left a few words out and it should be a "patient led by the nose NHS".... They see it as an ever-shrinking NHS.... The reasons for doing it are never really explained and this is a problem with the NHS and quite honestly is something I've been going on about

for years.’ Chair, South Redcity and North Yellowshire Trust PPIF

Patients’ distrust of the NHS was not limited to managers and politicians. Consultants were particularly targeted as being self-interested, with implications for the widely-held theory that clinicians are trusted by the public and should therefore be the main public advocates for change.

‘Doctors didn’t like going that far away from the golf course... and also the private hospital next door to St Mary’s. But my position on this is that I do not think the health service is run primarily for the convenience of consultants.’ Vice-chair, Brownborough PCT PPIF

This study did not investigate whether the location of private hospitals was a factor in these reconfigurations, although the allegation was rejected by managers and clinicians. The fact that none of the patients understood the clinical case may reflect some reticence on the part of managers and clinicians in discussing the safety element of change. Patients were also confused by conflicting messages coming from central government.

‘On the one hand we’re being told bring care to the community. I find this slightly trite. I’ve never seen the data.... The whole thing is driven by cost.... Against that you’ve got hospitals expected to specialise, going in the other direction.’ Chair, St Mary’s and Blueburb NHS Trust PPIF

This confusion may be due to the fact that managers and clinicians responsible for communicating the clinical case found it difficult to explain it to the public, although they had emphasised in their interviews that clinical quality was the main reason for change.

‘This goes back to public perceptions, where they think they are seeing a proper great doctor, but they are probably a student or a locum.... So it wasn’t particularly a safe system, but we never went public with that.’ Manager, St Mary’s and Blueburb NHS Trust PPIF

‘We didn’t say, “now look at the poor quality service you are getting at Blueburb” so I think that that was shied away from, rightly or wrongly and we expanded on the advantages.... Well I don’t know, we didn’t have data showing that and I think that hospital data doesn’t very well support that sort of analysis.’ Manager, Brownborough PCT

‘Part of the problem there was the reluctance to say this is clearly unsafe.... I think the real problem for the health service is to say, “we have to change this because it isn’t good enough”.’ Chief executive, Care Coalition, Redcity (involved in facilitating consultation)

The PATIENT arguments for centralisation of acute services were based on clinical understandings, such as those illustrated above, that for professionals were implicit; but these were not communicated in terms that the public understood. Managers’ and clinicians’ desire to communicate the positive messages may dilute the strength of the safety argument for reconfiguration, as will be discussed later.

The problem of trust was also demonstrated by a widespread view that consultation was not genuine. Patients often asserted that the decision had already been made, and that consultation was a formality rather than a genuine opportunity for the public to influence change.

‘I don’t think we had much influence. It was one of these consultations where they made up their mind already what they were going to do, they then went through the formalities of a consultation and did what they were going to do anyway.’ Vice-chair, Brownborough PCT PPIF

This was not necessarily seen as wrong, if there were practical reasons why options were not genuinely feasible, but it was felt that it was not an honest consultation. But a consultation which offers no real option for influence obviously has difficulties if one aim is to improve trust in decisions about health care.

‘I’m sure that they should have been more open about what they were wanting to do and why they needed to do it.... Really I felt the decision was made already because it had to be. It wasn’t an option to build on the North Yellowshire site, not the sort of hospital that was needed to replace the existing buildings.’ Chair, South Redcity NHS Trust PPIF

This viewpoint was also borne out by managers and clinicians, who conceded that there was a ‘paradox of consultation’ when there were practical imperatives meaning that alternative options were not feasible.

‘So what I am saying is that there was no option. Yes, we did a public consultation and it looked like a consultation, but there was only one outcome that was ever going to be achieved.... Saving the hospital, or saving it intact the way it currently is, is not an option, because if it was an option, we wouldn’t be out

there consulting and wasting time, money and energy.’ Manager, St Mary’s and Blueburb NHS Trust

This calls into question the aim of consultation. The real, effective input of the public and other external stakeholders is at the earlier ‘engagement’ phase, before the options are fully worked up. Plans were changed at that stage, as Table 9 showed (page 17). The statutory consultation phase – required by law – therefore has no clear function apart from being a way of communicating, or a safety net against particularly unacceptable proposals (indicating failures at the earlier ‘engagement’ phase). The fact that consultation is required for major change may even increase the focus of debate on preserving particular buildings, rather than on improving services.

If the primary function for consultation turns out to be as a tool for communication rather than for decision-making, this would undermine the objective of building trust. The consultation regulations may be counterproductive if the engagement phase has already set out the need for change, as some indicated.

‘If you didn’t have a duty to consult on the question of making a change we could have then had a good consultation about what’s the best thing to do given that we are going to have to make this change. It might have been a very different sort of dialogue.’ Manager, Brownborough PCT

The role of the public

It was difficult to select patient representatives who did not also have opinions as members of the public, and vice-versa. Again, the public interviewees were from groups involved in the local debate rather than the general public.

Many of the findings for patients were also applicable to the public.

The perception of the campaigners in South Redcity NHS Trust was that the changes were being driven by financial difficulties (although this was seen as a less important factor in St Mary’s and Blueburb NHS Trust).

‘They’re forced to make savings. They need to get it through the PFI process. But actually it isn’t about patient care.’ Chair, Save North Yellowshire Hospital

While CONSUMER viewpoints were dominant for this group, the extent to which arguments were based on VOTER was limited.

‘It would really boil down to easier access to facilities which one expects from local general hospital.’ Chair, Blueburb League of Friends

‘It’s about accessibility. First, middle and last’. Chair, Save North Yellowshire Hospital

There were different interpretations of CONSUMER access for managers and the public. Managers and clinicians viewed access as a technically measured goal. However, external stakeholders rejected transport consultants’ reports, viewing access more instinctively as a ‘common sense’ aim, measured from their geographic perspective rather than from the perspective of the whole community. Public groups rejected the technically-measured concept of access.

‘As we know these consultants are jolly expensive people, and it seems there is this syndrome of appoint a consultant for everything. I mean if you want to know how many cars are parked you appoint a traffic consultant. This does seem to be a waste of money.’ Chair, Blueburb League of Friends

Public and patients generally measured patient safety as a function of travel time to A&E, rather than trusting clinicians’ definitions related to hospital configuration, staffing or numbers of patients treated.

‘If you’re bleeding to death, if you are brain-injured, time is absolutely vital. I’ve spoken to [medical director] and... he enlightens me [to] the way in which ambulance crews can do so much.... However, there are many conditions in which time is of the essence.... People will die’. Chair, Save North Yellowshire Hospital

The issues of local debate were more complex, therefore, than a direct trade-off between CONSUMER (access) and PATIENT (quality) interests. Even where both sides agreed on the importance of an objective such as access, there were different interpretations of what it meant and how it was measured.

Again, public and patients do not always trust the expertise of clinicians. Public and patients on one hand, with popular measurements, and clinicians and managers on the other, with technical interpretations, contested each other’s interpretations and measurements of CONSUMER and PATIENT interests. The

interest types overlapped more than expected, and the battleground was as much about defining each other's expected goals as about claims of conflicting interest.

It was obvious with public interviewees – perhaps because they were not part of a wider organisation like a patient and public involvement forum or trades union, spanning both hospitals – that the key issue was the choice of site, rather than the principle of reconfiguration. For those involved, the process felt like each side supporting their local hospital.

'It's been a bit like a football trophy rather than choosing the correct site for an acute hospital.' Chair, Save North Yellowshire Hospital

In both these case studies the changes being proposed involved moving some acute services of two hospitals into one. This made the politics more complex. Rather than talking about staff, patients, public or politicians as a whole, it is necessary to consider the interests of those various groups separately, first at one site then at the other. The potential conflicts are increased by the number of sites in the equation.

The importance of the site choice also puts the emphasis onto involving and engaging people in the difficult choices about reconfiguration. The consultations in these case studies focused on engaging people in the model of care and the criteria for choice of hospital, in order to avoid the debate being dominated by discussion about buildings and locations.

'We'd gone out to engagement and consultation on what was essentially a non-site specific model. In other words, we said, "in reality we could probably provide these services from either site but these are the criteria we intend to use to come to a decision on this".' Medical director, South Redcity NHS Trust

The feedback on the model of care and the criteria were positive, according to the interviewees. However, the consultations did not tackle the 'tough choice' of hospital site.

'That I feel is dishonest, they should say it as it is. I actually think the public responds much better if you say look there are some disadvantages but we can't help that, we still think it's better on balance and this is what we're going to do about it but they will make consultation documents in this wretched positive style and it just leads to cynicism in the reader. People don't believe anything after a bit.' Chair, Council for Voluntary Services, Greenshire

'People engaged the population about what would they like, what would they like as a model of care.... They in that engagement flagged that it would be hinged to acute services but there wasn't a specific "it will be either North Yellowshire or South Redcity".... The public and the staff around North Yellowshire felt disappointed and probably in some way deceived.... I think that there was a tendency to talk about development but not the downside of it.' Manager, Redcity and Yellowshire SHA

The emphasis on the theoretical, non-site specific issues led to a constructive engagement of the public, staff and politicians in the theory. Similarly, the deliberative consultation conducted in preparation for the White Paper on community health and social care (Department of Health 2006) found that people would accept closure of a local hospital in order to move more services into the community. But winning the theoretical debate was only half of the battle. Thus even the most vehement 'Save our hospital' campaigner actually (privately) supported the clinical case for concentration of acute services.

'I'm speaking purely for myself here, I am persuaded by all of the clinicians on one site.... Well, we can quite see that you can't have neurosurgeons on two sites, the splitting of clinical teams is an issue now because of the EWTD [European Working Time Directive] and all of that.' Chair, Save North Yellowshire Hospital

The framework explored in this study focused mainly on the principle of reconfiguration. A further framework needs to be developed to help understand the positions and debates around the choice of hospital site, rather than the overall case for change. In the site choice debate, the CONSUMER and VOTER interest types – defined as tending to oppose reconfiguration and reject PATIENT and TAXPAYER interests – are compatible with campaigning to keep their local hospital open, with consolidation by transferring services from the further hospital. More work needs to explore why people do (or do not) accept the tough choice of hospital site. This is likely to depend more on the perceived procedural fairness of the decision-making process, as discussed below.

The fact that the NHS is mistrusted makes site appraisals more difficult, with the public in both case studies, like the patients already quoted, claiming that the site choice had already been made.

‘When they looked at the proposal for the Blueburb site to be expanded and the buildings to go upwards they just had guesstimates.... From my point of view the board had got its objective and was going to stick to it.’ Blueburb Residents Forum

As we have seen, managers agreed that the public were not able to determine the outcome of the reconfiguration, which was based on technical criteria. The role of public opinion in site selection was not clear to participants in the consultation. The consultations officially focused on the criteria for site selection rather than choice of site, but the public perception was that their stated preferences (expressed through petitions, responses and campaigns) would determine the site decision. The fact that the consultations provided a list of options, including some that were not feasible, contributed to this perception. Again, there was confusion about the different messages being given locally and nationally.

‘Patricia Hewitt said last week, it’s such a joke, she said that if one per cent of the population feel very strongly about something they can lobby their PCT and their PCT has to make a formal response. Well, that sounds wonderful and marvellous. We lobbied her with 48,000 signatures.... If you want people to take part more then put your money where your mouth is and give them the power. Because at the end of the day, NHS trusts will say, well we have to make clinical decisions and what we say goes.’ Chair, Save North Yellowshire Hospital

The role of politicians

The case studies interviewed local councillors who chaired or were members of joint overview and scrutiny committees (OSCs) that were examining the reconfiguration process, as well as local Members of Parliament. Politicians of all main parties were interviewed but we did not develop hypotheses relating to local and national party politics, in part because the numbers of interviewees were too small. Further research into the impact of party politics on debates locally and nationally would add to the understanding about hospital politics.

Councillor members of OSCs were an interesting test of lay persuadability. Despite being subject to electoral pressure, these local politicians became advocates for reconfiguration, all prioritising PATIENT interests, with one also favouring either TAXPAYER or CONSUMER but none referring to VOTER interests.

‘Because of the immense amount of knowledge one had to take on board, I began to see more clearly why people wanted not to have three acute hospitals, and instead have them more concentrated, so specialists could work together on some patients.’ Chair, Joint Redcity and Yellowshire OSC

‘We learnt a lot and we were convinced.’ Chair, Joint Greenshire and Brownborough OSC

Although councillors said that access was important, they perceived the reconfigurations as improving overall access through bringing about a new model of care with more community services.

‘We’re not talking about vast distances here, 15 miles at the most – and I felt people had to get used to the idea that they would only go to hospitals for the most acute things or chronic, and they would have other services nearer to home.’ Chair, Joint Redcity and Yellowshire OSC

Councillors did not perceive there was necessarily a difficult trade-off to be made, and did not therefore take the predicted position of VOTER and CONSUMER. This might indicate that if local politicians were given more responsibility in the process then they would be more responsible, rather than just making short-term political capital.

Two factors would qualify that hypothesis, however. First, the OSCs scrutinised the model of care and the criteria but avoided making any recommendation on the choice of hospital site.

‘We didn’t think we had enough evidence to sway it one way or the other. That is purely why we didn’t say South Redcity or North Yellowshire.’ Member, North Yellowshire OSC

‘I don’t really feel I’m in a position to make a judgment because I’m not a medically qualified person so that wasn’t our role at all. We were there to tease out the facts...’ Chair, Joint Greenshire and Brownborough OSC

Like the joint trades unions, therefore, the joint OSCs devolved the difficult choice to the NHS because each side would have preferred their own local hospital.

‘What would have happened is that Yellowshire people would all have voted for North Yellowshire,

Redcity would have voted for South Redcity.’ Chair, Joint Redcity and Yellowshire OSC

Second, North Yellowshire Council did oppose the reconfiguration after the decision was announced, when the local MP applied pressure. Therefore when the tough choice of site was decided, the local councillors reneged on their earlier non-political judgment and took a VOTER stance. Although the North Yellowshire OSC interviewee did not support the council’s opposition, he or she was more sceptical about the clinical case, particularly when the issue of deficits arose.

‘If they said they were just doing the changes to make hospitals better then I wouldn’t have been so cynical but it’s because they mentioned money.’ Member, North Yellowshire OSC

On the site choice, therefore, the predicted position was eventually adopted by the majority of local councillors in the affected area. After presenting lay OSC members with the evidence and engaging them in the debate, the consultation succeeded in persuading them of the principles. But then the reality of local hospital politics took over. First, the principle of reconfiguration was different to the reality of which hospital would be ‘downgraded’; second, others who had not been ‘deliberatively engaged’ were not similarly persuaded. This finding has pessimistic consequences for the local politics, which the positions of local MPs bear out.

MPs were the most inconsistent interviewees, being represented in all four types of public interest claim, despite the fact that they were theoretically incompatible with each other. The range of views presented makes it difficult to make firm conclusions about their position in the debates.

MPs were particularly conscious of the electoral pressure to back their own local hospital (VOTER). They were conscious of NHS managers’ and clinicians’ perception that politicians were interfering. Politicians were critical of the reconfiguration and consultation process, but conceded that even if consultation was done differently they would still oppose anything perceived as downgrading their local hospital.

MPs could often understand the argument for reconfiguration from a TAXPAYER perspective.

‘I think that you’ve got to drive for efficiency. We don’t need as many beds, we don’t need as many hospitals.’ MP for Brownborough

‘The driver was to produce better, more efficient, more modern, more cost-effective – I mean finance wasn’t completely out of it.’ MP for Redcity South West

But they did not feel that they could persuade their constituents by using financial or efficiency arguments. Only the two (Labour) MPs in Redcity backed the clinical case for fewer acute hospitals, as long as it was supported by devolving routine care into community settings.

‘Do you accept the clinical case for rationalisation and concentrate the acute services on fewer hospitals and on providing non-acute services near where people lived?... The clinicians supported it for these reasons. We were persuaded quite easily as it turned out despite the fact that [MP for Redcity South West] knew that South Redcity was in his constituency and I knew that North Yellowshire was very close to mine and that one of them was going to certainly go.’ MP for Redburb

Other (Opposition) MPs were dismissive of PATIENT arguments and believed the reconfiguration was about financial cuts. This perception was exacerbated by the high-profile problem of financial deficits.

‘Don’t try inventing arguments about why it would be safer over there. Just say, “it will save money.” So just admit it.’ MP for Blueburb

‘It was fairly clear that they were for financial and allegedly clinical reasons they wanted fewer sites... I guess the moral dilemma is when you do this kind of thing in the midst of lurid headlines about record deficit and the chairman of the trust resigning because frankly no one has a clue about finances? It is very hard to convince anyone that any of these changes are clinically driven.’ MP for N Yellowshire

Again, MPs were cynical about the motivation of managers and consultants.

‘I think there was only one [option], a gradual running down of Blueburb, and they couldn’t convince their own staff, they didn’t convince the consultants to operate on two sites.’ MP for Brownborough

In St Mary’s and Blueburb in particular, it was felt that the case for reducing hospitals had not been made, and that the transfer of services was being achieved in small steps without honest debate.

'If you put the argument to him that health care is changing, Fred Smith would accept it. Fred Smith doesn't want a battle, to be upset, he wants to be happy.... But these arguments have gone on, they've done it bit by bit, they've not told the truth. So the friction is there year after year after year.' MP for Brownborough

However, even where MPs were persuaded by the case for reconfiguration, they still supported their local hospital. Like patients, public and frontline staff, they were more concerned about the choice of hospital site than the debate on the principles. Reaching a settlement on the principles did not mean that reconfiguration was supported in practice. Even the Conservative and Liberal Democrat MPs who campaigned to save their constituencies' hospitals supported the case for rationalisation:

'I do actually accept the case for consolidation on fewer sites, I just actually think North Yellowshire and not South Redcity. So I was prepared to risk the wrath of a public meeting.' MP for North Yellowshire

'I'd do now what they're going to have to do and shut the place. I wouldn't say it publicly in those terms.... But once you start using all the arguments that you know about, how we must do this, how this will be efficient, there's only one answer. I don't want it. I'm doing my best to frustrate it.' MP for Blueburb

There were obvious splits on party lines for MPs whose constituencies were near to hospitals that might be perceived as being downgraded. Labour MPs supported their local hospital, but also supported the case for reconfiguration and went along with the decision once it had been taken.

'So I'd put the arguments to people that this is common sense, that the health service is changing, treatment is changing, I would put these arguments to people but it's my job to fight to a certain point to retain services locally.' MP for Brownborough

'I supported the principle of rationalising.... I felt I had to argue for North Yellowshire.... I wasn't entirely surprised when the MP for Redcity South West supported South Redcity and [MP for North Yellowshire] and I supported North Yellowshire.' MP for Redburb

A wider survey of the effects of party affiliation on MPs' positions on reconfiguration under different governments would provide an interesting follow-up study.

Like patients, public and frontline staff, MPs were more concerned about the choice of hospital site. There was fairly widespread agreement with the notion of reducing the number of hospitals – 'as long as it's not my one' – the reason given that voters would apply pressure, or that electoral opponents would otherwise capitalise on the issue. This problem is similar to the 'Not In My Back Yard'(NIMBY) attitude to planning unpopular but necessary facilities (such as wind farms or social housing).

Although people accept the case that hospitals need to change, they do not accept those changes when they affect their local hospital – they want to have services concentrated in their area, away from the next-door community – expecting a 'Hospital In My Back Yard' ('HIMBY').

While the consultation on the model and criteria was generally (but not universally) perceived to be good, trust in the process of appraising and selecting the site was very low; perceptions that the decision had already been made were widespread. As discussed, this was not untrue in the sense that the criteria favoured a particular site. But it had the appearance of a political fix for those who disagreed.

'So the public thinks they have gone for South Redcity so they can sell North Yellowshire out. I don't think it's as crude as that, I think the social engineering reasons were quite strong. And the political ones as well, you know Labour Government, Labour seat. If it only happened once you could say, you know it's just random, but it happens time and time again.' MP for North Yellowshire

'We don't know to be honest [how the final decision was made]. There's a received wisdom that these decisions are made at a much higher level than the trust or the PCT.' Blueburb League of Friends

Consultations presented a range of alternatives, including some options that were not feasible. As discussed, managers conceded in the interviews that if there had been alternatives to the preferred reconfiguration option then they would not be going to the trouble of the whole process. But managers perceived that consultation regulations required the presentation of a 'do nothing' option. This 'paradox of consultation', coupled with a non-transparent process of appraising the alternative options, played into the hands of opponents. This was illustrated by the decision on the South Redcity reconfiguration, which was announced at a public meeting where the public's preferences were invited despite the consultation having

been closed for months. This was not unreasonably perceived as a superficial exercise. The following announcement of the decision, based on 'votes' by the trusts and PCTs involved, further added to the perception of an unfair balance of power.

'The whole thing was structurally biased so that North Yellowshire could not win.' Chair, Save North Yellowshire Hospital

The idea of trusts and PCTs voting publicly on the options undermines the principle of consulting on the criteria and making an objective assessment on the basis of those criteria. This point was conceded by the Strategic Health Authority manager:

'When I came to Redcity and found that the option appraisal had already been carried out and the decisions they'd taken as a collective had been on the basis of an option appraisal but hadn't been done with a degree of transparency, then inevitably it became more vulnerable to being attacked.' Manager, Redcity and Yellowshire SHA

This 'paradox of consultation', coupled with an option appraisal that was not transparent, undermined trust in the decision.

General hypothesis conclusions

The hypothesis framework was a useful starting point for exploring the roles and positions of stakeholders in these reconfiguration studies. The four interest types were commonly expressed by interviewees, and there was some confirmation of the expected positions. There were also examples where the framework did not adequately describe the debate.

There were some positions expressed by interviewees that did not easily fit into these categories of public interest claims. There were varying interpretations of CONSUMER and PATIENT goals expressed by different stakeholders, with players on either side of the reconfiguration debate attempting to redefine the others' interests. Staffing factors, including working time regulations, did not obviously fit into any interest type. More broadly, the framework's focus on public interest claims does not incorporate claims based more on private (or more localised) interests – in particular those characterised by 'HIMBY'ism.

The proposals for reconfiguring local health care in these case studies and the way in which they were communicated, did not fit with a paradigm of centralisation. Rather than concentrating acute care and making claims on the basis of PATIENT and TAXPAYER interests, managers and senior clinicians were proposing to remodel the local health economy, concentrating some specialist services and devolving more routine care to community facilities. No hospitals in these case studies were being proposed for closure, and it was argued that more care would be provided locally, which was expected to neutralise opposition from local VOTER and CONSUMER positions.

In these cases, therefore, the continuing conflicts between different stakeholders may be less easy to explain. The retrospective nature of our study meant we were looking back at a process that had already reached some degree of political settlement. The model of care apparently satisfied elements of all four interest types and stakeholders professed to have adjusted their initial position to meet the goals of other groups. However, as these case studies have illustrated, there is more to settling the reconfiguration debate than agreement on a model of care and the principle of reducing acute hospitals.

The framework explored did not adequately describe the two-stage, dualist nature of debates in our case studies. While the consultations focused abstractly on the model of care and the criteria for site selection, they avoided the tough choice of which hospital to 'downgrade'. In both case studies the most controversial decision was which hospital to build up as the acute site. While stakeholders could accept the abstract case, they often remained loyal to their hospital, arguing that the other should be 'downgraded': the framework inadequately explains these more complex positions. The influence of private or localised interests requires a different framework.

The findings of this study suggest that analysts and policymakers need frameworks for engaging stakeholders in the model and the criteria for decision-making, and in the choice of hospital. This second question requires a developed framework that explains different groups' positions and can provide a way to understand how tough choices can be made with the engagement of stakeholders, if that is to be the objective.

Another recurring theme was trust. Stakeholders demonstrated repeated lack of trust, not only as expected in politicians and managers, but also in clinicians who were perceived as wanting reconfiguration for their own convenience. This presents a bigger set of questions than this study can attempt to answer, in particular as to whether this issue is a reconfiguration problem, whose solutions remain within reconfiguration policy, or a wider question of trust in government and professionals.

The fact that there may be wider trust problems should remain of interest to analysts and policymakers. The achievement of trust may be intrinsically important, as part of a public value approach to policy objectives (Kelly *et al* 2002); it is also instrumentally important to the success of policies for reforming public services (Taylor-Gooby 2006).

3. Towards a better politics of hospital change

This paper has described the process and politics of hospital change as dysfunctional. The NHS is neither achieving the best outcomes from hospital change, nor is it maintaining the trust that is needed to ensure that collective health services are sustainable in the long term. The local case studies described in section 2 bear out this diagnosis and provide useful lessons both for national policymakers and for local stakeholders in reconfiguration processes.

There is no structural magic bullet solution to the problems of hospital politics. Hospital change will always be technically and politically complex, and debate is a healthy part of the process. Moving from the current position to a better politics will require the progressive arguments for change to be made more effectively. However, improvements to the way we approach hospital change would allow a better politics to emerge, furthering progressive aims.

Our first paper highlighted some of the barriers to hospital change and made recommendations about how to develop proposals that could satisfy a range of interests. We have also tried with some success to stimulate a better debate about hospital change by highlighting the issues – like safety and efficiency – in national and local media. Although there are areas of policy and practice explored in this section that could be improved, a large part of the challenge is to improve understanding of the role of hospitals and how they need to change.

National hospital change strategy

The need for national leadership with local autonomy

An important principle of health reforms is the decentralisation of control away from the centre, so that local organisations can make appropriate and accountable decisions for their community. It is important, as we argue below, that local decision-making is made more accountable and autonomous, and the limits of the role of the Department of Health and Secretary of State should be clearly determined.

However, this should not mean that the policy and political role of the centre is not important. There is tension between localisation and central control, but at present there is neither local accountability nor national leadership. Although the Department of Health should not decide which hospitals need to change, our previous paper showed that hospital change is key to the achievement of important progressive aims. Hospital change should be a positive outcome of health service reform. At present, there has not been enough leadership at a national level in making the positive case for change.

The recent health service White Paper on care outside hospitals made the case for devolving some services to more local providers (Department of Health 2006). However it did not make the parallel case for the centralisation of other acute services, although this was a direct implication of the direction that the White Paper set out. The most recent policy on reconfiguration, published in 2003 and seen as a reaction to the 'Kidderminster problem', also emphasised the need to maintain services at a local level without making the concomitant case for centralisation (Department of Health 2003). The Department of Health has made much of localisation, and effectively left it to NHS organisations locally – and to the non-statutory National Leadership Network – to explain to their populations why, when politicians are heard talking about improving access to community services, some acute services are being centralised in fewer locations.

To some extent the absence of national leadership has been redeemed since this project began in May 2006, not only with the incoming NHS chief executive making the case for reconfiguration in the national media and but also with publications by some of the national clinical directors (or health tsars) (Alberti 2006, Boyle 2006, Colin-Thomé 2007, Shribman 2007a, 2007b). The national clinical director for reconfiguration, Sir Ian Carruthers, has also published a report to the NHS on delivering change in services, although it was an Annex to a letter from the chief executive of the NHS to managers, rather than a communication with wider audiences (Carruthers 2007).

While we welcome the fact that the Department of Health and national political leaders have entered the debate, their reports are not based on partnership with professional bodies, have not come out of a public debate and are thin on published evidence. The necessary decentralisation of consultation and decision-making processes has made it too easy for national government, including ministers, to distance themselves from the unpopularity of the tough choices that are an inevitable – and potentially desirable – outcome of national policy. There is still an overarching need for leadership of a national debate on the case and

objectives for hospital change.

The current policy from 2003, with its bias against change (driven by a lack of political appetite after Kidderminster), is clearly out of date. An update should not undermine local autonomy and accountability. But it should answer the questions that local stakeholders are asking. For example, what is the best evidence on where the trade-off between access and patient safety should be made for different specialities? We tried to explore some of these questions in our previous paper, but it should be the Government, in partnership with patients and professional bodies, that sets the strategic direction. This could be based on the six progressive objectives for hospital change we set out in our last report. Partners could be engaged to evaluate the evidence and provide guidance for local decision-makers.

This would have practical benefits – for example by spreading the cost of such research, rather than every locality reinventing the wheel. But it would also, importantly, begin to establish a national coalition of support for change, incorporating patient and professional organisations based on sound evidence, so that local organisations do not have to begin from a position of conflict and mistrust of professionals towards change.

A national policy on hospital change should also explain how some of the difficult tensions in current reforms should be resolved. Our previous paper highlighted some of these barriers to change.

For example, some routine operations have been ‘carved out’ so that they are provided by a stand-alone treatment centre rather than – or as well as – within a general hospital. Payment by results has also been introduced, whereby hospitals are paid according to the number of patients they treat for each procedure. These policies, some argue, have undermined the viability of some district general hospital services that are needed to back up accident and emergency departments (Royal College of Surgeons of England 2006). This claim is rejected by the proponents of the policies.

The movement of elective patients between hospitals under the policy of patient choice could also, theoretically, lead to the closure of non-elective services (whose patients have not chosen anything because they have been admitted in an emergency) where there is co-dependency between elective and non-elective care. The Government’s policy may be that elective and emergency services should be separated, in which case it would need to set out how this could be achieved where, as we have shown, there is a need for clinical teams to treat a certain volume of patients to maintain safety.

These consequences of carve-out and choice may be desirable, if the benefits of choice and competition outweigh the costs of closing emergency services – and our research has suggested that there are too many hospitals providing full A&E services in many parts of the country. However, the Government has not explained the arguments and its policy in response to these genuine local concerns, and local NHS organisations have not been able to answer these questions themselves. This project has not aimed to solve these disputes but a careful evaluation and debate on the evidence is required.

The concerns of local patients and residents about access to acute services in an emergency should also be addressed. The current review of urgent care should lead to clear policies setting out the case for centralising some acute emergency care. This should include some estimates of the optimal time window for treatment of particular conditions. For example, where angioplasty is available to people suffering a heart attack, the window for effective treatment is three hours, making it feasible to transport a patient to a more distant specialist centre. If professional and regulatory bodies can set out these guidelines more publicly, a partnership of stakeholders may be able to make a case for reconfiguration that is trusted by the local public, rather than leaving it entirely to local NHS authorities.

Our emphasis on the positive arguments and evidence for hospital change directs us to a more strategic approach to hospital change. This certainly does not mean that hospital change should be centrally dictated by technical experts in Whitehall, as previous attempts have become quickly obsolete and lack local appropriateness. Nor does it mean that choice and competition are not important levers for reforming the health service where appropriate. However, the chances of reaching effective outcomes and of involving and engaging local stakeholders in hospital change would be improved by a more strategic approach than the current situation of uncertainty, distrust and a lack of political and policy direction.

There has been some success in taking a more strategic approach in Scotland, where the Scottish Executive commissioned an expert advisory group to develop a strategy for reconfiguration in partnership with professional and staff bodies and public and patient groups. The report, *Building a health service fit for the future* (NHS Scotland 2005), achieved a much clearer vision and consensus of opinion than the disparate local processes in England.

The over-reliance on financial levers

The fact that the Government has not taken an open and strategic policy lead on hospital change means that it has relied on other methods for encouraging local organisations to review and reconfigure their hospitals. At the heart of the Government's approach to health service reform has been the use of financial incentives, most notably the use of payment by results to create a quasi-market of patients. The principle of paying hospitals according to the activity they have provided is sensible, but the over-reliance on this mechanism to drive through change is undermining the achievement of better outcomes and trust from hospital change, as this section explains.

The creation of more financially independent organisations in the NHS is an important part of the Government's reform programme. In order to make sure that NHS organisations properly steward public money, and are held accountable to deliver high-quality care, the Government has had to become more stringent about financial management. In a system of competing providers and set prices, financial incentives have to be real, so organisations have been made to take responsibility for and pay back deficits.

In theory, financial incentives should lead hospitals and other local organisations to review their local service configuration and make changes to reduce inefficiency and, it is hoped, to improve patient care. Deficits should arise from inefficient organisations, or where activity levels have fallen as a result of patient choice, or due to other changes in demand or technology that expose costs that are no longer efficient. One cause of deficits due to inefficiency may be that smaller hospitals cannot achieve economies of scale, in which case the financial incentive might lead them to merge, or be taken over, or to close. Alternatively, trusts could accrue deficits because hospitals might be larger than necessary, with high costs of maintaining too many beds for their patient population, in which case the financial incentives could lead them to reduce their capacity (for example, cutting down the number of excess beds).

However, the over-reliance on financial incentives – manifested in practice as deficits – to bring about hospital change will fail, on both technical and political criteria.

Technically, financial incentives alone will not lead to hospital changes to improve outcomes as set out in our previous paper (and in the clinical directors' recent papers we cited above). If financial incentives are the tool, the question must be asked, to what extent do the clinical arguments and financial incentives align? The Government has not provided a convincing answer. While there is some local management responsibility, inefficiency due to poor hospital configuration is not the main cause of organisational deficits.

It is not the aim of this paper to analyse and explain the causes of deficits. However, one main cause of the build-up of deficits in certain organisations is due to the inheritance of debt accrued by previous management teams in the context of a different financial regime in which overspending was tolerated. The accounting system has meant that inherited debt has left organisations with increasing repayments and decreasing allocations. This is now acknowledged by the Department of Health, and so-called double deficits are being phased out. Similarly, excess capacity accrued in some hospitals is difficult to eliminate quickly, particularly where private finance initiative (PFI) contracts add extra inflexibility to local facilities that may not be (financially or clinically) viable in the long term.

Whatever the technical arguments, it would be misleading to suggest that deficits are an accurate measure of the need to reconfigure hospitals. If deficits are the driver of reconfiguration, there is a risk that efforts to reconfigure hospitals will not be made in the right places. There would be more imperative to reconfigure hospital patterns in areas with deficits – that might be due more to inherited debt or deficits incurred for other systemic reasons – rather than in areas where there is over-capacity in the acute sector.

By the same token, there could be other parts of the country where there is an urgent need to reconfigure hospitals – in order to improve safety, provide more services in the community and focus on prevention – that fails to come about because the area is relatively financially healthy. In particular, the weighting of resources to areas with higher need due to socio-economic deprivation – which ippr supports – is not combined with sufficient incentives to ensure spending is efficient at the margin. This could allow those areas to maintain inefficient (and unsafe) acute services, rather than invest resources in prevention.

Although the technical risks of using financial deficits to drive through change are theoretical – and we have not attempted to demonstrate this other than publishing population-per-hospital data for different NHS regions – the political risks are evident. When we have expressed the positive clinical and social arguments for hospital change, we have met with constant scepticism based on the view that hospital change is due to financial cuts rather than rational planning.

On a macro scale the concept of cuts in the NHS is easily rebutted by reference to the real-terms doubling of resources, although there is debate about the effectiveness and productivity of health spending. At a local level the analysis – albeit not the implication – is true: hospital change is being driven nationally by financial incentives manifested as deficits in local health systems. Even if financial and clinical incentives were aligned, and deficits were leading to progressive hospital change in areas where it is most needed, it would be a very difficult political sell. As it is, the strategic tactic of using financial incentives is proving to be a political own-goal.

The public – along with other stakeholders including politicians and staff – do not trust change driven by financial forces. This is evident from this study and from other research on the politics of scrutiny committees (Day and Klein 2007). This is a major challenge for reform of the health service and, where similar tools are used, for wider public service reform.

Where finance is used as the incentive, it needs to be subtle and tailored, rather than a blunt tool. For example, enough time needs to be provided to allow sustainable changes to be made, rather than short-term cost-cutting that could actually reduce inefficiency as well as harming patient care. But the wider point is that the public are uncomfortable with market forces as a driver of change – and while policymakers may disagree, they have not won the public debate. Financial levers need to be accompanied by well-argued policies, and change should be managed to ensure that it achieves a wider range of publicly valued goals than just financial balance. That is why we urge the Government to set out a policy for hospital change, and to widen and sharpen the range of tools to achieve the changes that it seeks.

The relationship between choice and voice

There is a deeper conflict of policy paradigms that may come to a head in hospital change. Two parallel tracks have underpinned health service reform in recent years. The increased use of choice and market mechanisms has been accompanied by an emphasis on citizen involvement in health services, through such initiatives as foundation trust membership, involvement forums (to be replaced by involvement networks), statutory duties to consult and scrutiny powers for local government. ‘Choice’ and ‘voice’ should be linked more closely, as ippr has argued elsewhere (Farrington-Douglas and Allen 2005) for example, by harnessing the financial incentives of choice to encourage providers and commissioners to use patient feedback to inform health care service design. The power of choice should increase the incentives for health organisations to find out what patients and the public (as potential patients) want from their services. In a system of patient choice, hospital trusts do not want to worsen their reputation or lose potential patients by closing a popular service, so it is in their interest to engage and consult before making a decision. To some extent, therefore, the choice and voice paradigms reinforce each other.

However, the parallel tracks may also diverge when market forces imply a change in the pattern of services that conflicts with the patients’ voice. For instance a local population may value the security of a comprehensive district general hospital, but in fact its viability – financial and clinical – may be undermined by not enough patients choosing to use its services. Reconfiguration decisions are supposed to be taken by local commissioners, who currently have less incentive than hospitals to engage the public in order to protect their reputation. While the aim of public involvement policy is geared towards informing decisions about commissioning, in reality the public’s willingness to get involved in health is greatest when changes threaten their local hospital.

The health service can never be a perfect, choice-driven market. What are known as information asymmetries (for example, patients not knowing what the likely outcome of a one-off operation might be), plus the need for planned emergency provision with natural monopolies and a high degree of integration between different services, require a relatively heavily regulated system of provision.

Neither, however, can health providers be run efficiently and safely as a local democracy, since providers need to have reasonable managerial autonomy and clinical freedom, as well as robust patient and commissioner-led incentives, to safeguard public resources and meet changing health needs (as well as rising costs). There is a need for more local rather than only centralised public accountability, as this and other ippr papers recommend.

But the future of the NHS will need to combine a balance of choice, voice and clinical factors. It will continue to be characterised by conflicts and will have to negotiate solutions that can meet both citizen and user (as consumer and as a clinical patient) needs, including compromises between those interests. The following recommendations explore how the process of negotiation can be improved. However, the process

will continue to be complex and, at times, painful.

Communication, engagement and consultation

Three stages of consultation

Many of the problems we have identified with hospital change relate to the polarisation of opinion and the resultant fall-away of public trust in health service changes. We are not the first, however, to comment on the need to put time and resources into engagement and consultation; current guidance on reconfiguration emphasises public involvement throughout.

Therefore, we are not starting from a point of managerial autocracy. The current processes for consulting on hospital change are already quite complex. There is no lack of effort on the part of the NHS in consulting local groups and populations in the process of developing options and making decisions. However, the evidence from our case studies suggests that improvements could be made in both the policy and the process of consultation in order to improve the outcomes and degree of trust in hospital change.

There were three basic stages of consultation in the case studies, which follow the guidance. The initial 'engagement' phase involves exploring the need for change and the objectives before any specific options have been drawn up. An important part of this stage is first to inform stakeholders of the issues and help them understand the underlying principles behind the need for change. Next comes an official consultation, where the views of different stakeholders are sought more formally on a range of options. The consultation is not a referendum on the specific options. The final decision is made by a committee of NHS organisations informed by the results of consultation, based on a set of criteria on which the public and stakeholders' opinions have been sought.

To a great extent the success of engagement and consultation depends on the bodies running it. The aim of this paper is not to identify and disseminate good practice, as this is already done by the NHS and would require a larger sample of case studies. Our research did, however, identify some wider problems with the model of consultation which may explain – and illustrate – why hospital change is so difficult.

Transparency and information on hospital quality

The NHS does not have a culture of sufficient openness to make a sceptical public trust the process. If people are being asked to support controversial proposals, they need to have practical evidence to back up the theory. While the case for change was well made in the abstract, people were unsure as to whether to believe the claims, particularly about patient safety.

In the long run, this will only be overcome by a change of culture in the NHS, where data on safety is published routinely, including at a site-specific level. Although people working in the health service do not want to scare patients, if services are currently being provided at unsafe levels then the public has a right to know. The Healthcare Commission and the National Patient Safety Agency should lead this culture change by prioritising patient safety and clinical quality in their standards and publications.

Where a local trust has concerns about safety, royal colleges – including the Royal College of Surgeons – can provide what are known as 'invited reviews' of services. These provide an independent clinical view on the viability of existing services. If trusts made greater use of invited reviews at an early stage of the engagement process, and made the findings of the review public, they would be able to make the clinical case with the backing of an independent external body. This could also help to involve clinicians in advocating the case for change, as the emphasis would obviously be on clinical viability rather than on any short-term financial savings. It would provide a useful check on the NHS locally, to ensure that hospital change proposals adequately addressed safety issues and did not over-claim the need for centralisation of some services that in fact could still be safely provided at local hospitals.

Improving the transparency of hospital safety, including publication of information about quality, has policy benefits beyond just guiding reconfiguration decisions. Our recommendation fits into a wider agenda of improving patients' safety and the quality of health care. There is good evidence that publishing information about quality can lead to improvements in health care (Leatherman and Sutherland 2007). The inquiries into the Bristol Royal Infirmary also the Harold Shipman case both emphasised the importance of transparency for improving patient safety. As ippr has argued, information about clinical quality is also important to inform patients' choices of provider and treatment, with the necessary support to interpret and make choices (Farrington-Douglas and Allen 2005).

Engagement and frontline staff

The engagement phase seems to be the most important stage of the process. This is where the vital groundwork – creating a case for change and forging a coalition of interests. Potential problems can be identified and a set of principles can be established to which most people can relate. There is scope for innovative engagement in the process of decision-making at this stage, where different interest groups can be brought together to work out solutions and to understand each other's perspectives. The aim is to achieve a dialogue between the public, other stakeholders and the NHS.

Rather than passively gathering information about people's views, a specific aim of engagement is to improve public understanding of the issues facing decision-makers. This is the time for debate – by the time the process has gone into formal consultation, the capacity for either 'side' of the debate to influence the other will be much more limited.

As we identified, the association of proposals for hospital change with financial difficulties made it more difficult to achieve settlement on the principles of change. Proposals based on a national strategy for hospital change as outlined above, rather than on immediate local financial concerns, would enhance the chances of achieving local public agreement. Local processes should set out how their specific proposals fit in with the national strategy, with good evidence to back up the clinical case for change.

The NHS, in partnership with highly skilled individuals and organisations, has pioneered work in engagement. In section 2 we showed that, despite questions of trust associated with finances and party politics, in our case studies the NHS succeeded in explaining to most stakeholders the theoretical case for change. In order for a public body to have an understanding of the interests and concerns of the local community it may be sufficient to gauge the opinions of a small sample of people. Surveys, public meetings, forums and citizens' juries can therefore play a useful role in informing decision-makers.

However, an important aim for the process of hospital change is to inform the wider public and engage them in processes of change. All consultation-type processes suffer from the difficulty of engaging the wider public. There was a problem in both the case studies of the same 'usual suspects' turning up at every meeting – in fact for campaigning groups this was a specific tactic used to influence the process in favour of their local hospital. The NHS needs to reach out to a wider range of the public using more innovative techniques, including the popular media and new technologies for mass involvement.

In both case studies, in public meetings and in the media it was senior clinicians who presented the case for change. There is evidence that clinicians have greater credibility with the media and the public than managers and politicians, so this approach can have benefits. However, putting medical directors on the cover of consultation documents and in front of the cameras is not enough. From a perspective of managing change within the NHS (as distinct from persuading the wider public) it is obviously essential to win the backing of non-management frontline staff, the people who will be required to deliver those changes.

This project has not focused on the internal politics of change, but clearly there is need for better communication to and involvement of frontline staff in hospital change processes. Recent research on public perceptions suggests that the views of frontline staff are a major determinant of how much the public trusts the NHS (Edwards 2006). If staff are upset by hospital change proposals then their dissatisfaction feeds into the wider community. Involving staff at all levels is important, but in our case studies was not effectively achieved beyond senior management. Demonstrating the long-term sustainability of planned changes and providing support and retraining for displaced staff are essential to successful engagement.

Engagement and fairness in tough choices

Unfortunately, good engagement, that is getting staff, patients, public and politicians to understand the principles underlying the need for change, is not enough. In fact it is only half the process. The emphasis on the principles in these case studies meant that the NHS was late to start talking about the 'tough choices' that would need to be taken in order to achieve the agreed objectives. In a sense this is symptomatic of a political marketing approach that emphasises the positive benefits of change. Although we support the progressive case for hospital change, there are still difficult choices to be made before the process is complete.

In theory, a 'tough choice' could be avoided if the NHS had an unlimited capital investment budget and was able to bypass planning regulations, although there would still be relative winners and losers. But in reality, it is seldom possible to build a brand-new hospital on a neutral site between existing district general

hospitals. This means that, as in these case studies, the specialist acute services have to be centralised on one site rather than another. Although the services provided by the 'health economy' to the wider community may well be improved, there will often be relative winners and losers.

In our two case studies and elsewhere, the campaign to 'save our hospital' only gained momentum after the engagement and consultation stages, when the decision about choice of site had been announced. It seemed to come as a surprise to those supporting the 'downgraded' hospital that there was any chance of changes to their local building. Even those who accepted the case for change up until then assumed that the changes would be made at the more distant hospital.

More recently, campaigns have been established before plans are even developed as a pre-emptive defence of facilities, in the interest of the local community, rather than a debate on principles and the fairest settlement for the wider area.

Like NIMBYism, this issue of 'Hospital In My Back Yard' ('HIMBY') attitudes will never disappear entirely. Indeed it is a legitimate and predictable position in local debates and needs to be addressed seriously. However, the focus of contention on the choice of site, with competing private interests of local staff, politicians and communities, creates a different type of challenge.

Drawing on insights from behavioural economics and social psychology, ippr has recently argued that public services need to encompass the principles of 'procedural fairness' (Pearce 2007), as well as pursuing fair outcomes. Recent theories on attitudes to public services go beyond simple self-interest, exploring the circumstances under which individuals and communities consent to public decisions even when they do not benefit directly from them. For example, Kahan's work on the reciprocity of motivation argues that:

'When they perceive that others are behaving cooperatively, individuals are moved by honour, altruism, and like dispositions to contribute to public goods even without the inducement of material incentives. When, in contrast, they perceive that others are shirking or otherwise taking advantage of them, individuals are moved by resentment and pride to retaliate.' (Kahan 2002 :1)

The key to reciprocal cooperation is trust, rather than incentives. Acceptability of decisions is undermined if, as in the case of hospital site decisions, the process is not trusted and either side pursues, and perceives, a path of self interest. Applying the theory to the evidence on NIMBYism, Kahan finds that top-down compensation schemes for communities hosting unpopular public facilities often undermine public acceptability because local people believe that they are being bribed to accept an unfair decision. Civic-minded, reciprocating individuals will reject risks if these are perceived to be allocated unfairly, whereas fair allocation processes with bottom-up, negotiated compensation schemes are more acceptable.

Similarly, Frey *et al* (2004) argue that people value the procedures leading to outcomes, not merely the outcomes themselves. Involvement in and belief in the fairness of decision-making procedures enhance what they call people's procedural utility. For public decision-making, the fact that outcomes (or access to good services) may be more efficient and equitable following a change does not mean that the recipients of those benefits will feel an increased utility unless their need for procedural utility is also addressed.

These theories apply well to the picture of hospital change politics described in this report. The perception of many stakeholders is that the process of site choice decision-making is not transparent and fair, even if the overall outcome leads to more efficient and equitable services.

The NHS needs to address at an early stage the negative implications of hospital change for residents near to the hospitals that could lose some services. Kahan suggests that bottom-up, negotiated compensation for communities who perceive a loss of services from their local hospital may 'reverse deep-seated resentments and thus excite a reciprocal openness to siting decisions' (Kahan 2002: 21). For reconfiguration decisions, this could include the the maintenance of some less co-dependent specialist services on existing sites and siting of new community health services in 'losing' areas, but should not be pre-determined by planners who may end up undermining trust in the fairness of the decision on the main hospital site by creating a perception of buying off local interests.

According to the theory and the evidence from our case studies, the part of the process that needs the most care is the final decision about site. In these case studies the process for engagement and consultation was much better run than the final decision. It is particularly important that the decision-making process is transparent, and made in public (or at least with public representatives present). Campaigners felt that there were political fixes to ensure the changes did not affect hospitals in Labour constituencies, for

example. This left space for a post-consultation backlash. There should be consistency in the process whereby the reconfiguration committee makes its decision. If the engagement and consultation stages are meant to achieve a consensus on the rational criteria that will be used, for example, then it is illogical to have a voting system in which local PCTs state their preference and the majority wins.

The recent internal report on reconfiguration processes by Sir Ian Carruthers (2007) has begun to address the quality of project management. The requirement for authorities contemplating major changes to use the Office of Government Commerce Gateway process aims to improve quality-assurance in the business process, including scrutiny of plans and decisions by a project board. This may help to improve actual fairness, but not necessarily public perceptions of that fairness, as the process is not transparent and the public is unlikely to be aware of it. The legitimacy of decisions – the feeling of procedural utility – depends on the fact and perception of fairness.

The composition of the decision-making committee needs to engender trust in the process. One option that was suggested was that an impartial non-NHS figure, for example someone from another public service, from civil society or nominated by the local authority, should chair the project board. Another option that has been advocated is the use of citizens' juries to make the final decision. This, however, carries wider risks – that the jury might either abdicate from the tough choice by failing to select a viable option (as the overview and scrutiny committees did), or that it might make a decision, but one that lacks legitimacy with the wider community (particularly those who feel they have 'lost', as Parkinson (2004) suggests).

There is a need for more innovative deliberative approaches to engaging people in the 'tough choice' rather than solely the theoretical case for change, as well as making the final decision-making process feel fair and accountable. At present, the emphasis of the communication and engagement is in the early stages of the process – public involvement ends before the point of decision-making when it is most important.

There is a particular problem for local politicians in these debates. While those involved in reconfiguration argue that politicians should advocate and lead change, there is an inevitable – and legitimate – role that politicians will play in representing the local interests of their constituents. During the consultation stage this is a useful role, helping the NHS to assess the relative arguments for each site. It is important to involve and engage politicians in the case for change at this stage. If the process is fair and consistent, it will make it more difficult for politicians to continue credibly to oppose change on a HIMBYist basis after the decision has been taken. At this stage, unless there has been a major irregularity in the process, politicians who have accepted the case for change and the process of decision-making should be willing to accept the decision and explain it to their constituents. Although this behaviour cannot of course be mandated, fairer processes would make it more likely.

There are caveats to the centrality of procedural fairness in site choice in reconfiguration politics. Although site choice was a key focus of contention in these case studies, wider experience may vary and there is still considerable debate about the principles of change. Engaging and moving towards settlements on the principles of change remains of primary importance. As Pearce (2007) points out, there are wider goals for public policy than the maximisation of satisfaction or utility – procedural or otherwise – and that establishing fair procedures will not eliminate disagreement, or the need to take tough choices in the first place.

The role of formal consultation

Whereas the engagement phase is a two-way process, with the aim of improving public understanding and debating the principles for change, the consultation often becomes an adversarial process of positional bargaining. This is a feature of the way the consultation process is structured; it is perceived as a referendum on alternative proposals for change that can be blocked by protest. A fundamental question that arose during the case studies was whether the process of formal consultation on the basis of a series of 'options' was actually consistent with the realities of the pressures for change.

As discussed, there is a 'paradox of consultation' whereby people are asked if they would agree with changes when no organisation would go through the process if there was a viable alternative to maintaining the status quo. At its extreme, in these case studies the NHS felt it was required to present an option of 'do nothing and keep things as they are' as part of the consultation, even though maintaining such a prospect was unsustainable, for financial, staffing and safety reasons. Beyond that, there was also a question as to whether, if it became apparent at an early stage that the option of centralising on one site was unviable, it was appropriate to include that as an option for change. People felt that the consultation concealed a foregone conclusion, and they were possibly right.

The guidance on reconfiguration published in 2003 states that the NHS should define the limits of the possible at an early stage. This is clearly not being done where 'do nothing' and other unviable options are presented. The recent internal review of reconfiguration processes also raised this as an important factor, and required the NHS to ensure that proposals under consultation are quality-assured (Carruthers 2007). It is damaging to public trust in consultations if public bodies go through the motions on options that are not viable. The minimum standards, established in the national strategy described above, should provide a framework within which there is room for consultation. But consultation should not be a mechanism for preventing changes that are necessary to meet minimum standards.

This discussion suggests that the emphasis of the hospital change process should be on the engagement stage, where the case for change is explored with local stakeholders and options for change are developed deliberatively. The consultation stage should focus on the criteria for decision-making with an admission that there is a tough choice to be made. Finally, there needs to be a fair and transparent process for decision-making that people can accept. This would be a more honest approach than consultation based on a series of 'options' that are unviable.

These proposals may require the current consultation regulations to be reviewed. For example, the presentation of 'do nothing' as an option in consultations where the status quo is unviable, clinically or financially, is misleading and disingenuous. Similarly, the definition of a significant change to health services that triggers a statutory consultation should reflect the parameters of change, allowing a fast-track consultation where change can be shown to be necessary to maintain patient safety. This would ensure that consultation is more genuine and fit for purpose, rather than a tool for delaying necessary changes. Where there are genuine alternatives, consultation would become more meaningful and, as the next section will show, accountability and trust could actually be improved.

Regulation and accountability

Central accountability and regulation

A wider set of issues are raised by hospital change that relate to the accountability structure and regulation of local health services. It was felt by many interviewees that the current structures were not working.

Although the commitment of the local NHS to running consultations and involving the public in the process could not be questioned, the real accountability for NHS decisions remains upward, to the Secretary of State. Although the centre has tried to devolve decision-making to a local level, democratic legitimacy for health care decisions is derived only from central government (reflecting the history of the NHS and its funding from central taxation). Therefore, despite the efforts of the local NHS to explain the need for change and to involve people in setting the criteria for decision-making, there is an underlying perception that reconfiguration decisions were being directed by higher powers, usually located in the Secretary of State's office. Needless to say, stories of 'heat maps' provided to Labour MPs but not to other parties do not help dispel this perception, even though hospitals are being changed in constituencies of all political colours.

Overview and scrutiny committees (OSCs) have been established as a local accountability mechanism, manned by elected councillors and publicly reporting to the local population. OSCs in our case studies were professional and pragmatic, not just going for populist conclusions, suggesting that local accountability will not necessarily be parochial. However, a wider analysis of health scrutiny suggests there is variation across the country, with a mixture of populists and pragmatists (Day and Klein 2007).

As section 1 showed, in our case studies the committees avoided making recommendations on the choice of which site should centralise acute services and the 'losing' council in Yellowshire unilaterally reneged on the joint OSC decision to accept the case for change. Moreover, when an OSC does take issue with a local decision, the whole concept of local accountability is undermined by the fact that their only recourse is back up to the Secretary of State.

The fact that local OSCs have no recourse but to the Secretary of State leaves a local political accountability vacuum. Local people cannot turn to the PCT boards, as they are unelected, nor to councillors, as they have limited influence. This vacuum is currently filled by MPs, who can lobby the Secretary of State directly at Westminster. This is counterproductive for several reasons. The process of Westminster lobbying is mysterious and opaque, and therefore lacks trustworthiness for local people. There are inevitable suspicions about special favours for Labour MPs. There is also a 'moral hazard' for MPs who can make

political capital out of campaigns to 'save' their local hospital while having no power – or responsibility – for running the services they are criticising.

This conclusion points towards more genuine local accountability that accompanies responsibility for delivery. This would make the process more procedurally fair by reducing the role of MPs in lobbying Ministers for a particular hospital. However, we would not recommend a major restructuring of the NHS. The problems – and solutions – of local accountability may dovetail with the problems of regulation.

Local people's trust in the NHS was poor, in part because of the centralisation of accountability to the Secretary of State and the feeling that whatever the outcome of consultation, 'the Government' would make up its own mind. Some people suggested that an independent regulator would be a more trusted body to oversee the process and ensure that the decisions were technically correct and fair. Such a body does exist, in the form of the Independent Reconfiguration Panel (IRP), which was set up in 2003 to 'take the politics out' of reconfiguration. However, it has played a relatively minor role in formally reviewing reconfiguration decisions although it has provided more extensive informal advice on local processes in order to prevent disputes that might end up being referred to them at a later date.

We would not overstate the case for regulation of reconfiguration decisions. Bringing in an external body would not 'take the politics out' because, as this paper and others have argued, hospital change is a political process in the sense of being a process of debate and negotiation of different interests and values. A technocratic quango would not neutralise the strong feelings people have about their local hospital. A decision made by, or endorsed by, an independent regulator would not necessarily be accepted by local dissenters. Regulators lack democratic accountability and risk failing to take into account a wider range of interests if they have too much focus on the technical perspective. Although one local campaigner was demanding an IRP review, this was possibly more because they were convinced that the NHS decision would be overturned than because they would find an independent opinion more acceptable (although they claimed they would).

Local accountability and independent regulation

Although the argument for independent regulation should not be overstated, we still believe that the IRP (or an equivalent body) could play a bigger role in reconfiguration decisions. At present, the independence of an IRP review is undermined by a similar problem to OSCs, in that its role is limited to advising the Secretary of State, who is able to decide whether or not the panel reviews a decision in the first place. Such a pre-emptive ministerial veto was not in the original NHS Plan's concept of overview and scrutiny committees (Day and Klein 2007) and does not seem to be a suitable framework for an independent process. It would make sense, both in terms of filling the accountability vacuum and improving trust in the process, to provide OSCs with the power to request IRP advice directly. A greater threat of IRP review could ensure that the local NHS takes more care to make sure its processes are transparent and consistent with good practice.

The risk of changing the process is that it builds in more bureaucratic hurdles and delays necessary changes. The capacity of the IRP (or equivalent body) would need to be increased so that it can cope with the extra work. Its head office function should remain streamlined with perhaps a register of trained reviewers who could be called on to join a review when necessary, rather than a single panel expected to adjudicate on every case. The make-up of review panels might need to be reviewed, for example by including nominees from the Local Government Association to represent the OSCs.

There would be an argument for the local PCTs or Strategic Health Authorities to pay for the IRP's services, as an incentive to ensure that it cooperated with the OSC's concerns. Local authorities could also be charged to prevent frivolous referrals. There would also need to be a spectrum of proportionate types of review that it could carry out, from small-scale advice to a more comprehensive review of regional strategy, technical planning, consultation and decision-making. There would need to be filters for OSC requests to ensure that their request was justifiable and that there was enough evidence for their concerns.

At present the IRP formally provides advice to the Secretary of State, rather than to the local NHS. The Secretary of State can then require the local NHS to implement (or not) the IRP recommendations. This means that even with IRP advice, the Secretary of State is still open to political lobbying, with a suspicion of prejudice where this has happened. The independence of the reconfiguration regulation process can be questioned by opponents. If the IRP could be called in by local OSCs, then its advice would formally be to the local NHS rather than the Secretary of State, with the default expectation that the NHS should comply.

The NHS ultimately has to commission and deliver sustainable health services within the national policy

and financial framework. The final decision would rest with the NHS rather than the IRP, so its advice would not be binding, but rejection of its advice would put the NHS in a difficult position with its local scrutiny, as is discussed below, and would threaten the future career of PCT board members. The Secretary of State would however be removed from individual decisions, in order to improve trust in the independence of the decision-making process.

The role of politics

This should not be interpreted as 'taking the politics out' of reconfiguration; the process of hospital change is a political process of debate and negotiation rather than technical fix. Successful change requires a combination of management and politics. The IRP's role is as much about political arbitration as about technical judgment. However, it could take some of the party politics out by improving the strength of local scrutiny process at the same time as introducing more independent regulation and reducing the role of the Secretary of State. This would make the process more accountable but less party-political. Filling the local accountability vacuum would be the best way to reduce the space for opportunistic politicians to make political capital out of necessary tough choices.

Similarly, this is not about getting ministers 'off the hook', or ensuring that they do not get the blame for controversial decisions. Our proposals for a national strategy on hospital change would actually make the elected government more accountable for the overall framework for hospital change. However, government ministers should not be taking local management decisions. Central government is not best placed to make these decisions from a practical perspective; from a political perspective also, the close involvement of ministers does not engender trust where there is a suspicion, as was raised in our research, that decisions are being taken to benefit a political party. It is local managers rather than government ministers who need to be held accountable and empowered to make local decisions, with involvement of the local community through engagement and scrutiny processes. This dovetails with ippr's vision for accountability in central government, whereby politicians are responsible for policy decisions and officials are responsible for clearly defined operational ones (Lodge and Rogers 2006).

Increasing the role of OSCs would also need to be balanced by a change in their constitutions. Increased power should bring increased responsibility. There is currently a problem with OSCs stemming from the lack of coterminosity between local authorities and the health economies under review (although recent NHS organisational changes have made most PCTs larger). Networks of hospitals and community services typically serve populations crossing county and city borders. As in the Redcity and Greenshire case study, two councils created a joint OSC for the purposes of the reconfiguration. After the joint OSC chose not to refer the reconfiguration to the Secretary of State, the council for Yellowshire chose unilaterally to refer it.

Our findings have shown that a major factor in the politics of hospital change is that of 'HIMBYism', where people accept the need to change but want acute services to be centralised at their local hospital, rather than in the town down the road. The constituencies represented in local scrutiny should therefore be bigger than the immediate catchment of one particular hospital or there will always be a bias towards maintaining acute services at the nearest site.

The strengthened powers of joint OSCs should therefore be balanced by a removal of the capacity for local authorities to renege on their decision. Local scrutiny powers would, where necessary, be delegated to a joint scrutiny committee, rather than reserved for subsequent reversal of collective judgments. This might also ensure that local authorities nominate delegates who are trusted to represent the concerns of the council and have the authority to defend collective decisions.

If more regional assemblies are introduced, they could play a greater role in scrutiny. The London Assembly, for example, is increasing its health scrutiny role at the strategic health authority level. SHAs remain powerful regional bodies but at present have more links to Whitehall than to democratic organisations and are at too high a level for effective local engagement.

Democratic accountability and health services

The discussion of local accountability feeds into a wider question of democratic accountability in the NHS. The public and patient involvement functions have undergone frequent changes in recent years, with community health councils being replaced by patient and public involvement forums, in turn to be replaced by local involvement networks (LINKs) that will inform scrutiny committees on health issues on an area-wide rather than institution-specific basis. Meanwhile foundation trusts have been introduced with local governance of some hospital provision, which many argue as being in the wrong place (for example

Stoate and Jones 2006).

As local commissioners play a more significant role in determining local health services, there is an increasing need to tie them into local communities so that their decisions have legitimacy and reflect local priorities. The kind of strengthened scrutiny role combined with independent regulation described here could be a model for improving accountability of other local NHS decisions, including rationing decisions and spending prioritisation.

However, there is still no real local legitimacy for local health service decisions about commissioning. There has been discussion recently about making commissioning more locally accountable, with ideas ranging from putting commissioning into local authorities, to having elections to PCT boards. While our project has not focused closely on this issue, a more formal local link would help to make the process of making decisions more locally accountable, and would balance out against the centralisation of authority in the Secretary of State. However it is important that, while public voice is given ample opportunity to influence service commissioning and design, the NHS remains responsible for ensuring that services are delivered sustainably. In order to fulfil this function, commissioners also need to have the necessary autonomy.

One option that could balance NHS independence and local accountability might be for OSCs (or joint OSCs where authority has been delegated) to have the power to instigate a vote of no confidence in a PCT chair where they could show that proper consultation had not been carried out. While not immediately leading to the removal of a chair, this vote would send a strong signal to the chair, the non-executive directors and the Appointments Commission and would ensure that the local NHS involved local authorities more closely. With OSCs connected to the community via LINKs, this could ensure that the next generation of public involvement had some ultimate sanction other than referral to the Secretary of State.

Conclusion

Health care must be able to adapt to changing health needs and new technology and techniques. Hospital reconfiguration, as part of wider health system changes, is necessary for – and should be driven by – the achievement of progressive aims from the health system. Hospital change is necessary to achieve what the public value from health care – including improved health outcomes, safe and accessible services, and public trust.

However, this does not mean we have an uncritical view of hospital change. The current systems and processes for hospital change are failing to meet the progressive aims. In particular, public trust in decision-making about changes to hospitals, and confidence in the NHS more widely, is at a low point. This is a direct result of the current policies and processes, rather than just a criticism of public prejudices. The aim of ippr's Future Hospital project was to explore how to move towards a more functional politics of hospital change. Our vision is of a health system that is constantly evolving, where settlements can be reached between stakeholders that achieve the progressive goals set out in our first report, while maintaining public trust and confidence in the collective NHS.

Hospital change will always involve some degree of controversy. There are genuine trade-offs between different public interests. There needs to be a fuller public debate about the priorities for the health service and the role of hospitals in the future. Through the Future Hospital project ippr has aimed to stimulate such a debate, courting controversy on the way and using the media to raise public understanding. Judging by the extensive media attention and the number of downloads of our first report, there is an appetite for debate.

Our recommendations would take this further by engaging the stakeholders from professions, patient groups and civil society in the development of a more strategic approach to hospital change that pursues explicit progressive goals rather than relying on financial incentives.

Beyond hospital politics there is an ongoing tension in wider public policy between the principles of empowerment and democratic voice on the one hand, and the pursuit of policies that are necessary to achieve progressive outcomes on the other. This tension will remain, and continues to be a theme in the thinking that ippr is leading on other controversial areas in which public attitudes and progressive outcomes can come into conflict, including environmental sustainability, healthy behaviour and asylum and immigration. Information and fairness are intrinsic to achieving progress in these debates, and similarly in hospital politics.

Part of the solution therefore lies in a more informed public debate. The changes that we propose to the process and structure of hospital change will provide a better forum for communication, for tensions to be worked out and settlements reached. By leading the debate nationally, the Government, in partnership with other stakeholders, could establish a greater legitimacy for the values underpinning hospital change and improve the level of understanding. In a two-way process, the Government could then allow greater autonomy to the health service to reach local settlements within the framework of a national strategy on which there was greater agreement.

The degree of conflict over hospital change also reflects the problem of trust in government. While the wider determinants of public trust – from public attitudes to perceptions of leaders – cannot be addressed in this project, we did identify particular structural problems that undermined the trustworthiness of decision-making. We have set out how the role of ministers should be more clearly delimited, with greater ministerial accountability for the strategy and policy framework for hospital change, and greater local accountability for decisions made within that framework. There is no magic bullet for the problem of poor trust in public decision-making, but there are improvements in the structure and the fairness of the decision-making processes that could provide space for more trusted decisions – and less space for collective decisions in the public interest to be undermined by private interests.

In the long term, we believe these changes will help provide a better framework for hospital change in which the health system can meet the challenges of changing health care, achieve better and fairer outcomes and improve public trust in change and confidence in the NHS.

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