Thinking about acute hospital reconfiguration? The eight questions you need to consider first

2020 Delivery has been heavily involved in reconfiguration work since the firm’s inception. On the following pages we outline some of the key questions that you should pose if you are thinking about reconfiguration.
**STRATEGY & BUSINESS PLANNING**

There is evidence showing that small individual practices can almost always lose activity. Reconfiguration is not a silver bullet: Healthy Futures (North-East London) – implementation about to commence.

In some geographies/ health communities, reconfiguration has been relatively uncontentious, because they haven’t led to closure of A&E departments.

**PERSPECTIVES**

*Why are the politics so difficult?*

- The Conservative party was strongly opposed to reconfiguration whilst in opposition. Even since 2010, the Health Secretary has pledged to end ‘the imposition of top-down reconfigurations in the NHS’.
- Reconfiguration is much easier to implement in a centrally-planned system than in a competitive market-based system. In a competitive market, any hospital that loses activity also loses more income than it can save in costs, so that hospital’s financial position gets worse; therefore every hospital in a competitive system will try to block reconfiguration if it is likely to lose activity.
- The 2012 Health & Social Care Act promotes competition, and moves the NHS towards being a market-based system and away from being a planned system.
- Individual MPs will almost always oppose local reconfiguration because otherwise ‘we save our hospital’s candidates stand, and can defeat incumbent MPs’ (e.g., Richard Taylor in Kidderminster in 2001).

**What are the clinical benefits?**

- There is evidence showing that small centres are struggling to provide sufficient hours of consultant cover at evenings and weekends - for services such as A&E, maternity, paediatrics.
- The evidence for improvements in outcomes due to scale alone is mixed. However, there is evidence of outcome benefits from reconfiguration is combined with definition of new clinical pathways.
- Analysis by Dr Foster and the British Medical Journal has shown: clear evidence of outcome improvements for patients in London who have benefitted from the region’s reconfiguration of stroke services.
- Evidence that patients who are currently admitted at weekends and evenings (when many hospitals do not have senior cover for key services) have worse outcomes than weekday admissions.

**What are the financial benefits?**

- Our analysis highlights considerable evidence of economies of scale for different services. This evidence is consistent across workforce census data and financial sources. See ‘Where can I find out more?’ and Fig 1.
- However, in most instances the financial benefits from reconfiguration are sufficient only to address a majority of the financial challenge for a health community.
- Recent consultation in North-East London aimed at savings of £21m - only a small proportion of the overall financial challenge of over £300m in the region.

**Where can I find out more?**

2020 Delivery has been engaged in a large number of reconfigurations across a variety of services and health economies since the firm’s inception. Our analysis on the financial and clinical benefits of reconfiguration - which was published in 2010 - has been shared widely with senior NHS leaders and think-tanks, and can be viewed at: http://tinyurl.com/d42gcl

Contact Russell Cake, Health practice lead, for more information on 2020 Delivery’s reconfiguration work.

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**To reconfigure... or not?**

**Heart attack, stroke, major trauma**

Over the last 5 years, NHS London has reconfigured services for heart attack (new 8 centres in London, compared to 31 A&E), stroke services (6 centres in London) and major trauma services (4 centres in London). For each of these, ambulances will drive past several A&Es to get to the right centre. NHS London claims hundreds of lives have been saved by these changes.

Heart attack service reconfigurations are now close to complete across the country. Reconfiguration of heart attack, stroke and major trauma services have been relatively uncontroversial, because they haven’t led to closure of A&E departments.

Outcomes for all of these services are improving substantially, driven by reconfiguration but also by other factors (e.g., definition of best-practice pathways).

**Cancer**

The Calman Hine report of 1995 established a structure for all cancer treatment in the NHS in Cancer Networks consisting of cancer centres (where e.g., radiotherapy would be centralised) and cancer units. It set the principles of having specialist oncologists who would each see sufficient volume of their tumour type, rather than having a few generalist oncologists in each District General Hospital.

Cancer outcomes are improving substantially, but service configuration is still one driver out of many behind this improvement.

**A&E, maternity, paediatrics**

Reconfiguration of A&E, maternity and paediatrics services has been happening gradually for more than 20 years, with examples from all around the country.

A&E and maternity are probably the most politically contentious types of reconfiguration.

**Pathology**

Pathology services are changing in two ways:
- Point of care testing is becoming more common for the simplest tests. Testing next to the patient avoids samples having to go to a lab at all and gives the referring clinician an immediate result.
- ‘Cold’ tests being centralised, so that automation technology can be used to test effect. There is very strong evidence of financial benefits and quality benefits from this sort of centralisation.

**Paediatric cardiac surgery**

Already centralised to a small number (15) of centres nationally, and looking to centralise further to an even smaller number. The case for change is strong, both clinically and financially, but the process has slowed down due to court appeals and referrals to the Independent Reconfiguration Panel.

**What are the steps in the reconfiguration process?**

Pre-consultation
- Case for change assessed:
- Preliminary assessment of options to consider and to changes to decision-making process
- Decision made on preferred reconfiguration option

Public consultation
- 15 weeks Consultation on specific reconfiguration proposals, and on the process to be used to make decision

Post consultation
- Input from consultation received (may lead to new options to consider and to changes to decision-making process
- Decision made on preferred reconfiguration option

Possible judicial review
- If the consultation of the pre-consultation decision-making process failed to comply with all the terms of the relevant legislation, the process can be taken to judicial review – this has happened in a number of cases

Independent reconfiguration panel (IRP)
- Approves proposal: The IRP provides advice to the Secretary of State as to whether contested reconfiguration proposals should be allowed to proceed to implementation
- If IRP approves the reconfiguration, implementation can commence. IRP approval to implement can take two years or more, especially if implementation involves capital expenditure

**Where has reconfiguration been implemented recently?**

- Healthy Futures (North-East Manchester) – reconfiguration of A&E, emergency medicine, emergency surgery and complex cancer surgery in NE Manchester. Implementation recently completed, after 10-year process.
- Making it Better (Manchester) – reconfiguration of maternity and paediatrics services across 14 hospitals in and around Manchester. Implementation nearing completion after 10-year process.
- Maidstone and Tunbridge Wells (West Kent) – implementation of reconfiguration of maternity services, paediatrics services, emergency surgery, ambulatory surgical services, orthopaedics services across Maidstone Hospital, Kent & Sussex Hospital and Pembury Hospital. Completed in 2011 after ~ 8-year process.
- A Picture of Health (SE London) – implementation in progress for 7 years so far.
- Barnet & Chase Farm (North-Central London) – implementation about to begin.

**How new is reconfiguration?**

- Our case for change assessed; pre-consultation business case completed

**Evidence that reconfiguration can produce improvements in clinical outcomes (e.g., evidence on stroke services and complex surgery), especially where reconfiguration is combined with definition of new clinical pathways**

- Evidence that reconfiguration can alleviate existing problems with lack of senior medical presence at night and weekends
- Evidence that fewer, larger services can save money at the same time as improving outcomes

**Why reconfigure acute hospital services?**

- Evidence that reconfiguration can produce improvements in clinical outcomes (e.g., evidence on stroke services and complex surgery), especially where reconfiguration is combined with definition of new clinical pathways
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- Evidence that fewer, larger services can save money at the same time as improving outcomes

**Against**

- General public opposition makes reconfiguration difficult to implement
- Reconfiguration involves substantial effort over 5+ years from managers and clinical leaders
- In some geographies/ health communities, increases in travel times for patients and relatives are material relative to gains in clinical outcomes
- Reconfiguration is not a silver bullet: delivery of clinical and financial benefits post-reconfiguration is still dependent on strong management and clinical leadership

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Russell Cake is a Director and co-founder of 2020 Delivery, leading the firm’s Health practice. He has extensive experience of serving a wide range of NHS organisations and, prior to 2020, Delivery led work on the NHS reform programme in the Prime Minister’s Delivery Unit. He has considerable consulting experience from his time at 2020 Delivery and previously at McKinsey & Company, and he also has operational management experience as a Chartered Mechanical Engineer at ICI Plc. Russell has a Bachelor’s Degree and a Master’s Degree in Engineering from Cambridge University, and is also a former professional cricketer.