

Reconfiguring hospital services

Briefing

September 2011

Key messages

NHS hospitals face mounting financial and workforce pressures. Reconfiguration of hospital services can provide a powerful means of improving quality in an environment where money and skilled health care workers are scarce. In some places, reconfiguration is needed urgently, in order to protect patient safety. However, the current reconfiguration process is lengthy, wasteful and carries significant risks to the delivery of safe services. There are also risks that prospective legislative changes will make an already complex and bureaucratic process become more so and that there will be a lack of the strategic leadership required to lead and deliver change. A major stumbling block in many hospital reconfigurations is public concern and political opposition. While there are opportunities to improve the process within the proposed legislative framework, we believe that ways need to be found to de-politicise the process and to make decisions on the basis of quality, safety and efficiency, while retaining strong public engagement in local decision-making.

Opportunities to improve reconfiguration within the proposed legislative framework

The reconfiguration process within the proposed legislative framework can be improved in a number of ways.

- **Setting and enforcing minimum standards for clinical care.** The NHS Commissioning Board should set minimum evidence-based quality standards for key clinical conditions in conjunction with the National Institute for Health and Clinical Excellence (NICE) and the professional bodies. These should be incorporated into the essential standards of quality and safety set by the Care Quality Commission (CQC) as part of their registration requirements.
- **Improving the quality of public engagement.** Health and wellbeing boards should 'host the conversation' between clinicians and local populations and provide active support to clinical commissioning groups and others. Links should be established between local health and wellbeing boards and clinical senates.
- **Improving the scrutiny function.** The basis of referral from overview and scrutiny committees to the Secretary of State should be tightened up. One option is for the referral to focus on whether there has been adequate consultation. Committees should also be required to publish their members' political mandates alongside their deliberations to ensure transparency.
- **Strengthening clinical leadership.** Clinical senates should be asked to advise on clinical reconfiguration and identify clinical areas in which service reconfiguration is

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needed. Strategic leadership is also needed across multiple providers, and therefore multiple clinical commissioning groups, in conjunction with the proposed clinical senates.

- **Ensuring the economic regulator takes account of clinical and quality issues in its deliberations.** Monitor should be explicitly required to take account of the views of relevant clinical senates and of other clinical advice – for example, from professional bodies – when taking action to protect service continuity or assessing whether a trust can change the terms of their licence and the range of services that they provide. A consistent approach is required between Monitor and the CQC.
- **Speeding up the process.** Maximum timescales should be set for the scrutiny function and for decisions by the Secretary of State.
- **Clarifying roles, responsibilities and accountabilities with respect to reconfiguration decisions.** In particular, setting out who will lead strategic reconfiguration planning in future and how to resolve any conflicting views from the many different statutory bodies that might be involved in the reconfiguration process including clinical commissioning groups, health and wellbeing boards, Monitor, the CQC and the NHS Commissioning Board.

Options to de-politicise the process

There are two more radical options to de-politicise the current process:

- allow the Independent Reconfiguration Panel, rather than the Secretary of State, to be the final arbiter on reconfiguration proposals
- use an independent body, with a mandate for change, to tackle issues in particular areas.

Introduction

This briefing considers why hospital services need to be reconfigured, why the NHS has such difficulty reconfiguring hospital services, and how the process might be improved. The focus of our discussion is the reconfiguration of clinical services, not trust mergers or other changes in governance. As Fulop *et al* (2011) have pointed out *Reconfiguration is that measure of change which directly addresses operational rather than structural change: hospitals may merge, form networks, or change their divisional or governance structures, without reconfiguring services.*

Our work has been informed by discussions with stakeholders across the system including the chief executives of trusts, commissioners, and those formally involved in the process at local and national level, including a number of the Royal Colleges.

Context

Over the life of the NHS, hospital services have been subject to continued reorganisation and rationalisation. In the past 50 years, in line with international trends, the number of acute hospitals has reduced by 85 per cent,¹ and the number of sites at which elements of highly specialist care is delivered has reduced even further. In England, general acute care is now delivered in just over 200 hospitals and at the same time the average size of hospital has grown from 68 beds (Ministry of Health 1962) to just over 400 beds,

¹ Author calculation based on current beds and estate information (Department of Health) and information in the 1962 Hospital Plan.

the average acute trust (which may have multiple hospital sites) has just over 580 beds (Department of Health 2011c).

These changes reflect developments in medical practice. Advances in medicine and surgery have driven clinical staff and equipment to become more specialised. As skilled specialist staff are scarce and budgets are limited, services have been centralised onto fewer, larger sites, in order to ensure patients are cared for by staff with the necessary skills and supporting specialist equipment. In addition, there has been decreasing reliance on bed rest as part of treatment; for example, most routine surgery is now undertaken as day surgery. The average length of stay in hospital is currently just less than six days and 80 per cent of all patients have stays of less than three days (HES 2009/10). In the past five years the number of acute beds in England has fallen by just under 9,000 (8 per cent) to just over 100,000 beds (Department of Health 2011a).

The future drivers of reconfiguration

Demographic changes and the shifting burden of disease will require a fundamental shift from the hospital as the core focus of health service delivery to the community. Recent reports by the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Paediatrics and Child Health (RCPCH) lay out arguments for significant change:

The combined force of the National Health Service Reforms and workforce and financial pressures, against a backdrop of rising demand, increasing complexity and changes in demographics, means that the delivery of women's health care in the current configuration cannot be sustained.

(RCOG Expert Advisory Group Report 2011)

In the case of children's services, the RCPCH (2011) argue that to maintain quality in the light of constraints on the workforce, the number of paediatric inpatient sites needs to be reduced from 218 to approximately 170.

The Royal College of Physicians (RCP) has highlighted a need for greater senior medical input 24 hours a day, 7 days a week; reductions in the number of consultants available to deliver this will create further pressure to reconfigure services.

The Royal College of Physicians is concerned with the mounting evidence of sub-standard care delivered to patients who are admitted to hospital in the evening and at the weekend, and believes that this is related to the difficulties in providing sufficient input to these patients from consultants. The supervision and training of junior doctors is also adversely affected by a lack of senior input at these times... The RCP believes that there is now an urgent need to review rotas and the structure of the entire medical team to ensure that medical inpatients receive direct input from consultant physicians on a seven day a week basis.

(Royal College of Physicians 2010)

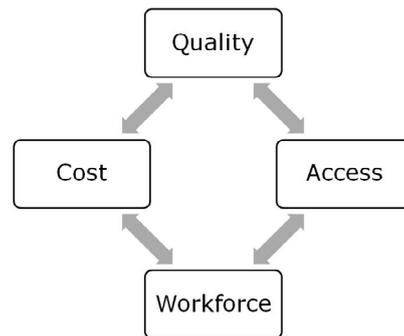
The need for change is also recognised by the current Secretary of State, Andrew Lansley (in McLellan and Golding 2011): *It's impossible for us to achieve the changes we are talking about without there being changes in the capacity of acute hospitals and the configuration of acute hospitals. Whether there are fewer in total is a moot point.*

In any reconfiguration of hospital services there are four interlinked drivers: quality (including safety), workforce, cost and access (see Figure 1). The challenge is to try to arrive at a configuration that optimises all these elements - as far as this is possible given the complex trade-offs that exist between them. Quality considerations include: access to highly trained professionals in all disciplines, compliance with clinical guidelines, access to diagnostic technologies and other support services, as well as strong clinical

governance and, for some conditions, the time it takes to access services. There are trade-offs between the quality and financial gains achievable through the concentration of services and the social and clinical costs to the patient of reduced access. There are also inter-dependencies between services – for example, withdrawal of paediatric services can threaten obstetric services, which rely on paediatricians to provide care for the newborn child.

Below, we consider the current pressures for change within each element. We also consider the evidence available to help local decision-makers arrive at optimal solutions.

Figure 1: Drivers of hospital configuration



Quality and Safety

There is wide variation in the quality of care delivered by NHS hospitals. Reconfiguring services can be a powerful means of addressing this variation.

There has been a wealth of clinical evidence for many years that specialist clinical services such as stroke, trauma and heart surgery should be concentrated in fewer centres. This would allow the latest equipment to be sited with a critical mass of expert clinicians who regularly manage these challenging clinical problems, and are backed by the most up to date research. The greater volumes of patients mean that doctors are better at spotting problems and treating them quickly. Survival and recovery rates would improve markedly with many lives saved.

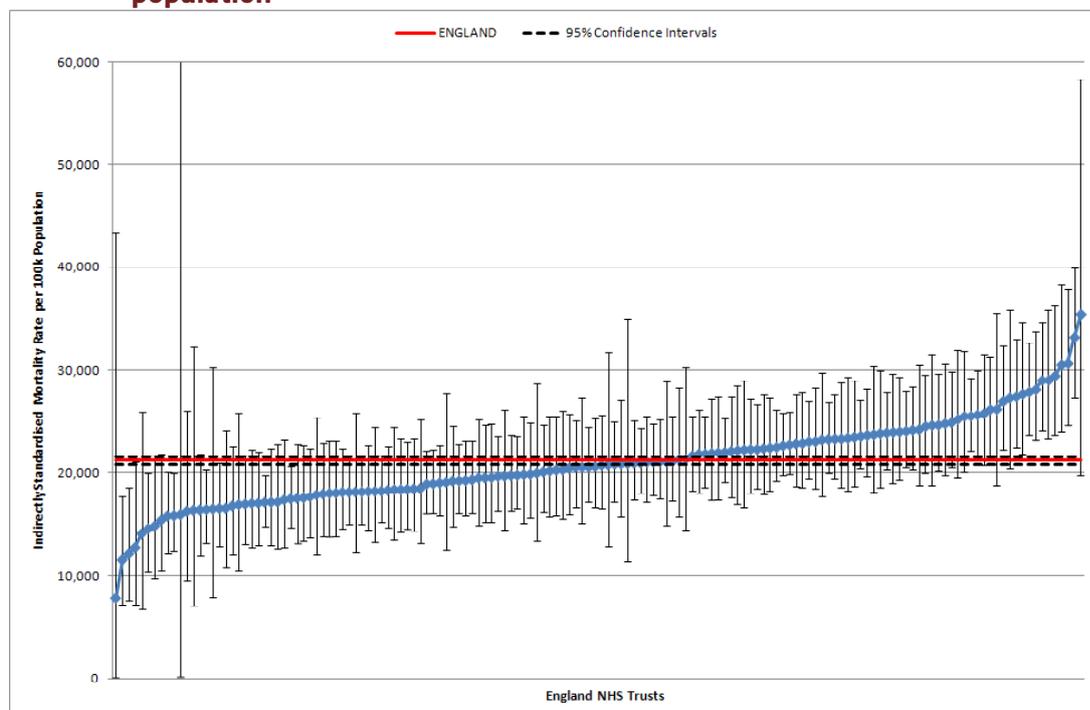
(Letter from Presidents of Academy of Medical Royal Colleges and others to *The Guardian*, 28 April 2010).

In London, it has been estimated that the recent reconfiguration of stroke services will save more than 400 lives a year (NHS London 2010). This is through the establishment of stroke networks that have concentrated specialist stroke expertise and diagnostics in fewer units, while retaining local access to stroke rehabilitation services in local hospitals. Ambulance protocols ensure that patients who will benefit from specialist intervention are taken to units that can offer this expertise 24 hours a day, 7 days a week.

Figure 2 shows the variation in stroke mortality rates across acute hospital sites across England. The lowest standardised rate of mortality within 30 days of emergency admission to hospital following a stroke was 7,795 per 100,000 population, and the highest standardised rate of mortality within 30 days of emergency admission to hospital following a stroke was 35,389 per 100,000 population, a greater than fourfold difference. Ignoring confidence intervals, if all trusts performing over the 25th percentile were to improve their outcomes to the rate of the top-performing quartile (18,141 deaths per 100,

000 standardised population) there would be 2,117 fewer deaths per year from stroke in England.

Figure 2: Deaths within 30 days of emergency admission to hospital: stroke (ICD10 codes: I61-I64), all ages, 2008/9 standardised to 2004/5. Indirectly age and sex standardised mortality rate per 100,000 population



Source: National Centre for Health Outcomes Development. Website. www.nchod.nhs.uk
(Data path: Home page>Compendium Indicators>Indicator Specifications>Alphabetically>Deaths within 30 days of emergency admission to hospital: stroke)

NB - Because we are measuring death a lower rate is 'good' and a higher rate is not so good.

There is good evidence to support centralisation of some services like stroke and trauma and highly specialist surgery such as children's heart surgery (Spurgeon *et al* 2010, NHS Specialised Services, 2011). But for many other conditions there is no clear causal link between volume and outcome and where there is a link, the threshold for quality improvement can be quite low (Glanville *et al* 2010). It can be just as important to look at other factors such as nurse staffing (Friese *et al* 2008), hospital system resources (Bellal *et al* 2009), compliance with guidelines and knowledge transfer (Schell *et al* 2008). A more compelling and linked driver for reconfiguration of services in many trusts is their capacity to provide junior and senior medical cover 24/7.

Workforce

As indicated above, there are particular pressures on the medical workforce, both senior and junior. England is relatively unique in its practice of training doctors in all district general hospitals and relying on relatively inexperienced doctors to provide the front line of medical cover, particularly out of hours (European Union Select Committee 2004). The introduction of the European Working Time Directive (EWTd), restricting the number of

hours junior doctors can work, has made it harder and more expensive for smaller units to ensure that medical expertise is available at all times of the day and night.

Since the application of EWTD to junior doctors there has been a 50 per cent increase in the number of junior medical staff required to fill a rota and provide 24/7 care, and many units have struggled to achieve this. The RCPCH conducted a survey in 2009 that suggested that almost three-quarters of the trusts that responded would not be able to cope with the demands placed on them by the changes; they have calculated that overall there is a shortfall of 600 doctors and as a consequence some paediatric units will have to close (RCPCH 2011, p 16): *Although it may appear desirable for every hospital to have an inpatient paediatric unit, given the finite number of trained paediatric doctors and nurses there is a limit to how many units can be staff safely.*

Pressures on the workforce are also likely to increase. The number of doctors in training is expected to fall after recent expansion and there are already shortages in some areas of nursing, for example, midwifery. There are alternatives that can be explored; skilled nursing staff can substitute for medical staff, in particular junior medical staff – for example, neonatal nurse practitioners can provide frontline care in neonatal units. Providing skilled staff with more direct support from staff without clinical training can also increase the amount of direct clinical care they can provide. Stronger teamworking across disciplines can also be more cost and clinically effective. However, the shortages in skilled nursing staff are so acute in some areas that these solutions will not avoid the need for service change. Workforce pressures are likely to be one of the most significant drivers of reconfiguration in the short to medium term.

Cost

The need to find the equivalent of £20 billion of productivity improvement savings over the next four years creates a major imperative. There are also a number of trusts for whom reconfiguration is expected to be necessary to achieve a sustainable financial position and foundation trust status. The introduction of a national tariff creates further pressures for hospital-based services; it disadvantages small units and those with high capital costs, as neither factor is reflected in its calculation. This exacerbates financial pressures and drives hospitals to adopt an economic strategy based on increasing activity.

As Palmer (2011) laid out, there are limits to the operational efficiencies that can be achieved within hospitals; to deliver more significant productivity improvements requires redesigning the way patients flow into, through and out of hospital, in order to allow reductions in hospital capacity and to make savings. Unfortunately, there is little evidence to guide health planners on the 'optimal' size of hospital services, not least because hospitals contain a disparate collection of services, each with their own efficiency drivers.

One of the most comprehensive assessments of hospital efficiency from the NHS Centre for Reviews and Dissemination (Aletras 1997) suggested that optimal hospital size lay between 200 and 600 beds. Normand (1998) suggested that there is no good evidence to demonstrate that closing small hospitals saves money but that merger of particular services (eg, intensive care, accident and emergency (A&E) services, cardiac surgery) could improve quality and save money. NHS London (Judd 2010) argues that the recent reconfiguration of stroke services has achieved improvement in quality as well as significant cost savings.

Overall, there is little evidence to demonstrate that significant cost savings can be achieved from reconfiguration in the short to medium term, and significant change frequently requires transitional and capital support. However, reconfiguration can deliver improvements in quality and safety without significant additional cost.

Access

There are strong political and policy pressures to sustain, and where possible increase, local access to services particularly those needed in an emergency such as A&E and maternity. There are also good social and quality reasons to provide good access to services. The majority of hospital users and their carers are elderly and many will rely on public transport or on others to take them to hospital; having to travel long distances can create difficult journeys. For people with life-threatening conditions delay is also linked to poorer outcomes (Nicholl *et al* 2007). However, it is the timing of the start of appropriate treatment, rather than the timing of arrival at hospital that affects the outcome, so interventions by paramedics and/or rapid access to the specialist team once at the hospital can offset or overcome the risk created by the additional travel time (Spurgeon *et al* 2010). It is also possible to create pathways of care that support the most care being delivered close to home with only specialist elements having to be delivered further away. This has happened in stroke care, with acute care provided in specialist centres and rehabilitation more locally, and in cancer care, with follow-on chemotherapy being delivered in local settings, in some cases in the home.

The current process

Reconfiguring hospital services can be a drawn-out and resource-intensive process. Under the 2006 NHS Act, commissioners are required to undertake public consultation on any proposals for 'significant' service change, such as the reconfiguration of clinical services. Before any proposals are taken out to public consultation, Department of Health guidance (Nicholson 2010) requires commissioners to assess whether proposals comply with four key tests for service change, set out by the current Secretary of State, the four 'Lansley tests':

- support from GP commissioners
- strengthened public and patient engagement
- clarity on the clinical evidence base
- consistency with current and prospective patient choice.

The Department of Health has not set specific thresholds for any of the four tests as *the process should be locally-led and designed, and needs to allow flexibility given that schemes will be at different points in their lifecycle.* (Nicholson 2010, p 3)

National guidance then requires proposals to go through a 'gateway' process to assess their robustness before going out to consultation (see box below and Figure 3).

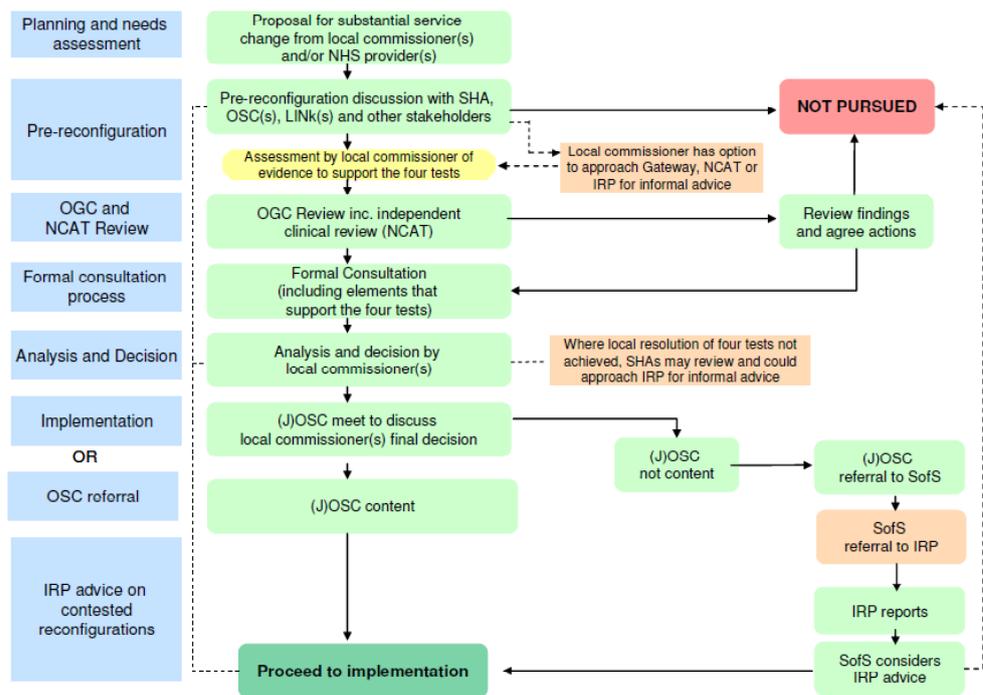
Gateway reviews

Gateway reviews are undertaken at key stages of a programme to provide assurance that it is ready to proceed to the next stage in its lifecycle. There are six different reviews that can be undertaken, depending on what point has been reached. Reviews are between 2-4 days in length and involve a team of 2-4 people.

- Gate 1 - Business justification
- Gate 2 - Delivery strategy
- Gate 3 - Investment decision
- Gate 4 - Readiness for service
- Gate 5 - Operations review and benefits evaluation

Figure 3: The revised reconfiguration process for new proposals

This flowchart summarises the full reconfiguration process. Not all service reconfigurations will necessarily go through every stage of this process, for example where it is agreed locally that full public consultation is not required, though the application of the four tests remains an integral and fundamental part of any process.



Source: David Nicholson, Department of Health, Letter: 29 July 2010

Commissioners may also seek an independent assessment of the clinical evidence base either by the National Clinical Advisory Team (NCAT) or another independent body of clinicians such as one of the Royal Colleges.

At the end of consultation process the local overview and scrutiny committee(s) (made up of elected representatives from the local authority) may refer proposals to the Secretary of State if it believes that the consultation has been inadequate or the proposals are not *in the best interest of the local population*.

If proposals are referred by the overview and scrutiny committee to the Secretary of State he or she may seek the advice of the Independent Reconfiguration Panel. The IRP is an advisory body that formally reviews and advises the Secretary of State on contested proposals. It also provides informal advice to organisations involved in developing proposals for NHS service change. The Independent Reconfiguration Panel's terms of reference require it to assess whether the proposals will provide 'safe, sustainable and accessible services for the local population', taking account of issues of quality, patient choice, GP referral preferences and the quality of public engagement. It also has to take into account 'any other issues Ministers direct'. The Secretary of State is not legally obliged to act on this advice and currently is the final arbiter on reconfiguration decisions.

Strategic health authorities (SHAs) and primary care trusts (PCTs) also play a significant role within the current framework. PCTs lead change at local level and the SHA oversees the whole process, deciding whether proposals have met the four tests, and whether to engage the Gateway Team and/or National Clinical Advisory Team. It is not clear who will adopt this oversight in the future, but we assume it will fall to the NHS Commissioning Board and its local outposts (see discussion below).

Problems with the current reconfiguration process

The public and local politicians find it hard to accept change to hospital services, often because the case for change is not well articulated. Hospitals play a role in the community above and beyond that of health care provider. Professor Naomi Fulop (personal communication, July 2011), who has carried out significant research in this area, described to us their importance: *They are the living embodiment of public services, they are deeply symbolic, they're bigger even than the NHS, they are the public's symbol of public services and a safety net and that's really important to understand.*

This resistance to change means that the current process can be protracted and expensive. Its drawn-out nature can leave quality issues unresolved and threaten the quality of patient care. For example, the reconfiguration in South East London took more than six years, and services at Queen Mary's Sidcup had closed on 'emergency' grounds before they were given final official support for closure by the Secretary State and the strategic health authority (Palmer 2011). As well as poor outcomes for services, the whole consultation process can leave the public and staff feeling unhappy.

These discussions [through the consultation] were thought to have had a very negative impact on staff morale and caused distress to the public. Overall the community felt let down and shared a great deal of cynicism regarding the whole process.'

(House of Commons Health Committee 2007, p 78)

Also, as we can see from the evidence above, it can be hard to lay out a clear case for change given the many interdependent factors. It is not always possible to provide clear evidence of the quality differential between providers and to demonstrate how reconfiguration will address this. There is a recognition that part of the problem lies with commissioners and the way in which they have conducted reconfigurations. The Independent Reconfiguration Panel has recently set out the key weaknesses in the consultations that it has reviewed (Independent Reconfiguration Panel 2010) (see box below).

Another major problem with the current system is that the different stakeholders in the process have conflicting interests, often aligned to one but not all of the key drivers for change. An overview and scrutiny committee and other local politicians are likely to focus on access and may perceive that loss of a local A&E service is 'not in the best interest of

Independent Reconfiguration Panel assessment of key shortcomings in local consultations

- Inadequate community and stakeholder engagement in the early stages of planning change.
- The clinical case has not been convincingly described or promoted.
- Clinical integration across sites and a broader vision of integration into the whole community has been weak.
- Proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services.
- Important content missing from the reconfiguration plans and limited methods of conveying them.
- Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care.
- • Inadequate attention given to responses during and after the consultation.

their population'. A commissioner may prioritise value for money and clinical outcomes. Clinical leaders and the professional bodies may prioritise the dimensions of quality and workforce issues.

At the moment the process provides no transparent means of looking at these trade-offs and seeking an outcome that balances all. The four Lansley tests usefully, directly or indirectly, pick up issues of quality, safety, access and cost but fail to recognise the workforce drivers. It should also be noted that the overview and scrutiny committee is not explicitly required to take into account quality and safety or the taxpayers' interest and value for money. As well as concerns about the basis on which an overview and scrutiny committee may make a referral there are concerns about their make-up and function (House of Commons Health Committee 2007). As Spurgeon *et al* (2010, p 210) pointed out, while financial, clinical and safety arguments are rehearsed during a reconfiguration process, *the strength of the political perspective is, in the end, greater. This has a major impact on the issue of sustainability.*

The need to find a way to engage the population in a dialogue about these trade-offs has never been more pressing. In many parts of the country there is an urgent need to take forward reconfigurations, based on effective public and clinical engagement but within a reasonable timeframe.

Proposed policy changes

The process laid out above reflects the organisational structure of the NHS as inherited by the current government, but overlaid with the presumption that the commissioning lead will shift to GP-led commissioning groups. This process does not take account of some important features of the new Health Bill now going through parliament.

Abolition of SHAs and PCTs

The Health Bill proposes the abolition of SHAs and PCTs, and at a local level there is already significant restructuring in anticipation of this. The 10 current SHAs are forming 4 clusters, and 150 PCTs have reduced to 50 PCT clusters and may reduce further. It is expected that

these clusters may evolve into the local offices of the NHS Commissioning Board (see below).

NHS Commissioning Board

The NHS Commissioning Board will be nationally accountable for the outcomes achieved by the NHS and will have a statutory duty to secure continuous improvement in the quality of health services (Department of Health 2011a). The Board will provide leadership for the new commissioning system, authorising and overseeing the operation of clinical commissioning groups. It will provide, in conjunction with NICE, evidence-based summaries of what high-quality care looks like for particular service areas. It is expected to take on many of the roles and responsibilities currently discharged by the Department of Health, strategic health authorities and primary care trusts. The NHS Commissioning Board and its local outposts may therefore be expected to have some oversight of major reconfigurations.

Care Quality Commission

The Care Quality Commission (CQC) is the independent quality regulator of health and adult social care services in England. The CQC registers services if they meet the essential standards of quality and safety required by the law and check that they continue to do so. Hitherto they have played only a small role in driving any reconfiguration of hospital services and have had a much bigger role in social care. Under their new regulatory powers they have the capacity to impose a wide range of conditions on trusts or in extremis to suspend or cancel registration if providers fail to meet essential standards of quality and safety.

Monitor

As economic regulator for the health care sector the 'New' Monitor's role will include:

- licensing all providers of health care - the terms of the licence will set out the 'mandatory' services to be provided by a foundation trust
- ensuring that providers and commissioners do not behave 'anti-competitively' and that patient choice is protected and promoted
- supporting the continuity of 'vital' services in the event of financial failure.

These functions will almost certainly result in Monitor's active engagement in major reconfiguration decisions, either in ruling on whether the proposals support competition and choice or in overseeing clinical reconfigurations after financial failure.

Health and wellbeing boards

Local authorities will be required to establish health and wellbeing boards that will be responsible for undertaking joint strategic needs assessment (JSNA) and developing a joint health and wellbeing strategy, with significant public engagement in the process. Clinical commissioning groups are expected to take account of local strategies when developing their commissioning plans, and the health and wellbeing boards will be able to refer these plans to the NHS Commissioning Board if they are not satisfied that the plans do reflect the local strategy. While the health and wellbeing boards will not have a formal scrutiny function with respect to service reconfigurations, as this will be retained by the scrutiny committee, one might expect them to be heavily engaged in developing any proposals, and supporting public involvement. It should be noted that the current Bill proposes that while local authorities will retain the scrutiny function, they can choose who should undertake

this function for them and they can – for the first time – involve members of the public as well as elected representatives.

Clinical senates

The clinical senates will be established by the NHS Commissioning Board to provide a broad range of clinical expertise and support to the clinical commissioning groups and the NHS Commissioning Board. They may have some oversight of clinical networks. In their response to the Future Forum report (Department of Health 2011b, p 17), the government described the role of clinical senates as taking *an overview of health and health care for local populations and provide a source of expert support and advice on how different services fit together to provide the best overall care and outcomes for patients.*

Implications

Looking to the future, there is uncertainty about who within the new system will drive forward strategic reconfiguration plans. In addition, an already complex and bureaucratic process seems likely to become more complex and potentially confusing. Commissioners who currently have to engage with providers and the public and be subject to scrutiny by the SHA, Gateway, NCAT, the overview and scrutiny Committee, the IRP and ultimately the Secretary of State will now also be required to engage with one or more health and wellbeing boards, Monitor and relevant clinical senates. It is far from clear how all these players will fit in with the process outlined in Figure 3 (above), and who will be accountable to whom. There is also a major issue of capacity. The clinical commissioning groups will on average be smaller than the PCTs they are replacing, with significantly less management resource and with GP leaders who frequently work only part time. Successful engagement processes to support reconfiguration are very time and resource intensive. It is hard to see how they will be able to undertake this function without significant threat to their other duties.

How the process of reconfiguration could be improved

In many parts of the country there is an urgent need to take forward reconfigurations, based on effective public and clinical engagement, but within a reasonable timeframe. Failure to do this presents significant risks to quality. Yet the current process involves protracted and sometimes hostile local reconfiguration debates. We consider below a range of options that we believe could improve the dialogue between public, politicians, clinicians and managers around the reconfiguration of services, and enable more timely and consensual change. The engagement process can be hard for NHS managers who tend to see it as technocratic exercise (a view reinforced by mechanisms such as Gateway) and when the current process has a significant political element that can create a major obstacle to change. We have therefore set out our proposals in two groups: first, proposals on how the current process could be improved; second, proposals that could ensure that quality, safety and efficiency arguments are not trumped by politics, national or local, and that could thereby remove some of the current stumbling blocks to change.

Improvements to the current process within the future legislative framework

We believe there are opportunities to improve the current process, within the proposed system, in the following areas:

- setting and enforcing minimum standards for clinical care
- improving the quality of public engagement

- strengthening clinical leadership
- ensuring the economic regulator takes account of clinical and quality issues improving the scrutiny function
- speeding up the process
- clarifying roles, responsibilities and accountabilities.

Setting and enforcing minimum standards for clinical care

The stakeholders we spoke to, and Keith Palmer's recent analysis (Palmer 2011), suggest that market forces alone will not deliver the service change necessary to drive up quality, particularly where it requires collaboration between providers to deliver the new model of care, as was the case in stroke and trauma services. We believe there are opportunities at a national level to set minimum standards for clinical conditions where there is a clear evidence base, such as stroke, acute myocardial infarction, major trauma, complex surgery, obstetrics, paediatrics and cancer. These could then be incorporated into the essential quality and safety standards imposed by the CQC as part of its registration requirements. Hospitals that fail to meet the standards would not be able to provide services for that condition.

Recommendation

The NHS Commissioning Board should set minimum evidence-based quality standards for key conditions in conjunction with NICE and the professional bodies. These should be incorporated into the essential standards of quality and safety set by the CQC as part of their registration requirements.

Improving the quality of public engagement

Effective public engagement is a critical component of service change. The lesson from the Independent Reconfiguration Panel is that the public should be engaged throughout the process. The proposed health and wellbeing boards, if actively engaged in the process, could facilitate this. As Jeremy Taylor, Chief Executive, National Voices put it to us:

The health and wellbeing boards could be seen as a focal point for hosting the conversation that needs to take place between the providers, commissioners and local community. If you look at what the Future Forum report said, it very much had the vision of the HWB as being the main platform for organising major consultations on service change, so in one conception the HWB should be responsible for ensuring those things are carried out properly.

(Personal Communication, July 2011)

Our conversation with the Royal College of Physicians (written communication, August 2011) also suggested that health and wellbeing boards could *'not just act as a forum for public engagement, but in facilitating informed dialogue between the public and clinicians. Establishing links between local HWBs and regional clinical senates could be an important step'*.

Recommendation

Health and wellbeing boards should be used to 'host the conversation' between clinicians and the local populations, providing active support to clinical commissioning groups and others leading clinical reconfiguration. Links should be established between local health and wellbeing boards and clinical senates.

Strengthening clinical leadership

Strong clinical leadership is needed for hospital reconfiguration to deliver its intended benefits and to give the public confidence in that change. The proposed clinical senates could identify opportunities for reconfigurations of service that are sensitive to local context. While the clinical senates can play a helpful advisory role in this area they have no statutory status. This suggests a potential leadership gap at regional level unless the NHS Commissioning Board outposts, through the PCT clusters, take on this role. It will be important that Monitor does not provide an unhelpful obstacle to this approach.

Recommendation

Clinical senates should advise on clinical reconfiguration and identify clinical areas in which service reconfiguration is needed. Clinical leaders are needed at regional level to lead strategic change in conjunction with the proposed clinical senates.

Ensuring the economic regulator takes account of clinical and quality issues

Increased competition will play an increasingly important role in reconfiguration.

If you have diversity of provision and personal choice and power, some providers will be better and some worse. Inevitably, some will not, whether it's because they can't attract the patient or the pupil, for example, or because they can't get results and hence can't get paid. Some will not survive. It is an inevitable and intended consequence of what we are talking about.

(Letwin, July 2011)

This means a growing role for the new economic regulator Monitor through its responsibilities for regulating competition, licensing providers and managing the failure regime. It will also be important that judgements about choice and competition take a comprehensive view of the public interest and the potential quality and financial benefits of any proposed changes.

Recommendation

Monitor should be explicitly required to take into account the view of clinical senates and other professional clinical advice when taking action to protect service continuity in the event of provider failure or assessing whether trusts change the terms of their licence and the range of services that they provide. A consistent approach is required between Monitor and the CQC.

Improving the scrutiny function

There was almost universal agreement among those we spoke to that the current basis for referral of proposals by the overview and scrutiny committee was too loose. The term 'not in the best interest' does not reflect the complexity of the matters under consideration. It was felt that, in common with the legal basis for judicial review, their focus should be on the process of engagement rather than the content. One option would be for the overview and scrutiny committee to assess whether the Lansley test of strengthened public and patient engagement had been met. There is also scope for refining what should be subject to full public consultation and scrutiny. In giving evidence to the House of Commons Health Committee in 2007, Candy Morris, chief executive of the South East Coast SHA, suggested that it could be helpful to have a different name for 'consultation' where urgent changes need to be made to differentiate from more interactive processes where there is mutuality in finding potential solutions (House of Commons Health Committee 2007). There should

also be greater transparency about the composition of scrutiny committees and their members' political mandates.

Recommendation

The basis on which referrals are made to the Secretary of State should be tightened up. One option is to focus on the process of consultation. A distinction should also be made between instances where there are genuine alternatives under consideration and real opportunities for consultation and instances where urgent change is required and clinically there is only one credible option. Committees should also be required to publish their members' political mandates alongside their deliberations.

Speeding up the process

Decision-making timescales should be reduced, to avoid the seemingly endless delays that can accompany the current process. The IRP has already demonstrated that it is possible to act swiftly.

Recommendation

Maximum timescales should be set for the scrutiny function and for decisions by the Secretary of State.

Clarifying roles, responsibilities and accountabilities

The prospective legislative changes could make an already complex and bureaucratic process become more so. It will be critical to clarify who is able to drive forward reconfiguration, particularly at a strategic level and who should be holding who to account and for what? What will be the respective roles of the NCB, Monitor and the health and wellbeing boards? One can imagine a situation in which all three have different views on the future configuration of services - who will have the final say?

Recommendation

The government must address the current uncertainty about which bodies will have the levers with which to drive forward strategic reconfiguration and the capacity to do so. To resolve potential conflict, guidance provided in 2010 (see diagram, Nicholson 2010, p 6) will need to be updated to reflect the functions of the new statutory bodies and regulatory changes. This will need to clarify how any conflicts in opinion between the statutory bodies on a proposed reconfiguration of service will be resolved.

Options to 'de-politicise' the process

We consider here two more radical options to de-politicise the current process:

- allow the Independent Reconfiguration Panel, rather than the Secretary of State, to be the final arbiter on reconfiguration proposals
- create an independent body with a mandate for change to tackle issues in particular areas.

The Independent Reconfiguration Panel to act as the final arbiter on reconfiguration proposals

There are also opportunities to de-politicise the process if the Independent Reconfiguration Panel, not the Secretary of State, is given the role of final arbiter on reconfiguration decisions. This would be even more logical if referral decisions were only

The Ontario experience

The HSRC was composed of medical professionals, academic health science professionals, former hospital board members and others with expertise and experience in the health sector. The Commission covered all health services in its remit including acute, long-term care and mental health. The Commission was not charged with cutting costs. It identified \$1.1 billion savings in a total programme spend of \$17 billion which were then reinvested in other services. They also recommended an investment of \$2.1 billion capital to support the restructuring process. The goal was to ensure the continuation of high quality, accessible and cost-effective health services. To develop restructuring options, they sought input from local health planning bodies and the local community. Following consultation, analysis and consideration formal 'Notices of Intention to Issue Directions' were issued to the affected institutions, together with the reasons for the decisions made. They drove the establishment of clinical networks, invested in home care and long-term care to facilitate hospital closure in some places and enable hospitals to focus on the care of acutely ill patients. Overall, the process was judged to be a success and the Commission was able to do a job that could not have been done by others. However, they felt they would have done their job better had they:

- also had a mandate to restructure primary care
- had a clearer vision of where the system was trying to get to
- had capital and revenue funding to support the transition and invest in community services prior to disinvestment in hospital care
- worked harder at public engagement.

on the basis of the adequacy of consultation, mirroring the basis on which a judicial review would consider reconfiguration decisions. Taking the Secretary of State out of the process would also be in line with the suggestions set out in *Liberating the NHS* in which the Secretary of State is expected to concern him or herself less with operational detail and more with strategic direction. It would make the process more transparent, and would send a strong message at the local level that these issues should not be decided on basis of politics. However, some we spoke to were sceptical of the capacity to distance politicians from the process of reconfiguration.

They have to be accountable ultimately and unless you make the NHS not funded by taxation, as long as it remains that way, then the Secretary of State has to be responsible and accountable and if you take it away they'll just interfere anyway, which is what they do and I can give you a number of examples where they have done it.

(Expert stakeholder)

Also, if the IRP undertook this role it would become larger, more expensive and potentially less swift. It would no longer be advisory but would be required to be a statutory body, open to judicial review.

Establishing an independent commission to take forward the restructuring of health services in a region

A more radical solution would be to adopt an approach taken in Ontario, Canada. In 1996, the Health Services Restructuring Commission (HSRC) was established by the Ontario Government as an arms-length body to support the process of hospital restructuring

in Ontario (HSRC, 2000). The HSRC had a four-year mandate, under which it was able to *direct hospitals to amalgamate, transfer or accept services, change their volumes, cease to operate or make any other changes considered to be in the public interest.* (HSRC 2000, p1)

The process is not dissimilar to that adopted in this country to support the closure of the long-stay mental health and learning disability hospitals during the 1990s. Central government facilitated the transfer of resources ahead of hospital closure to enable the development of community services. While not always ideal, the process did facilitate significant change and investment in community-based care. This option could be relevant for specific areas in which large-scale change is needed, such as London.

Conclusion

Clinical reconfiguration of hospital services is urgently required in some locations to improve the quality and safety of patient care within tight financial and workforce constraints. Current processes for implementing reconfigurations are protracted, do not provide adequate or transparent ways of examining and balancing competing interests, and do not fully take into account all the drivers for change including workforce considerations. There is an opportunity to improve these processes through effective public and clinical engagement and by placing responsibility for final decisions in the hands of a body at arm's length from politicians. Failure to take action to improve the current situation presents unacceptable risks to quality.

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