The Health Foundation

Invitation to tender

Trends in health and care supply

The Health Foundation is seeking a supplier to work with us to analyse changes in the configuration, volume and mix of health and care services in England.

April 2023

Prepared by

Hardeep Aiden, Research Manager
The Health Foundation
Tel: +44 (0)20 7257 8000
www.health.org.uk

Deadline date: Midday, Wednesday 19 July 2023

Accompanying documents

- Sample contract

1.0 Summary

The health and care system is under intense pressure, with persistent workforce shortages, and patients and service users struggling to access the care and support they need. To ensure the health and care system remains financially sustainable, we need a better understanding of the changing configuration of health and care services and trends in the volume and mix of supply across the whole system.

At the same time, the UK has greater regional inequalities than most comparable countries on multiple measures, including productivity, pay, educational attainment and health.[1] To address this, the UK government has set out an aim to level up the country, promising to increase prosperity, widen opportunities and ensure that no region is left behind. It has set an ambitious target to narrow the gap in Healthy Life Expectancy (HLE) between places where it is highest and lowest by 2030, and to increase HLE by five years by 2035.[2]

Against this backdrop, the Health Foundation is interested in exploring the direct and indirect consequences of the changing configuration (including mergers, acquisitions and closures) of health and care supply in England, and trends in the volume and mix of services. We are particularly interested in differences between places, especially those with different levels of deprivation, looking as far back as relevant datasets allow.

We want to understand whether changes in the configuration, volume and mix of heath and care supply has affected not only access to health and care services, but also employment and other forms of economic activity within communities, and how this differs by geography. This work will eventually lead to the creation of a comprehensive time series database that the Health Foundation can use for future work on health and care supply in England.

The deadline to submit proposals is **midday, Wednesday 19 July 2023.**

We anticipate tenders up to **£300,000 (inclusive of VAT and expenses).** Tenders above this amount will be considered if the proposal represents exceptional value for money.

2.0 About us

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

3.0 Background to the project

The health and care system is under intense pressure, with persistent workforce and capacity shortages, and patients and service users struggling to access the care and support they need. Over the past five years, the Health Foundation's REAL Centre (Research and Economic Analysis for the Long term) has worked to build an increasingly robust understanding of changing patterns of demand. However, to ensure the health and care system remains sustainable and capable of responding to these changing patterns of demand, we need a better grasp of the changing configuration of health and care services and trends in the volume and mix of supply across the whole system. Understanding how trends in expenditure, activity and cost vary across settings can inform decisions on spending reallocations within existing budgets and help improve workforce, capacity and budget planning. It can also support resilience in the system, ensuring adaptability to longer-term changes in care needs, as well as helping stakeholders to understand how the distribution of health services may affect health inequalities.

Since its inception, the NHS estate has continually been reconfigured through mergers, acquisitions and closures. The 1962 Hospital Plan aimed to close over a thousand community hospitals and construct (or reconstruct) over 200 larger hospitals.[3] Between 1997 and 2006, more than 100 NHS trust mergers took place under New Labour's market reforms of the NHS, with a further 50 mergers between 2010 and 2015.[4] The majority of changes have consolidated neighbouring services within larger and more complex organisations, with stated goals of improving efficiency and quality of care.[5] These changes have not been limited to acute care: the number of primary care/GP practices in England fell from over 8,000 in 2013 to fewer than 6,500 in 2022 – a decline of 20% caused by closures and mergers.[6] It is important to note that the change in provision of primary care is harder to track than for hospitals, which generally have better records.

In 2016, sustainability and transformation partnerships (STPs) were introduced as geographical groupings of health and care organisations to develop 'place-based plans' for the future of health and care services in their areas.[7] Many of these were based on major consolidations of services, again ostensibly motivated by goals of improving efficiency and quality of care. The reconfigurations that have been proposed (and implemented in some areas) have led to the closure of community hospitals and significant planned reductions in the number of community hospital beds in some locations, alongside mergers to form major acute centres and investment in community hospitals in others.[8] These reductions are a continuation of the long-running decrease in the total number of hospital beds in England, which has halved over the past 30 years from around 299,000 in 1987/88 to 141,000 in 2019/20.[9]

STPs have gradually evolved into integrated care systems (ICSs) – partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing regional inequalities.

The UK has greater regional inequalities than most comparable countries on multiple measures, including productivity, pay, educational attainment and health.[10] Successive governments since the 1960s have implemented policies to try and address these divides. Recent initiatives have included the creation of regional development agencies by the New Labour government in 1998, the Northern Powerhouse initiative introduced by the coalition government in 2014, and more recently the levelling-up agenda.

Action to ‘level up the nation’s health’ is now a key plank in the UK government’s levelling-up agenda. It has set an ambitious target to narrow the gap in Healthy Life Expectancy (HLE) between local authorities where it is highest and lowest by 2030, and to increase HLE by five years by 2035.[11] This target was set out in the Department for Levelling Up, Housing and Communities (DLUHC) white paper, but it does not include details of the measures the government will take to meet this target.[12] These are instead due to be set out in a Department for Health and Social Care white paper designed to tackle the core drivers of disparities in health outcomes.

The DLUHC white paper observes that differences in levels of health between regions are an ‘important explainer of differences in regional outcomes’. At a local level, people in the top decile (least-deprived) areas of the UK can currently expect to live around a decade longer than people in the bottom decile (most-deprived) areas. This inequality is driven by a variety of factors, including differences in green/blue spaces, educational opportunities and employment. Other factors such as demographics also matter. Access to and quality of health services are also important drivers of health outcomes and can vary by area. The COVID-19 pandemic has made these disparities starker. Disparities in access to health care have widened in the most deprived areas, with waiting lists in England having increased by 55% in the most deprived 20% of areas, compared with 36% in the most affluent quintile.

Communities are almost invariably organised around a few key institutions and organisations which are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, employment and training, and buildings and land assets. These organisations are now considered to be ‘anchor institutions’, signalling the pivotal roles and responsibilities that they play in the social and economic fabric of the communities in which they are located. Among these anchor institutions, hospitals are frequently cited as the most important.[13,14] The closure of hospitals that are anchor institutions affects the local economy through job losses in the hospitals themselves and in related supply chain industries, and through a reduction in consumer service industries, such as stores, restaurants and banks – and this in turn influences the health and wellbeing of communities and regions.

Beyond hospital and community services, there are significant inequalities in primary care – people in more deprived areas have reduced access to services, and GP practices in these areas are relatively under-funded and under-doctored compared to practices in more affluent areas. The direction of policy is to deliver primary care at scale with a wider range of professionals working together to deliver general practice services, and to develop community diagnostic centres (CDCs) that reduce pressure on hospitals by providing quicker and more convenient access for patients. However, the location of these scaled practices and CDCs is a barrier in many parts of the country – only an estimated one in five CDCs are based in the community (such as shopping centres) rather than on a traditional health care site (such as a hospital or a primary care centre).[15,16]

4.0 Details of the work

4.1 Aims

The overall aims of this project are to:

- analyse changes in the configuration, volume and mix of health and care services in England over time
- identify key trends in terms of geography (eg towns vs cities, rural vs urban) and deprivation-based characteristics.

We also want to create a comprehensive time series database, which provides a health and care 'asset' register that the Health Foundation can use for future work on health and care supply in England. The asset register will measure closures and mergers, and will include identifiers such as practice codes and General Medical Council (GMC) numbers. Before creating the database, the supplier will need to establish a sophisticated conceptual framework to examine changing configurations of health and care supply. Once the database is built, the supplier will be expected to run some initial analyses to test and refine their work.

The conceptual framework, the methods and the initial analyses of changes in the configuration of health and care services and key geographical trends should be presented as a series of reports to the REAL Centre.

Throughout the project, the supplier will work closely with the REAL Centre to ensure that the supply-side data from this project complements the demand-side data from the Centre's other projects, in order to improve the Centre's capabilities for future analysis on health and care supply and demand.

4.2 Research questions

- How can we conceptualise the changing configuration of health and care services in terms of volume and mix?
- How can we measure changes in the configuration of health and care services over time and geographically?
- How do these changes in the configuration of health and care services relate to inequality? For example, what have the direct and indirect effects of these changes been on access to health and care, employment in health and care, and wider economics metrics for communities (we do not expect the supplier to derive causality but are interested in a description of changes that have occurred)?

4.3 Scope

- We are particularly interested in the changing configuration of the following types of services: GP, acute, diagnostic, community, mental health and residential care. The supplier will be expected to provide a clear plan of what they will measure and at what level this will be recorded.
- Some health services are (or were) provided by community hospitals and so we are also interested in changes to community hospitals (ie cessation or addition of services, or retention of services with capacity changes or hospital closures).

- We want to look at trends since 2000, if possible, but expect the supplier to look as far back as the relevant datasets allow. We expect there to be a trade-off between the breadth of services that can be mapped and the geographical level at which they can be mapped (ie more comprehensive data may be available at a local level and not at a national level or vice versa).
- In addition to England, we would welcome the inclusion of Wales and Scotland if the supplier is able to do this.

4.4 Approach and methods

We propose that these research questions are addressed using a two-stage approach:

1. Establish the conceptual framework needed to examine the changing configuration of health and care services in terms of mix and volume.
2. Map and analyse key variables from the conceptual framework to determine the usefulness of the underlying database.

Below we have outlined our ideas and expectations for each stage, but this is not definitive. Suppliers should describe their approach for stage 1 in detail and then outline their approaches and methods for stage 2 (see assessment criteria).

Given the nature of the work across the two stages, we would expect multidisciplinary research teams or partnerships to apply. We anticipate proposals that draw on appropriate models, techniques or insights from health economics, economic geography, health geography or other relevant disciplines. The budget for this project has been set accordingly.

Stage 1: establishing the conceptual framework needed to examine the changing configuration of health and care services

Objective A: to define concepts and metrics that are appropriate for considering the configuration of health and care services
The supplier will be expected to use the existing literature on health and care services configurations (including centralisation) and inequalities to define relevant reconfiguration factors, processes and outcomes for this study in relation to the following types of services: GP, acute, diagnostic, mental health, community and residential care. In the international literature, indicators such as bed numbers per population are often used as a measure of capacity but do not provide a full picture of the capacity within providers (as factors such as opening hours can also be used to measure capacity) and are not relevant to many providers (eg GPs).

There are at least five key considerations when analysing changes to health and care services: workforce, quality, cost, access and technology. By exploring these considerations, we expect the supplier to develop a range of measures that may be useful for understanding the changing configuration of health and care supply. For example, cost considerations often result in capacity changes such as bed availability or changes in opening hours; and changes to access are frequently cited as a consequence of change, eg increasing residential distance from different health and care services or reduced opening hours (ie 9–5 on weekdays rather than 24/7). On the other hand, there is often an expectation that centralisation of health and care services reduces access to care, but less consideration of potential quality gains that may help reduce inequalities through higher quality services.

Objective B: to establish the kinds of communities or places affected by the reconfiguration of health and care services
One of the key challenges for the supplier is to consider and define 'areas of interest' in the context of this work. Reducing inequalities in health and care related to socioeconomic deprivation is a key factor. But the levelling-up agenda has also identified geographical inequalities in relation to rural and urban areas, and towns and cities within the same region. This is of particular interest with respect to the reconfiguration of health and care services due to the gradual shift from community-based services to more centralised services located in major towns or cities within regions. This may also tie in with the literature on anchor institutions (see above).

Objective C: to establish place-based measures of health, social and economic conditions
In addition to health measures, the supplier needs to establish place-based measures of the social and economic conditions associated with the 'areas of interest' identified in objective B, which are of value to research and policy stakeholders. These measures should acknowledge that some of the consequences of reconfiguration are direct (eg new hospitals or hospital closures inevitably lead to workforce changes) while other changes may be indirect (eg workforce changes may eventually lead to more/fewer families in a local area, which could lead to changes in schools and public services).

In terms of health measures, the supplier will be expected to produce direct measures of access to physical infrastructure (eg based on the HHI index), health and care activity for the population (eg volume of appointments in primary care or hospital admissions adjusted for population need), and some measures of health and care outcomes (eg Healthy Life Expectancy, readmission rates, mortality rates, delayed discharges from hospitals or access to care).

The supplier will also be expected to produce appropriate measures of social and economic activity (eg jobs or investment) for regions/communities. The levelling-up white paper presented a capital-based framework for discussing the conditions that drive disparities between areas, suggesting that areas with sufficient capital are more likely to have the conditions needed for higher economic productivity. The supplier could consider using this framework, or adapt elements of it, for their own conceptual framework.

Stage 2: mapping and analysing key variables from the conceptual framework to determine the usefulness of the underlying database

Objective A: to operationalise the conceptual framework
During this stage, the supplier will be expected to operationalise the conceptual framework by compiling a portfolio of analytical outputs based upon time series exploration, which the Health Foundation can use for future analytical work on health and care supply in England. The analysis will be conducted in the Health Foundation's Secure Data Environment (DAP), thus ensuring all policy principles of the Health Foundation's Information Security Management System (ISMS) are adhered to.

The table below highlights some of the datasets that we deem to be relevant for the creation of the time series database (where all content has been subject to statistical disclosure control if required), but it is not exhaustive.

Theme	Example datasets
Health and care services: infrastructure	Estates Return Information Collection (ERIC), Care Quality Commission (CQC) care directory
Health and care services: access	Journey Time Statistics (JTS)
Local conditions and outcomes: health and care	Hospital Episode Statistics (HES), GP data, Clinical Practice Research Datalink (CPRD)
Local conditions and outcomes: social and economic	Index of Multiple Deprivation (IMD), Labour Force Survey (LFS)
Local conditions and outcomes: demographic	Office for National Statistics (ONS) population estimates

Objective B: to map key variables from the conceptual framework
Using the emerging database, the supplier will be invited to produce thematic maps on the changing configurations of health and care services in England (and more widely if possible), combined with changing health, social and economic conditions for the 'areas of interest' identified in stage 1.

We expect the supplier to use a geographic information system (GIS) or a similar approach to connect relevant national datasets to a map of England (and other nations if possible). We recognise that this will involve a trade-off between geographic precision and completeness in the information that is mapped (eg scale issues). We expect the supplier to make informed decisions on how to achieve levels of granularity that are appropriate for exploring interactions between relevant variables.

Objective C: to establish hypotheses and undertake preliminary analyses
After mapping the data, we expect the supplier to undertake a second stage of data exploration, eg using Exploratory Spatial Data Analysis (ESDA) tools. This will allow the supplier to gain a deeper understanding of the phenomena under investigation and make more informed decisions about the content of the database.

An example of the kind of analysis we might expect at this stage is examining changes in the distribution of community health services over time by deprivation, and the potential links with changing social and economic conditions.

We understand that precise plans for stage 2 are dependent on the outcomes of stage 1, but we expect prospective suppliers to outline their indicative plan and budget for stage 2.

Summary of expected approach and objectives

Stage	Objective
Stage 1: establishing the conceptual framework needed to examine the changing configuration of health and care services	Objective A: to define concepts and metrics that are appropriate for considering the configuration of health and care services
	Objective B: to establish the kinds of communities or places affected by the reconfiguration of health and care services
	Objective C: to establish place-based measures of health, social and economic conditions
Stage 2: mapping and analysing key variables from the conceptual framework to determine the usefulness of the underlying database	Objective A: to operationalise the conceptual framework
	Objective B: to map key variables from the conceptual framework
	Objective C: to establish hypotheses and undertake preliminary analyses

4.5 Roles and responsibilities

The research partner's responsibilities:

- We expect to have regular meetings, including collaborative working sessions, as well as to work asynchronously on agreed tasks with the research partner. Our rhythms of working will be agreed at the inception meeting but we expect the majority of meetings to take place virtually via Microsoft Teams.
- We expect the partner to make sure that the workplan is delivered and to steward an iterative approach. This includes updating the workplan and resource plan accordingly.
- The partner will make reasonable allowances for the time required to fulfil these obligations and will flag early to the Health Foundation team if too much resource is being used or resource is not aligned to the agreed workplan, which might risk us not achieving our desired outcome on time and on budget.
- The partner will work with the Health Foundation's REAL Centre to define what data we would want to collect on the supply side based on the data we have on the demand side in order to improve our capabilities for future economic analysis on health and social care supply and demand.
- The research partner will actively and regularly contribute to decision-making processes to move the work forwards.
- The research partner will document and communicate learning, insights and assumptions as we go, so that both the partner and the Health Foundation team have a record of the journey taken and decisions made.
- We expect the partner to share reflections, rationale and insights on methods used, to build the capability of the Health Foundation programme team.

The Health Foundation's role and responsibilities:

- We will work with the research partner to confirm the approach to the work before it begins.
- A core delivery team will oversee the work, consisting of members of the Health Foundation's Research team and the REAL Centre.
- At the inception meeting, we will give the research partner an overview of work in this area which has already been undertaken by the Health Foundation, including projects we have previously funded, key learning from relevant reports and insights from key stakeholders.
- We will attend stakeholder meetings, co-working sessions and workshops when relevant.
- We will work alongside the research partner to iteratively develop a list of prioritised problem areas and recommendations for next steps.
- We will work with the research partner to make sure that the deliverables are appropriate.

5.0 Deliverables

- A report covering the analysis of the changes in volume and configuration of health and care supply in England over time, and identifying key trends in terms of place-based (eg towns vs cities, rural vs urban) and deprivation-based characteristics and changes in the mix of different types of health and care services.
- Visual assets accompanying the report, which map the consolidation of health services in communities against health outcomes and socioeconomic conditions (eg access to healthcare services, employment and other forms of economic activity within communities) over time.
- A comprehensive time series database which provides a health and care 'asset' register that the Health Foundation can use for future work on health and care supply in England (with estimates for the ongoing maintenance of the database after its initial release).

This research is expected to contribute to the wider evidence base in this area. For example, by:

- Mapping the number, location and types of services provided by community hospitals (with and without beds) and GP services over time and would provide a baseline for observing future changes in community-based health services.
    - We want to focus on measuring capacity (eg the number of available hospital beds and GP practices) rather than activity/how this capacity is used in practice (eg utilised beds and number of GP appointments). This will allow the measurement of accessibility to health and care over time. Some measures of health outcomes would also be key (eg mortality rates, emergency readmissions).
- Providing much needed evidence to support decision making on future consolidation plans in England or more widely.

6.0 Costs

Responses to this invitation to tender (ITT) should include accurate pricing, inclusive of expenses and VAT. We will assess tender responses based on perceived quality of service and demonstrable ability to meet the brief, rather than lowest cost, but value for money is a selection criterion (see below).

Based on previous evaluations commissioned by the Health Foundation, we anticipate tenders up to a **maximum of £300,000 (inclusive of VAT and expenses)**.

We will commission this research by issuing a contract for services and we expect VAT is likely to be payable on all aspects of the work. Please consult your contracting team or finance team to ensure that VAT has been included appropriately before submitting your proposal and budget.

7.0 Information call and FAQs

Information calls offer applicants the opportunity to hear more about the project and to ask questions to clarify understanding.

We will hold an information call during the week commencing 24 April 2023. If you would like to attend, please register your interest by emailing us at research@health.org.uk. It is not essential, but you are encouraged to take part.

If you have any questions about the project, please email them to us in advance of the information call if possible. Please note that we will not be able to answer specific technical questions about individual tender responses.

Our responses to these questions will be added to an FAQ document, which we will continually update until the ITT closes.

The FAQ document will be published after the information call.

8.0 Instructions for tender responses

The Health Foundation reserves the right to adjust or change the selection criteria at its discretion. The Foundation also reserves the right to accept or reject any and all responses at its discretion, and to negotiate the terms of any subsequent agreement.

This work specification is not an offer to enter into an agreement with the Foundation, it is a request to receive proposals from third parties interested in providing the deliverables outlined. Such proposals will be considered and treated by the Foundation as offers to enter into an agreement. The Foundation may reject all proposals, in whole or in part, and/or enter into negotiations with any other party to provide such services whether it responds to this specification and request for response or not.

The Foundation will not be responsible for any costs incurred by you in responding to this specification and will not be under any obligation to you with regard to the subject matter of this specification.

The Foundation is not obliged to disclose anything about the successful bidders, but will endeavour to provide feedback, if possible, to unsuccessful bidders.

Your bid is to remain open for a minimum of 180 days from the proposal response date.

You may, without prejudice to yourself, modify your proposal by written request, provided the request is received by the Foundation prior to the proposal response date. Following withdrawal of your proposal, you may submit a new proposal, provided delivery is effected prior to the established proposal response date.

Please note that any proposals received which fail to meet the specified criteria contained in it will not be considered for this project.

9.0 Selection criteria

The complexity of this project means that the research partner must be able to draw on a range of appropriate methods, which favours proposals from multidisciplinary research teams. We anticipate proposals that draw on appropriate models, techniques or insights from health economics, economic geography, health geography or other relevant disciplines. The budget for this project has been set accordingly.

We would also welcome tenders from partnerships or consortia. For example, the research could be undertaken by one team who can draw upon a network of researchers with different skills and expertise. The research could also be undertaken by a consortium, but there will need to be one lead partner to provide quality assurance and project oversight.

Requirements:

- Skills and expertise in relevant research approaches and analytical techniques.
- Understanding of appropriate models, techniques or insights from health economics, economic geography, health geography or other relevant disciplines.
- Knowledge and awareness of health and care services in England and supply issues.
- Appropriateness of proposed methods.
- Appropriate project management, risk management and quality assurance expertise.
- Demonstrable capacity to deliver the evaluation(s) on time, on budget and to the required standard, with proven ability to flex resource capabilities and adapt to changing environments where required.
- Ability to work collaboratively with a range of stakeholders.
- Strong communication skills.
- Value for money.
- Willingness to travel to project sites and events.

10.0 Selection process

Please complete your application via our online portal by midday, Wednesday 19 July 2023. We will not accept proposals submitted after this deadline or in any other format.

We will be hosting an information call during the week commencing 24 April. Please email research@health.org.uk if you would like to attend.

If you have any queries about the application process which are not addressed in this document, please email them to research@health.org.uk.

Interviews and selection will take place on **8 or 9 August 2023.**

We will communicate the final decision during the week commencing **14 August 2023.**

It is important for suppliers to demonstrate that the right calibre of staff would be managing the project from the outset. Therefore, we would encourage you to make sure that the core project team members are available for interview if you are shortlisted.

The exact start date will be agreed following the final decision, but we intend to have an inception meeting with the chosen supplier during the week commencing **4 September 2023**.

11.0 Other information

The Foundation reserves the right to adjust or change the selection criteria at its discretion. The Foundation also reserves the right to accept or reject any and all responses at its discretion, and to negotiate the terms of any subsequent agreement.

This ITT is not an offer to enter into an agreement with the Foundation, it is a request to receive proposals from third parties interested in providing the deliverables outlined. Such proposals will be considered and treated by the Foundation as offers to enter into an agreement. The Foundation may reject all proposals, in whole or in part, and/or enter into negotiations with any other party to provide such services whether it responds to this ITT or not.

The Foundation will not be responsible for any costs incurred by you in responding to this ITT and will not be under any obligation to you with regard to the subject matter of this ITT.

The Foundation is not obliged to disclose anything about the successful tenderers, but will endeavour to provide feedback, if possible, to unsuccessful tenderers.

Your tender is to remain open for a minimum of 180 days from the proposal response date.

You may, without prejudice to yourself, modify your proposal by written request, provided the request is received by the Foundation prior to the proposal response date. Following withdrawal of your proposal, you may submit a new proposal, provided it is delivered before the original proposal response date.

Please note that any proposals received which fail to meet the specified criteria contained in it will not be considered for this project.

12.0 Confidentiality

By reading/responding to this document, you accept that your organisation and staff will treat the information contained within it as confidential and will not disclose it to any third party without prior written permission being obtained from the Health Foundation.

The Foundation may ask suppliers to complete a confidentially agreement.

13.0 Conflicts of interest

The Health Foundation's conflicts of interest policy describes how it will deal with any conflicts which arise as a result of the work which the charity undertakes. All external

applicants intending to submit tenders to the Foundation should familiarise themselves with the contents of the conflicts of interest policy as part of the tendering process and declare any interests that are relevant to the nature of the work they are tendering for. Applicants can find and download the policy from the Foundation's website at the following location: www.health.org.uk/COI.

References

[1] McCann P. Perceptions of regional inequality and the geography of discontent: insights from the UK. Regional Studies (www.tandfonline.com/doi/full/10.1080/00343404.2019.1619928).
[2] Department for Levelling Up, Housing and Communities. *Levelling Up the United Kingdom White Paper: Executive Summary*. 2022 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1095544/Executive_Summary.pdf).
[3] Maybin J. *The reconfiguration of hospital services in England.* The King's Fund. 2007 (www.kingsfund.org.uk/sites/default/files/field/field_publication_file/briefing-reconfiguration-hospital-services-england-jo-maybin-kings-fund-november-2007.pdf).
[4] Gaynor M, Town Robert J. *Competition in Health Care Markets.* The University of Bristol. 2012 (www.bristol.ac.uk/media-library/sites/cmpo/migrated/documents/wp282.pdf).
[5] Collins B. *Foundation trust and NHS trust mergers 2010 to 2015*. The King's Fund. 2015 (www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Foundation-trust-and-NHS-trust-mergers-Kings-Fund-Sep-2015_0.pdf).
[6] Fifth of GP practices have closed or merged since NHS England was formed. www.gponline.com. 2022 (www.gponline.com/fifth-gp-practices-closed-merged-nhs-england-formed/article/1790429).
[7] Charles A. *Integrated care systems explained: making sense of systems, places and neighbourhoods.* The King's Fund. 2022 (www.kingsfund.org.uk/publications/integrated-care-systems-explained).
[8] Davidson D, Ellis Paine A, Glasby J et al. Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study. *Health Serv Deliv Res* 2019;7(1) (www.journalslibrary.nihr.ac.uk/hsdr/hsdr07010#/abstract).
[9] Ewbank L, Thompson J, McKenna H et al. *NHS hospital bed numbers: past, present, future.* The King's Fund. 2021 (www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers).
[10] McCann P. Perceptions of regional inequality and the geography of discontent: insights from the UK. *Regional Studies* 2020;54(2) (www.tandfonline.com/doi/full/10.1080/00343404.2019.1619928).
[11] Department for Levelling Up, Housing and Communities. *Levelling Up the United Kingdom White Paper: Executive Summary*. 2022 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1095544/Executive_Summary.pdf).
[12] *Ibid.*
[13] Vaughan L, Edwards N. The problems of smaller, rural and remote hospitals: Separating facts from fiction. *Future Healthc J.* 2020;7(1):38-45. doi: 10.7861/fhj.2019-0066. PMID: 32104764; PMCID: PMC7032574 (https://pubmed.ncbi.nlm.nih.gov/32104764/).
[14] Smallbone D, Kitching J, Blackburn R. *Anchor institutions and small firms in the UK: a review of the literature on anchor institutions and their role in developing management and leadership skills in small firms.* UK Commission for Employment and Skills. 2015 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414390/Anchor_institutions_and_small_firms.pdf).
[15] Wickens C, Jefferies D, Sircar S. *Are community diagnostic centres really moving care closer to home?* The King's Fund. 2022 (www.kingsfund.org.uk/blog/2022/10/are-community-diagnostic-centres-really-moving-care-closer-home).
[16] In a written question to the House of Commons, Dan Corden and Maria Caulfield discussed the location of CDCs that are (a) open and (b) planned as of July 2022 (HC Deb 5 July, 2022, UIN 31211) (https://questions-statements.parliament.uk/written-questions/detail/2022-07-05/31211).