King's Fund Briefing

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The Reconfiguration of Hospital Services

The reconfiguration of acute and community hospital services in England has recently come to dominate discussions about NHS reform – both locally and nationally – and is provoking a great deal of controversy. This briefing examines the background to the current debate, identifies the main factors driving the changes, explores how these changes are likely to affect patients and asks whether the new models of care will offer value for money.

What changes are being proposed?

The term 'reconfiguration' encompasses a wide variety of proposed changes. These include changes to physical infrastructure – for example, the closure of whole buildings, or the closure of wards or departments within larger institutions and the transfer of those services elsewhere; changes to the nature of the services provided by the NHS – for example, the level of specialism available at accident and emergency (A&E) or maternity departments; and changes to the location of the services provided – for example, the transfer of routine care of chronic conditions, such as diabetes, to non-hospital settings or the performance of diagnostic tests outside of hospitals.

Just as reconfiguration implies a wide variety of proposed changes, there is no simple set of factors driving these plans to re-organise services. Factors may include the following: the pressure to achieve financial balance across the NHS at a time when many trusts are facing deficits; the introduction of the government's recent policy to move more care out of hospitals and into the community on the grounds of improving efficiency and access; the re-organisation of care on the grounds of evidence that some services are safer when delivered in certain configurations; and the need to respond to external changes, such as the extension of the European Working Time Directive to cover the hours of junior doctors.

The precise meaning of reconfiguration is further clouded by the debate that currently surrounds many of the proposed changes – a debate that has ignited strong community loyalties to local institutions, mobilising local political forces and making rational argument more difficult.

As yet, there is no comprehensive list of all the planned reconfigurations. In October 2006, 15 per cent of England's newly reorganised primary care trusts (PCTs) were in the process of consulting on changes to the organisation of acute hospital services in their local area.[1] It was recently revealed that the Department of Health had produced a 'heat map' showing which hospitals had been the subject of media reports. According to the map, there had been 35 reports of what the Department of Health termed 'acute multi-site working'. This phrase may be referring to reconfigurations, but there were no further details to clarify whether this was the case.[2]

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At the turn of the year, the Department of Health will be putting proposals for a 'whole series of reconfigurations' out for consultation.[3] As a result of the reconfigurations, specialised and emergency care look set to be centralised within fewer, large hospitals, while more outpatient and diagnostic procedures will be provided in community-based facilities. These changes are likely to result in a reduction in the scope and scale of services offered by some hospitals, which could mean the closure of some wards, services or entire hospitals.

A brief history of hospital configuration

Reconfiguration has become conflated with other aspects of the government's reform agenda (for example, increased use of the private sector) and has triggered off a level of public and professional protest within the NHS that is unprecedented within Labour's administration.

However, the underlying debate about how hospitals should be reconfigured is not a new one. Previous administrations have also grappled with the tensions between the strength of community (and professional) loyalty to local institutions, and the implications of new evidence about the safety and clinical- or cost-effectiveness of services – particularly where the evidence calls into question the viability of local institutions.

The size and location of those local institutions are more the product of historical chance than of a rational planning exercise. When the NHS was established in 1948, a patchwork of hospital services that had previously been run by local authorities and voluntary organisations were nationalised. Some areas had very few services while others had a duplication of services. An increase in the amount of money available for hospital building projects in the early 1960s and recognition of the 'greater interdependence of the various branches of medicine'[4] prompted a review of existing services. In 1962, Enoch Powell, the Minister of Health at the time, published the *Hospital Plan for England and Wales*, which announced that large district general hospitals (DGHs) of 600–800 beds, serving populations of 100,000–150,000, should form the mainstay of hospital provision over the coming decades. These DGHs would provide almost all inpatient and outpatient care, in addition to maternity and geriatric services. The majority of DGHs would have an A&E department and would be able to offer care in most specialties. The remaining specialties, such as radiotherapy and neurosurgery, would be offered only in larger teaching hospitals or other specialised centres.

International economic pressures during the mid-1970s meant that less money was available for the hospital building programme than had been envisaged when the *Hospital Plan* was published. Services developed along different lines in different regions, with some areas concentrating services into large sites and others retaining their smaller hospitals. By 1980, the Department of Health recommended that, while the model of the large DGH should be retained, the services they provided could be delivered across a number of sites using existing medium-sized hospitals.[5] As a result of this, the DGH survived into the 1990s as an 'organisational concept',[6] which in many areas was realised as a group of smaller sites located fairly close together, rather than as one large hospital site as originally conceived.

In addition to proposing a model of hospital care based on the large DGH, the 1962 *Hospital Plan* had envisaged a role for small community hospitals in providing outpatient, maternity and long-stay geriatric services. The benefits of small community hospitals were re-emphasised in the Department of Health's 1980 paper on the future of hospital services, which argued that local hospitals were more accessible for patients and staff as well as being easier to manage than their larger counterparts. Nevertheless, throughout the post-war period, large numbers of small hospitals – many offering only a single service such as maternity care – have closed, typically against strong local opposition. As a result, the average DGH today serves a much larger catchment population than was originally envisaged in the 1962 *Hospital Plan*. There are now an estimated 160 hospitals offering acute care in most specialties.[7]

Labour's record on reconfiguration

Since the Labour government came to power in 1997, two themes have been developed: the desire to move less complex services out of hospital and into the community 'closer to home', wherever possible; and, more recently, the suggestion that certain specialist services should be concentrated into bigger hospitals on the grounds that they will provide a higher quality of care.

Care closer to home

The current policy of moving less complex care out of hospitals and into primary care and community-based facilities was initially proposed by the Department of Health as a way of reducing hospital bed use among the elderly. The Department's National Beds Inquiry (1998–2000) commissioned a review of evidence on the cost-effectiveness of such a strategy and found that the evidence was inconclusive.[8]

However, following on from the Inquiry, the Department of Health conducted a large-scale consultation of stakeholders and the public on a number of possible developments for hospital services, and this revealed 'near universal'[9] support for a system that would deliver more care closer to home rather than in hospital settings. It is worth noting, however, that the consultation also revealed that 'the majority felt that there was a need to at least maintain adequate numbers of acute beds';[10] so while respondents may have favoured care closer to home, they may not necessarily have been willing to tolerate an equivalent reduction in some hospital services. Nonetheless, an interest in providing more care closer to people's homes has underpinned official policy on service configuration since 2000.

Until now, service configuration has remained a low-order priority for the government. *The NHS Plan* (2000) focused on increasing the number of new hospital buildings, promising an additional 100 by 2010, some of which would be delivered through the private finance initiative (PFI). In addition, events that took place in Kidderminster in 2001 – when a junior minister lost his parliamentary seat to retired consultant Richard Taylor who led a campaign against plans to downgrade a local hospital – underlined the serious political risks of hospital closures.

The development of services 'closer to home' emerged as a priority in the Department of Health reports *Keeping the NHS Local* (2003) and was developed more fully in the White Paper *Our Health, Our Care, Our Say* (2006).[11] The range of services available in a community is principally the decision of local NHS organisations; however, the government has recently established both incentives and targets to help steer local planning in line with national policy objectives. These include: a stipulation that plans for any major building projects will only be approved if they are compatible with the model of concentrating more activity and resources in primary and community care; and £750 million of capital funding set aside for building and renovating community hospitals and polyclinics over the next five years.[12]

The government has been accused of sending conflicting messages on the subject of community hospitals – failing to intervene when local community hospitals close, while simultaneously offering funding for the renovation and building of new facilities. The government's response has been that decisions on the availability of such facilities are a matter for local PCTs. It is also important to remember that some community hospitals may have served functions in the past that differ significantly from the services they will be expected to provide in the future. For example, a community hospital that has previously provided maternity care and is in a poor state of repair may not be the best facility from which to provide diagnostic tests in the future. To complicate matters further, there are differences in people's understanding of the term 'community hospital'; for some this implies a place that offers rehabilitation and convalescence – care that now might be better delivered to patients at home.

A recent policy development that seems to conflict with the government's stated agenda of moving more care closer to home is payment by results. Under this system, hospitals are paid a set price for the care that they provide to each patient they treat. This creates an incentive for hospitals to increase

rather than reduce the number of patients that they treat in hospital in order to maximise their income. Recognising this potential conflict, the Department of Health is in the process of considering how the price for NHS treatments – the tariff – could be redesigned in order to enable and encourage components of patient care to be provided in community and primary care settings. For example, it might be possible for a patient recuperating after an operation to be cared for in a community facility rather than in the acute hospital that carried out the procedure; in which case, part of the payment that currently all goes to the acute hospital would instead go to the community facility. In addition, the Department of Health has adapted the tariff from the start of the 2006/7 financial year so that hospitals are only paid half of the usual tariff price for emergency admissions beyond an agreed number.[13]

Specialist care further away from home

The 2006 White Paper *Our Health, Our Care, Our Say* stated that newly developed primary care and community facilities would be complemented by specialist hospitals. These would focus on providing complex surgery requiring general anaesthetic as well as fully-fledged emergency departments. This proposal, and its implications for existing non-specialist DGHs, has yet to be fully fleshed-out by the government. However, developing specialist centres, which are by definition fewer and more dispersed than DGHs, is not a new idea. Developing such centres for cancer care has been government policy since the publication of the *Cancer Plan* in 2000.[14] Recommendations to centralise hospital services – primarily emergency services – in order to secure high-quality clinical care have also come from the Audit Commission, who proposed centralising A&E services in 1996, and the Royal College of Surgeons, who have been calling for bigger hospitals with large catchment areas since 1997.[15] [16]

The fact that the development of specialist centres may mean longer travelling times for some patients was confirmed in the 2006 government discussion document *Direction of Travel for Urgent Care*.[17] It proposed that urgent medical cases that cannot be treated by ambulance staff or in minor injury units should be taken to a hospital with the right specialist facilities, which may not necessarily be the nearest acute hospital: 'patients with a heart attack... could be taken straight to a hospital with cardiac catheterisation laboratories where they can get primary angioplasty, not necessarily via the nearest A&E.'[18]

It is already the case that some patients requiring highly specialised care are transferred to a specialist hospital from their local DGH. For patients in this situation, a system in which they are taken directly to the specialist hospital by the ambulance, rather than via their local DGH, might actually reduce the time they spend in transit.

Why are changes being proposed now?

There are a number of reasons why the reconfiguration of health services is being proposed now. The continuing trend toward the specialisation and sub-specialisation of medicine favours a health system that comprises larger hospitals offering a wide range of specialist care, rather than a greater number of comparatively smaller 'general' hospitals, as envisaged in the *Hospital Plan*. Drivers towards reconfiguration that have emerged more recently include: the direct and indirect consequences of government policy; financial pressures at both national and local levels; and the need to reduce the working hours of junior doctors in line with the implementation of the European Working Time Directive.

Consequences of government policy initiatives

In addition to those policies that explicitly support the government's 'care closer to home' agenda, a number of other recent policy initiatives are having an impact on the way services are configured. Chief among these are patient choice and (as noted above) payment by results. Patient choice was rolled out across England in January 2006; since then, all patients referred for hospital treatment by their GP should have been given a choice of providers, including independent sector treatment centres as well as local NHS and foundation hospitals. Introduced alongside patient choice was payment by results.

Since these payments form a significant proportion of hospital income, any hospital failing to attract sufficient numbers of patients could become financially unviable – a prospect that is likely to prompt trusts to consider whether they will be able to continue providing services in the same way in the future.

Financial pressures

Financial pressures within the NHS are being felt at both local and national levels, adding urgency to decisions about which services should be provided, where, how and by whom. At a local level, the presence of financial deficits in individual NHS organisations is forcing trusts to consider which services they can afford to provide and which must be cut. In some trusts, financial problems that have been exacerbated by a regional-level failure to rationalise services in the past have prompted a review of the services delivered across the local health economy – for example, in parts of Sussex. At a national level, the anticipated end to large increases in funding for the NHS after 2008 is prompting the Department of Health to focus on how the delivery of health services across the system as a whole can be made more cost-effective.

The European Working Time Directive

An additional and even more immediate pressure towards reconfiguration comes from the implementation of the European Working Time Directive for junior doctors, which will take full effect from 2009. After this date, the working hours of junior doctors will have to be reduced to a maximum of 48 hours a week. Furthermore, the European Court of Justice has ruled that time spent asleep but 'on call' by junior doctors in hospitals counts as work time. Prior to this directive, junior doctors could spend a maximum of 72 hours a week 'on call'. Given that hospitals use junior doctors to provide medical cover overnight, a reduction in the hours that they can work means that hospitals with small numbers of trainee doctors may no longer be able to provide 24-hour medical cover. Those hospitals that are able to continue providing cover may need a greater number of consultants in order to supervise the increased number of junior doctors and to contribute more time to out-of-hours medical cover. These pressures create a further driver towards the centralisation of services, particularly emergency services, into fewer, large hospitals.

How will patients be affected by these changes?

Better care?

Since the late 1990s, a number of the medical Royal Colleges have been recommending the development of more specialist hospitals with larger catchment areas. The Royal College of Surgeons recently reiterated its 1997 recommendation that hospitals should have catchment areas of ideally 500,000, but at least 300,000, arguing that this is necessary to ensure that consultants in the main surgical specialties are available to provide emergency cover; to provide the necessary concentration of case-load for training trainees; and to ensure a sufficient workload to maintain surgical expertise in sub-specialties.[19]

Research conducted by the Department of Health suggests that for certain complex procedures, those surgeons and hospitals that perform a high volume of that procedure will have better patient outcomes in terms of healthy survival. This association is particularly strong for cardiology procedures, neurosurgery, liver transplants and major vascular surgery.[20] This evidence supports the case for centralising some complex, planned procedures.

There is less of a consensus as to whether this volumes–outcome association extends to more common procedures: in 2004 the Department of Health concluded that the research to date did not support 'any general prescription... that service concentration leads to improved outcomes for patients';[21] whereas a review conducted for NHS Scotland in 2005[22] found that in addition to the association being strong for some complex procedures, there was also a link between volume and outcomes for more common procedures.

As to how the quality of care provided in community or primary care settings compares with the same services provided in acute hospitals, there is not yet a developed body of research evidence from which firm conclusions can be drawn.

Access to services?

Proposals to centralise hospital services for complex procedures and provide more care closer to home will in theory make some services more accessible to patients and others more difficult to reach. Whether this matters in clinical terms is unclear. The Academy of Medical Royal Colleges has recently pointed to the risks to those living in remote areas if emergency services are concentrated into fewer hospital sites.[23] In other, more densely populated areas, the risks to patients created by the extra time taken for them to reach hospital may be lower. Some of the disadvantages created by reduced access (in all areas) may be offset by the better emergency facilities and staffing levels that the larger hospitals can offer.

However hospital services are organised, the impact on accessibility will depend critically on how services in the community are organised – specifically, whether community and primary care facilities can succeed in providing effective alternative local services for treating less complex emergencies that do not require the resources of an acute hospital. The question of who will assess patients in order to allocate them to the most appropriate service will also be key to the success of the reconfigurations.

Will providing more services in the community give better value for money?

In order for the reconfigurations to generate savings, the delivery of services in the community would need to be more cost-effective than it is in acute hospitals, and the new community and primary care services would need to replace rather than add to those currently provided by acute hospitals.

Evidence from research on the cost of providing services in community and primary care settings rather than in acute hospitals has yielded mixed results. Cost-effectiveness seems to vary between different types of community or primary care-based services.

For example, one randomised control trial of patients requiring non-urgent treatments for skin problems found that there was 'considerable additional cost' associated with treatment by a GP with Special Interests (GPwSIs) compared with traditional outpatient treatment.[24] By contrast, another study, which used a cost minimisation analysis to compare the cost of standard hospital care with early-discharge and home-based care for elderly patients, found that early discharge and home care was nearly 25 per cent cheaper than standard hospital care.[25]

In relation to the question of whether community facilities will replace rather than replicate some acute services, the government cites a research project that compared the hospital bed use of patients in the NHS with that of patients who were part of the Kaiser Permanente Health Plan in California.[26] The lengths of hospital stay among NHS patients were three times longer than those of patients in the Kaiser Permanente Plan, and the researchers attributed the shorter stays of the patients in California to the plan's use of intermediate facilities and home and community-based care plans.

However, there are a number of methodological issues that caution against drawing firm conclusions from this study. For example, as the researchers themselves acknowledge, the Kaiser programme had 'considerably more specialists per 100,000 population than the NHS',[27] in fact as many as three times the concentration of cardiologists, which could account for the shorter lengths of hospital stay.

There is some evidence to suggest that GPs with Special Interests (GPwSIs) do not reduce demand for outpatient services, and that minor injury units, NHS walk-in-centres and NHS Direct do not reduce demand for A&E services. An assessment by the Audit Commission of GPwSIs found that, in 80 per cent of the PCTs examined, the introduction of these new services had not reduced hospital waiting times.[28] Two more recent studies, conducted for the NHS Service Delivery and Organisation R&D

Programme (SDO), also found that the introduction of GPwSI clinics did not reduce waiting times at local hospital outpatient clinics.[29]

A systematic review of A&E services also conducted for the SDO reported that the presence of minor injury units, NHS walk-in centres and NHS Direct has not been shown to reduce attendances to A&E departments – except possibly where they are co-located within A&E departments.[30]

In a recent report on the future of the acute hospital, the NHS National Leadership Network concluded that there was no guarantee that reconfiguration would necessarily lead to cost savings and recommended that the cost impacts of different service models should be monitored at a national level 'as a matter of urgency'.[31]

Who has the final say on whether local services are reconfigured?

Decisions about the reconfiguration of health services are the responsibility of local PCTs and strategic health authorities. Although the government argues that many of its reform principles are likely to be popular, for instance, 'care closer to home', in reality reconfigurations are often unpopular, being perceived as reducing, rather than enhancing, access to services. In addition, it is not at all clear what the phrase 'closer to home' really means. For example, single handed GPs have been encouraged to move in with other larger practices – effectively moving care further away from home for their patients – yet this is generally regarded as a positive move. And, of course, concentrating specialist care in fewer hospitals is likely to mean more travelling for some patients and their families.

Following commitments made in *The NHS Plan* (2000) to introduce greater accountability and patient involvement in decisions about local health services, the Health and Social Care Act 2001 created a legal duty for NHS organisations to consult their local populations on the ongoing planning of health services and on any decisions that could affect the operation of the local health service. The Act also requires local NHS bodies to consult their local authority's 'overview and scrutiny committee' (OSC) on any 'substantial' plans for developing or changing the provision of health services in the local area.[32]

Since 2002, overview and scrutiny committees have had the power to refer decisions by the NHS to the Secretary of State for Health if they consider that either the public consultation process was inadequate or that the proposed change is not in the interests of the local area. By the end of July 2006, 16 such cases had been referred to the Secretary of State by OSCs.[33] The rate of referrals has increased substantially, with one in 2002, none in 2003, and 14 between 2005 and mid-2006.[34] This suggests that the number of consultations is both increasing (perhaps prompted by financial pressures) and/or that local disagreement with reconfiguration proposals is growing.

The Secretary of State can choose to refer cases to the Independent Reconfiguration Panel – a group of experienced clinicians and managers who offer advice and guidance on managing configuration changes – but the Secretary of State's decision is always final. Just two of the 16 cases received by the Secretary of State to the end of July 2006 were referred to the Independent Reconfiguration Panel.[35]

A published summary of some of the decisions taken by the Secretary of State on contested reconfigurations over the past four years[36] suggests that the majority have supported the original decision of the local NHS. There was just one reported case of the Secretary of State supporting the objections made by an OSC against the decision of the local NHS.

What happens next?

Although there is pressure on the NHS to reconfigure quickly, it is not yet clear what range of options will emerge. The government has commissioned a number of projects that seek to identify new ways of providing good quality care while preserving easy access.

A series of pilot programmes was launched in 2003, following publication of the Department of Health paper *Keeping the NHS Local*. One of these programmes aimed to develop networks among groups of hospitals in certain areas to enable the smaller hospitals to remain open despite not having some specialist facilities or overnight medical cover. Also launched in 2003 was the Hospital at Night project, developed by the NHS Modernisation Agency and the Joint Consultants Committee. This introduced the concept of multi-disciplinary teams providing medical cover at night across four hospitals, thus reducing the reliance on junior doctors. An assessment of the four Hospital at Night pilots published in 2005 found that the model had been successful in helping hospitals to comply with the European Working Time Directive and in improving care for patients and the lives of hospital staff.[37]

In 2006, 30 'demonstration sites' located in community facilities were set up at the request of the Department of Health with the aim of establishing 'appropriate models of care that can be used nationwide'.[38] These sites will experiment with using GPwSIs and specialist nurses to deliver simple diagnostic tests, after-treatment care, outpatient follow-up appointments and support for people with long-term conditions. They may also provide outpatient and day-case care. Once safe and effective models have been established, the government says it will be the responsibility of GPs and PCTs to commission care from these new services.

The Department of Health is developing a web-based toolkit called SHAPE (Strategic Health Asset Planning and Evaluation), which, when provided with local data on clinical activity, the physical design of services and projections on future patterns of need, will operate as a 'scenario-planning tool', enabling the user to establish an 'optimum service delivery model and to identify investment needs and disinvestment opportunities to support delivery of the model'.[39]

In terms of reconfiguring emergency services, the Department of Health is planning to work with clinicians towards the end of 2006 to 'identify more clearly what is clinically safe'.[40] However, they have also advised commissioners to map the needs of their communities and develop a plan for services based on the principle of delivering them in the community rather than in acute hospitals where possible.

The configuration of acute services has been a political issue for almost as long as the NHS has been in existence; however, present government policy, the effects of financial deficits and the pressures created by the extension of the European Working Time Directive to cover junior doctors have given the issue a new sense of urgency. The partial nature of the evidence base and the potential for short-term financial and political concerns to influence local decisions make it all the more important that there is real transparency about the costs and benefits of proposed changes.

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[32] What constitutes a 'substantial' plan or change was not defined by the Act and the Department of Health has advised that this is something that organisations should agree among themselves at a local level.

[33] Burnham A, Minister of Health (2006). 'Parliamentary Answer'. Hansard, HC (series 5), col 1248W, 25 July.

[34] Calculated by comparing Health Select Committee (2006). 'Letter from Rosie Winterton MP, Minister of State, Department of Health, to Dr Richard Taylor MP: Annex A'. *Health Select Committee Minutes of Evidence*, 26 January. House of Commons website. Available at: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/866/6012601.htm (accessed on 17 November 2006), with Burnham A, Minister of Health (2006). 'Parliamentary Answer'. Hansard, HC (series 5), col 1248W, 25 July.

[35] Burnham A, Minister of Health (2006). 'Parliamentary Answer'. Hansard, HC (series 5), col 1248W, 25 July.

[36] *See* Health Select Committee (2006). 'Letter from Rosie Winterton MP, Minister of State, Department of Health, to Dr Richard Taylor MP: Annex A'. *Health Select Committee Minutes of Evidence, 26 January.* House of Commons website. Available at: www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/866/6012601.htm (accessed on 17 November 2006).

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