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BRIEFING PAPER

Number 8105, 9 October 2017

Reconfiguration of NHS services (England)

By Alex Bate

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Summary

Hospital and community health services in the NHS are often subject to changes in location or the type of treatment provided, usually as part of a reorganisation of services across a larger health geography.

NHS service reconfiguration can occur for a variety of reasons, for example to respond to financial or workforce pressures, provide more effective clinical outcomes, improve patient access to healthcare or react to new technological developments.

In England, reconfiguration decisions are largely made by local health commissioners or providers, with patients having a legal right to be involved, and local authorities having a right to scrutinise proposals. However, local decisions are often affected by national Government policy directions, or by pressures stemming from Government funding arrangements. The Secretary of State for Health also has limited powers to directly reconfigure services in the case of provider failure.

Reconfigurations can often be contentious with patients, particularly where they include proposals to close or downgrade a local hospital, and local politicians can often be held responsible for unpopular decisions made by health authorities or central Government. This is sometimes known as the 'Kidderminster effect', after Dr Richard Taylor, who defeated the sitting Wyre Forest MP David Lock in 2001 as an independent Health Concern candidate, following the downgrading of Kidderminster Hospital's Accident & Emergency department.

Many current reconfiguration proposals in the English NHS are being delivered through Sustainability and Transformation Partnerships (STPs) – 44 area-based partnerships between local authorities and NHS bodies, delivering NHS England's Five Year Forward View strategy.

1. Recent reconfiguration policy

Across successive Governments, trends in reconfiguration policy over the past decade have emphasised that decisions should be made at a more local level, with more treatment provided outside of hospitals, in addition to centralisation of some hospital-based services.

1.1 Reconfiguration under Labour, 2006-10

In 2006 the Labour Government published the White Paper *Our Health, our care our say*, which set out a reform agenda for Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to deliver more healthcare outside hospitals and in the home.[1]

A King's Fund briefing at the time reported that although the public supported some aspects of the White Paper, "a substantial proportion" opposed providing hospital services locally, as it was feared that this could lead to the closure of local hospitals.[2] The *Our Health* agenda also posed problems for local MPs facing potential hospital closures. A 2010 report by Reform highlighted a number of examples of Labour Ministers opposing local service reconfigurations proposed following the White Paper's publication.[3]

2006 also saw the passing of the *National Health Service Act 2006*, which set out a duty on health providers and commissioners to involve local service users, where reconfigurations were proposed.[4] The Act initially set out a duty to ensure patients were "involved in and consulted on" changes, although this was changed to "involved (whether by being consulted or provided with information, or in other ways)" by the *Local Government and Public Involvement in Health Act 2007*. More information on consultation and the duty to public involvement can be found in section 2.

As part of the 2008 *NHS next stage review* led by Lord Darzi, which introduced the idea of the NHS Constitution as well as other reforms, a supplementary report, *Leading local change*, was also published. This set about building upon the patient involvement reforms in the 2006 Act, and set out five pledges that Primary Care Trusts (PCTs) should have regards to on proposed service changes:

- Change will always be to the benefit of patients
- Change will be clinically driven
- All change will be locally-led
- You will be involved

[1] Department of Health, *Our health, our care, our say: a new direction for community services*, January 2006
[2] The King's Fund, *King's Fund Briefing: Our health, our care, our say*, February 2006
[3] Reform, *Fewer hospitals, more competition*, March 2010, p19
[4] A similar duty had previously been set out in section 11 of the *Health and Social Care Act 2001*

- You will see the difference first[5] (that is, no services are withdrawn until new and better services are available).

Alongside the fourth pledge, new statutory guidance on the duty to involve patients, set out in the 2006 Act, was published.

1.2 Reconfiguration under the Coalition Government

Despite many of the proposals to encourage greater locally-led decision making on service reconfiguration, there remained criticisms of the Labour Government that decisions were often made from above, without local support. This criticism was also set out in the 2010 Coalition Agreement:

> We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.[6]

In June 2010, the then Health Secretary Andrew Lansley announced a moratorium on all future and ongoing reconfiguration proposals, and that future reconfigurations could only go ahead if commissioners assessed that they met four new tests.[7] These tests require any proposals to demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice[8]

The Coalition Government then passed the *Health and Social Care Act 2012*, which abolished Strategic Health Authorities (SHAs), and replaced PCTs with smaller Clinical Commissioning Groups (CCGs). A 2014 report by the Health Select Committee raised concerns that this would mean less co-ordination for decision-making on service changes:

> In oral evidence, John Appleby [King's Fund] argued that changing services or closing whole hospitals "is difficult, I think, and has become more difficult." He said that
>
> > One of the reasons for that is that in many areas we do not have a co-ordinating body to oversee some of this stuff. We got rid of strategic health authorities. There may have been some very good reasons to get rid of SHAs, but one of the things they helped with was to co-ordinate across an area. We now have a more fragmented system, in a sense. It is, in a way, typified by the letter that went round the system about the integration transformation fund that was signed by four different bodies. In a way it was good that it was signed by four, but it also illustrates what has happened to the system. Doing these things quickly, it seems to me, is still difficult and perhaps more difficult.
>
> […]

5 Department of Health, *NHS Next Stage Review: Leading Local Change*, May 2008
6 HM Government, *The Coalition: our programme for government*, May 2010, p24
7 HC Deb 21 June 2010, cc5-6WS
8 Department of Health, *Revision to the Operating Framework for the NHS in England 2010/11*, June 2010, p8-9

> It is unclear who will take the lead on system change on a local or regional level. An issue at local level is that CCGs are smaller than the PCTs that they have replaced, and have control over fewer functions. The Committee was told that with more organisations in the system, none of which are big enough or influential enough to shape the system, strategic change will have to be brought about through collaboration "which, history suggests, tends to be less effective".
>
> This is potentially a very significant issue. There is a consensus that integration of services across health and social care and reconfiguration of health services are vital if the NHS is to maintain levels of service provision while making the efficiency gains demanded of it, and to maintain or improve quality of the treatment provided.[9]

1.3 The NHS Five Year Forward View and beyond

In 2014, NHS England's *Five Year Forward View* set out proposals for service transformation through 'new models of care', which would integrate primary care, community services and hospitals, as well as providing more out-of-hospital care.[10]

These proposals for service transformation are set against substantial financial pressures. The 2015 Spending Review announced a new funding settlement for the NHS, but confirmed that this would have to be accompanied by £22 billion of efficiency savings by 2020/21.[11] NHS England identified £7 billion of national efficiency savings, leaving £15 billion to be found at a local level.[12] This follows an earlier push for efficiency savings, known as the 'Nicholson challenge', which achieved around £20 billion of savings between 2011/12 and 2014/15.[13]

The new models of care, as well as any accompanying reconfiguration of services, will largely be implemented by new Sustainability and Transformation Partnerships (STPs), which are made up of representatives from health organisations and local authorities. Several of the 44 STPs have included proposals for individual hospital closures or service changes as part of their plans.

Concerns about the transparency and scale of proposed reconfigurations through STPs have been raised, including by the Labour Party, whose 2017 general election manifesto included a commitment to halt and review STPs:

> Labour will halt and review the NHS 'Sustainability and Transformation Plans', which are looking at closing health services across England, and ask local people to participate in the redrawing of plans with a focus on patient need rather than

9 Health Committee, *Public expenditure on health and social care*, 12 February 2014, HC 793 2013-14, para 75-78
10 NHS England, *Five Year Forward View*, October 2014, p17-28
11 HM Treasury, *Spending Review and Autumn Statement 2015*, Cm 9162, November 2015, para 1.97-1.103
12 NHS England, *NHS Five Year Forward View: Recap briefing for the Health Select Committee on technical modelling and scenarios*, May 2016, para 4.4
13 PQ HL2354, 30 October 2014

> available finances. We will create a new quality, safety and excellence regulator – to be called 'NHS Excellence'.[14]

More information on STPs is set out in section 5.

In addition to the four reconfiguration tests introduced in 2010, a new hospital bed closure test was introduced in April 2017. Proposals that involve significant bed closures will not be able to go ahead unless NHS England assesses that one of three conditions have been met:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).[15]

[14] Labour Party, *2017 Manifesto: for the many not the few*, May 2017, p69
[15] 'New patient care test for hospital bed closures', *NHS England press release*, 3 March 2017

2. Consultation and scrutiny

NHS service reconfigurations, particularly those involving the closure or downgrading of a local hospital, can be particularly controversial with local communities. As a result, both the public and local authorities have statutorily defined roles in the reconfiguration process, to ensure that their voices and concerns are heard prior to any decision being made.

Most of these rights to involvement are set out in the *National Health Service Act 2006 (as amended)*. NHS bodies that fail to meet their statutory duties to involve and consult could ultimately find themselves subject to judicial review, which can significantly delay any reconfiguration proposals. These duties must be met, in addition to the four reconfiguration tests and the bed numbers test set out in section 1.

A 2015 study into NHS reconfigurations by the National Institute for Health Research (NIHR) found that a number of proposed reconfigurations had been stalled or stopped because of public opposition:

> Many reconfigurations encountered public or clinical opposition that we found reported in local and national news. Campaigners were often concerned that the proposed changes would reduce access to services or increase waiting times in A&E departments, or that downgrading 'anchor' services such as A&E or maternity would lead to further closures over time. Out of the implemented reconfigurations, we found evidence that eight encountered significant public and political opposition, characterised by websites and the use of social media such as Twitter and Facebook, petitions delivered to 10 Downing Street, rallies and public meetings. These campaigns were often supported by local members of parliament (MPs) and councillors. This activity tended to slow the approval process as additional clinical or judicial reviews were conducted. Two partially implemented reconfigurations also encountered opposition from the public and local politicians, focusing on the ability of the remaining A&E department to cope with demand in one case and concerns around accessibility to the remaining site in the other case. In the stalled reconfiguration, significant clinical opposition from commissioners led to the formal withdrawal of the plan.[16]

2.1 Public involvement

Section 242 of the *National Health Service Act 2006 (as amended)*, sets out a duty on health bodies (NHS trusts and foundation trusts) to:

> Make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in–
>
> (a) the planning of the provision of those services,
>
> (b) the development and consideration of proposals for changes in the way those services are provided, and

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16 NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, p24

> (c) decisions to be made by that body affecting the operation of those services.[17]

"Users of those services" can have a broader meaning that just patients receiving treatment. For example, parents of children using paediatric medical services should also be treated as users of those services.[18]

The original 2006 Act included a duty to ensure service users were "directly or through representatives, involved in and consulted on" (as did the section 11 of the *Health and Social Care Act 2001*, which the 2006 Act replaced). However, this was changed to a broader duty to involve by the *Local Government and Public Involvement in Health Act 2007*.

The *Health and Social Care Act 2012* brought in a similar duty on commissioners for public involvement on changes to the commissioning of services.[19] Although these are similar to the section 242 duty on NHS trusts, commissioners are not able to discharge their duties through representatives, only through involving service users themselves.

CCGs must also set out a description of their arrangements to meet their public involvement duties in their constitution, as well as a statement of the principles they will follow in implementing these arrangements.

Information on what is meant by involvement for NHS trusts is set out in 2008 statutory guidance, and for commissioners in 2017 statutory guidance. Although consultation is not explicitly required by the 2006 Act, the law firm Mills & Reeve argue that it will be appropriate in most major reconfigurations:

> In summary, any significant commissioning decision or reconfiguration will be caught by these statutory requirements. You will note that the statute does not insist on "consultation", but seeks to make sure that service users are "involved". In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.[20]

Consultation may also be insufficient by itself. The 2017 statutory guidance states that:

> Involvement should not typically be a standalone exercise such as a formal consultation. It will generally be part of an ongoing dialogue or take place in stages.[21]

Landmark Chambers' analysis of case law on section 242 notes that there is no duty of public involvement on NHS trusts for proposals that

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17 Section 242 (1B), *National Health Service Act 2006* (as amended)

18 [2012] EWCA Civ 472, para 7

19 NHS England's duty is set out in section 13Q of the amended 2006 Act, while CCGs' duty is set out in section 14Z2.

20 Mills & Reeve, *Reconfiguring services: when must NHS bodies consult the public? How do they go about doing it? And how can they protect themselves from legal challenge?*, October 2013

21 NHS England, *Patient and public participation in commissioning health and care*, May 2017, p30

are considered non-viable. Therefore some options may be discounted on clinical or financial grounds without public involvement.[22]

2.2 Local authority scrutiny

Under section 244 of the *National Health Service Act 2006 (as amended)*, a local authority's Overview and Scrutiny Committee (OSC) has the right to review and scrutinise proposed changes to health services in their area. NHS providers and commissioners also have a duty to consult with OSCs over any substantial reconfiguration proposals.

Where an OSC disagrees with a proposal for its area, or it feels that the relevant health organisation did not meet its duty to consult, the local authority has the right to refer the decision to the Secretary of State for Health.[23]

Although scrutiny is often carried out through an OSC, regulations give local authorities the flexibility to enact scrutiny through an approach of their choosing. Examples of possible configurations given by the Department of Health include:

- It may choose to continue to operate its existing health overview and scrutiny committee, delegating its health scrutiny functions to the committee.
- It may choose other arrangements such as appointing a committee involving members of the public and delegating its health scrutiny functions (except the function of making referrals) to that committee.
- It may operate its health scrutiny functions through a joint scrutiny committee with one or more other councils.[24]

Regulations also give local authorities the power to request information from health bodies and to summon individuals to answer questions.[25]

Where a local authority decides to refer a reconfiguration proposal, the Secretary of State can request advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. Not every referral will be reviewed by the IRP, and the Secretary of State is not bound to accept its recommendations.

In addition, there are some circumstances where there is no duty for NHS commissioners and providers to consult local authorities. These are where a Trust or CCG is to be established, dissolved or varied, and when reconfiguration proposals are made by a special administration (see section 3).

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22 Landmark Chambers, *Reconfiguration of NHS Services, Patient Engagement Duties on CCGs and NHS Trusts and the Role of Local Authorities*, February 2016, para 22

23 Regulation 23(9), *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013*, SI 2013/ 218

24 Department of Health, *Local Authority Health Scrutiny*, June 2014, para 3.1.9

25 Regulations 26-27, *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013*, SI 2013/ 218

3. Trust Special Administration

3.1 Power to reconfigure failing NHS trust services

The Trust Special Administration (TSA) regime was introduced by the *Health Act 2009*, which amended the *National Health Service Act 2006*, and has been further amended since. This is also known as the unsustainable provider regime.

TSA legislation allows the Secretary of State to appoint an administrator to take over the running of an NHS trust at risk of financial failure or failure to provide adequate services.

The rules are different for NHS foundation trusts. For these trusts, NHS Improvement[26] rather than the Secretary of State is responsible for appointing an administrator. NHS Improvement can either choose to intervene itself, or be required to by the Care Quality Commission (CQC).

Once an administrator is appointed, the trust's previous chairman and directors are suspended, and the administrator produces a draft report and proposals for change.

Although there are legal consultation requirements for the draft report, including obtaining a written report from local authorities, the CQC and Local Healthwatch organisations, this is a more limited right of public involvement than for other NHS reconfigurations. Duties of public involvement and local authority oversight set out in section 2 are overridden by the TSA regime.

The Secretary of State will then make a final decision based on the administrator's final report (or approve or reject NHS Improvement's final decision, in the case of foundation trusts). As well as proposing changes to services delivered by the trust, a decision is made on the trust's future. Options for this include:

- a restructuring of the foundation trust such that it leaves administration to continue in its restructured form
- acquisition by, or merger with, another foundation trust (following consultation with and the agreement of the proposed merger partner)
- the dissolution of the foundation trust in administration and the transfer of its services and staff to another foundation trust and/or to the Secretary of State (for onwards transfer).[27]

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[26] Monitor was previously responsible for appointing an administrator for foundation trusts, before Monitor became part of NHS Improvement in April 2016

[27] Monitor, *Statutory guidance for trust special administrators appointed to NHS foundation trusts*, February 2015, para 7.3

3.2 Power to reconfigure services of other NHS trusts

Section 120 of the *Care Act 2014* gave a TSA, appointed to a failing Trust, the powers to make recommendations that go wider than the trust under administration, and can affect other trusts not under the administrator. This was considered one of the more controversial changes to the TSA regime, and was opposed by the Labour Party at the time of its introduction.[28]

During the Parliamentary passage of the *Care Bill*, the then Health Minister Dr Dan Poulter argued that trusts do not operate in isolation, and system wide change that crosses organisational boundaries is sometimes necessary:

> Clause 119 [section 120 in the Act] was introduced following calls to the Government by key stakeholders representing NHS providers—the Foundation Trust Network and the NHS Confederation. Like us, they recognise the experience of how the regime has operated. They know that issues of financial and clinical sustainability of health services nearly always cross organisational boundaries, and they were clear that the Labour Government's regime needed amendments to make it effective in the spirit that the right hon. Member for Leigh intended when he created it in 2009. Let me read out again what was said in the impact assessment to the 2009 TSA regime—his regime. It states:
>
> "NHS Trusts…are not free-floating, commercial organisations."
>
> It also says:
>
> "State-owned providers are part of a wider NHS system."
>
> We fully agree with that, and that is what we are ensuring we take into account in the TSA regime. That is what clause 119 is about.[29]

Critics of the clause however, such as Labour's Jamie Reed, raised concerns about implications for well-performing trusts:

> The simple truth of the Government's hospital closure clause is that a successful local hospital, the type that the Secretary of State enjoys getting his photograph taken in, can be closed without due process, simply because the one down the road is in trouble. It is as logical as removing a patient's leg to cure a headache.[30]

Lewisham Hospital Judicial Review, 2013

The changes were introduced in part in response to an earlier High Court decision with regards to Lewisham Hospital in South London.

In 2012, a Trust Special Administrator was appointed to takeover South London Healthcare NHS Trust (SLHT), which had operated with substantial deficits for many years. Following the administrator's final report, the Secretary of State Jeremy Hunt decided to reconfigure a number of hospital services in the area, including A&E and maternity services in Lewisham Hospital.

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28 HC Deb 11 March 2014, cc272-275
29 HC Deb 11 March 2014, c265
30 HC Deb 12 May 2014, c442

As Lewisham Hospital was operated by a different trust, Lewisham Healthcare NHS Trust, campaigners argued that it was outside the Secretary of State's powers to enforce changes through the TSA process. Lewisham Council and Save Lewisham Hospital Campaign launched a judicial review against the Secretary of State, and the High Court ruled in their favour in July 2013.[31]

The new clause was subsequently introduced to the *Care Bill* at Lords report stage, in October 2013.[32]

During later debates in the Commons, Lewisham East MP Heidi Alexander drew explicit parallels between the Lewisham Hospital decision and new clause 119:

> The Government have tried to spin clause 119 as some sort of clarification of existing policy. That is nonsense. It is a direct result of the Lewisham hospital case that was heard in the courts. We know that the previous Government produced guidance that said that the TSA regime should not be used as a back-door approach to reconfiguration. This is a fundamental change in policy. It removes the legal protection that currently exists for successful hospitals located adjacent to failing hospitals that have been placed into administration.[33]

31 [2013] EWHC 2329 (Admin)
32 Clause 118, *HL Bill 53 2013-2014, as amended on Report*, 22 October 2013
33 HC Deb 11 March 2014, c243

4. Drivers of service reconfigurations

In 2014, the King's Fund looked into 108 reconfiguration proposals from 2007 to 2012, and identified five key drivers behind them, which came from both national Government policy and local service needs:

- Cost
- Workforce
- Quality (including safety)
- Access
- Technology[34]

The King's Fund publication built on earlier work by the same authors for the NIHR, working alongside the Nuffield Trust, which looked at 123 proposals over the same time period. The NIHR work identified four of the five drivers in the King's Fund report, but did not look at technology. It argued that all reconfigurations were a trade-off between their four identified drivers:

> In any reconfiguration of hospital services there are four interlinked drivers: quality (including safety), workforce, cost and access. The challenge for local services 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 relevant disciplines, compliance with clinical guidelines and 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 interdependencies between services – for example, the withdrawal of paediatric services can threaten obstetric services, which rely on paediatricians to provide care for the newborn child.[35]

4.1 Cost

Financial pressures were one of the two main drivers for reconfiguration identified in the King's Fund and NIHR studies, alongside workforce pressures. The NIHR study highlighted cost pressures as drivers in reconfiguration proposals for: whole hospitals and trusts, A&E services, mental health services, maternity care, paediatric care, elective surgery, and primary and out-of-hospital care.

Many of the proposed reconfigurations that were reviewed sought to reduce costs through centralisation of services, where more patients

[34] The King's Fund, *The reconfiguration of clinical services: What is the evidence?*, November 2014, p14

[35] NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, p1

would be seen at fewer locations. For some services, this came alongside some new, smaller locations to mitigate the impact (for example, more community services for mental health reconfigurations, and more urgent care centres for A&E reconfigurations.). However, limited evidence of financial savings was found for any of the proposed reconfiguration models.[36]

The idea of centralisation as a measure to relieve financial pressures is based on the idea of a larger hospital absorbing the capacity of a smaller, less-used unit. However, as the Nuffield Trust argued in 2015, this only works where units have spare capacity:

> The greatest potential savings from reconfiguration come when services from one hospital can be absorbed into the available capacity at another and a site is fully closed. Yet many English hospitals and their specialist units — such as maternity — are running at full capacity. The only way to accommodate new activity is to build additional facilities that may cost more than the facilities they replace. Savings are further reduced if services continue to be provided on the old site, for example, providing an urgent care centre, a midwife-led unit or paediatric assessment unit to support local access to services.[37]

A 2014 report by Monitor, *Facing the future*, also looked at economies of scale through hospital reconfigurations, and found a limited correlation between size of hospital and financial performance (although it did find a slight cost-scale relationship in maternity services). It also highlighted evidence showing that hospitals with over 600 beds started to exhibit diseconomies of scale.[38]

With regards to economies of scope (a reduction in unit costs when the number of services delivered rises), the King's Fund report also found little evidence of this for hospitals.[39]

However, the Nuffield Trust has argued that although the evidence base may be limited, that is not to say that reconfigurations never deliver savings, pointing to the examples of Trafford General Hospital and stroke services in London.[40]

Although the reconfigurations in the NIHR and King's Fund studies were from between 2007 and 2012, cost pressures are likely to remain a significant driver of future reconfigurations, particularly in light of the £22 billion of efficiency savings the NHS in England is expected to deliver by 2020/21.

There are also likely to be cost pressures from other Government policy objectives, such as the introduction of seven-day hospital services. A 2013 report by the Healthcare Financial Management Association

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[36] NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, pp xxvii-xxix

[37] The Nuffield Trust, *Fact or Fiction? Reconfiguring hospital services will deliver significant savings*, March 2015

[38] Monitor, *Facing the Future: smaller acute providers*, June 2014, p18-21

[39] The King's Fund, *The reconfiguration of clinical services: What is the evidence?*, November 2014, p23

[40] The Nuffield Trust, *Fact or Fiction? Reconfiguring hospital services will deliver significant savings*, March 2015

(HFMA) found that savings from shorter inpatient stays were unlikely to cover the additional costs required in all cases:

> Investment in seven day services after admission is unlikely to be cost-neutral in most trusts under the present configuration of services. However, it is fair to conclude from this small study that the move to seven day services does appear achievable, but it may be too expensive and unsustainable for all existing hospitals to move all their current range of services to a seven day basis. Reconfiguration of services may substantially reduce the cost, but this has not been tested in this research.[41]

The King's Fund and NIHR reports also looked at the issue of estates management as part of NHS bodies' financial considerations. The 2017 *NHS Property and Estates* review by Sir Robert Naylor looked at the efficiency of the use of NHS estates and proposed the creation of a new NHS property board to provide support on modernising NHS bodies' estates and releasing surplus land. In addition to the surplus land issues, the report also argued that land disposals as part of significant service reconfigurations could deliver savings of more than £0.5 billion per year.[42]

4.2 Workforce

Workforce pressures were identified, alongside cost pressures, as the main driver of service reconfigurations in both the King's Fund and NIHR studies. The NIHR study highlighted workforce pressures in reconfiguration proposals for: whole hospitals and trusts, A&E services, mental health services, maternity care, paediatric care, elective surgery, and primary and out-of-hospital care.

Many of the proposals, including for centralisation of services, were intended to improve staffing levels in the face of existing shortages. This was particularly the case in A&E reconfigurations, where reference was often made to meeting Royal College of Emergency Medicine guidelines on recommended staffing numbers.

However, the NIHR report found limited evidence of the proposals having any impact on staffing levels.[43] The Nuffield Trust also raised doubts about the impact of centralisation on staffing in 2015:

> Many hospitals are motivated to reconfigure services because they do not have enough doctors, particularly as they try to move to seven-day consultant-delivered care. For example, two hospitals may want to reconfigure A&E services onto one site in order to achieve a critical mass of staff to deliver 24/7 care.
>
> This will limit savings from medical staff. People may anticipate savings in junior doctors as they only have to provide junior doctor cover on one site instead of two. However, the number of

[41] HFMA & NHS England, *Costing seven day services*, December 2013

[42] Independent report by Sir Robert Naylor for the Secretary of State for Health, *NHS Property and Estates: Why the estate matters for patients*, March 2017, p3

[43] NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, pp xxvii-xxix;33

> patients in the centralised service will be similar to the combined numbers of the two sites.[44]

A 2014 report by Monitor also highlighted that many, particularly smaller, hospitals, were addressing consultant shortages through partnerships and networks, rather than through centralisation.[45]

With an ageing population, demand for NHS services is forecast to increase further, and therefore workforce pressures will likely continue to be drivers of service reconfiguration.

The Chief Executive of NHS Employers, Danny Mortimer, was reported in July 2017 in *The Guardian* as saying that the recruitment of EU nurses was "drying up", although the number of junior doctors applying from the EU appeared so far to be unaffected.[46]

As argued above by the Nuffield Trust, workforce pressures may also be affected by the Government's commitment to seven day hospital services.

4.3 Quality and safety

Although the NIHR study largely identified improving outcomes and safety issues as subsidiary drivers of reconfiguration proposals, it argued that they may have played a greater prominence than initially indicated:

> We cannot discount the possibility that the dominance of workforce drivers could be viewed as a proxy for safety concerns. It is possible that proposals would downplay safety issues as this could raise public concerns.

Health policy in recent years has focused on a move towards greater centralisation of services, in part to improve clinical outcomes. In an article for the *Telegraph* in 2014, the outgoing Chief Executive of NHS England Sir David Nicholson argued that:

> We know centralised, large units, with concentrated expertise and technology, work best in providing the most effective care, so we need to ensure this approach is applied to other parts of the service, for people with very rare conditions, and for significant planned surgery.
>
> For example, people with multiple long-term conditions need a senior clinician taking responsibility for active coordination of the full range of support, from lifestyle help to a stay in hospital.[47]

The NIHR study identified quality and safety drivers in reconfiguration proposals for A&E services, maternity care, paediatric care, and specialist care (vascular services, stroke and major trauma). Moves to centralise A&E and maternity services were identified as some of the most consistently contentious proposals amongst the public.

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[44] The Nuffield Trust, *Fact or Fiction? Reconfiguring hospital services will deliver significant savings*, March 2015

[45] Monitor, *Facing the Future: smaller acute providers*, June 2014, p10

[46] 'Brexit fears trigger exodus of crucial EU health and social care workforce', *The Guardian*, 5 July 2017

[47] ''NHS has to adapt to survive', says chief executive', *The Telegraph*, 11 February 2014

For A&E services, these proposals often included a greater use of walk-in centres and urgent care centres, to provide more treatment away from accident & emergency departments. The NIHR report found little evidence that more out-of-hospital urgent care facilities reduce hospital A&E attendances.[48] Moves to increase out-of-hospital facilities were a major feature of the 2013 NHS England review by Sir Bruce Keogh, *Transforming urgent and emergency care services in England*. The evidence base for the report found that inconsistencies in provision of out-of-hospital services were affecting their effectiveness:

> Urgent care services are characterised by variation and a lack of standardisation and clear information. This contrasts with the strong identity of A&E departments. Variation in acceptance and quality of care provided can result in delayed treatment or multiple contacts and a poor experience of care, as well as inefficient use of expertise and resources.[49]

With regards to the centralisation of maternity services, many of these proposals were driven by Royal College of Obstetricians and Gynaecologists guidance that favour obstetric units with more than 2,500 births as more clinically sustainable.[50] However, the King's Fund evidence review found limited evidence linking hospital unit size and quality of outcomes.[51]

With regards to specialist services, the reports found more evidence linking quality outcomes with more centralised, high-volume treatment centres. For stroke care, this was often through a 'hub and spoke' model, where patients received specialised care at hyper-acute centres, supported by an increase in the range of clinicians who could provide acute input, such as physicians and specialist nurses. The reconfiguration of stroke services in London was one such centralisation, which was argued to have saved 400 patients a year.[52] However, the NIHR report noted that there were issues with the results being obtained through a 'before and after' study, as compared to a randomised control trial.

4.4 Access

Changes to hospital access for patients are often one of the most contentious aspects of reconfiguration proposals. The NIHR study found that although access would often be affected by proposed reconfigurations, it was very rarely a stated driver in the 123 plans observed by the authors.

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48 NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, p36

49 NHS England, *The Evidence Base from the Urgent and Emergency Care Review*, June 2013, p12

50 NIHR, *Insights from the clinical assurance of the reconfiguration of services in the NHS: The drivers of reconfiguration and the evidence that underpins it - a mixed-methods study*, March 2015, p65

51 *Ibid.*, p76

52 'NHS needs to close wards and hospitals to centralise care, says doctors' leader', *The Guardian*, 24 July 2012

The former IRP chair Dr Peter Barrett argued in 2012 that access may be seen less as a driver of reconfiguration, and instead something that needs to be accommodated to other pressures and drivers:

> The reality is that easy access to all services in all locations is neither logistically nor financially possible. Whether or not there are enough doctors – or nurses and support staff - to run such a service, there are simply not enough patients within a category of care to make providing all services at all DGHs feasible. Accessibility has to be a trade-off that offers sufficient coverage and the right level of specialist expertise for a population within the logistical and financial boundaries of what the NHS can realistically provide.[53]

Centralisation was behind many of the proposals analysed in the NIHR study, which often led to the removal of units in particular areas. However, it can also be argued that if centralisation is accompanied with increased community or home-based services, this may actually lead to improved patient access. This rationale is partly behind successive Governments' moves to provide more services outside of hospital, although removal of services, particularly emergency services, from an area, will likely remain contentious. This point was raised by former Liberal Democrat MP John Pugh, in a 2013 article for the Nuffield Trust:

> To put it bluntly, the public simply want their way. If the hospital or the hospital unit cannot be both in A and in B, don't expect the inhabitants of B to be reconciled readily to it being in A or the honourable member for B to say so. Nevertheless, I don't think the public are quite as unreasonable as clinicians and hospital chiefs often suppose.
>
> They will travel to the ends of the earth to get life-saving treatment and a high quality intervention, but they sensibly see no need to travel far for basic triage or first-base treatment. They carry around in their heads a notional idea of the distance they must travel for medical reassurance. In my constituency, cancer patients travelled without complaint right across Merseyside to the Wirral.
>
> Yet the town was outraged when a reconfiguration meant that children suffering accidents had to be triaged just eight miles away in the next town. Clinicians have no such maps in their heads. They tend not to use local buses and regard roads as a purely council matter. They know roads can be a problem – but not an NHS problem.[54]

NHS England guidance to commissioners notes that proposals often fail to build public support where the case is not made strongly enough for the reasons behind increased patient travel times. The guidance makes clear that travel times should be considered as a key requirement in any proposed service changes.[55]

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[53] Independent Reconfiguration Panel, *Safety, Sustainability, Accessibilty - striking the right balance: reflections of a retiring Chair*, July 2012

[54] Dr John Pugh, *Reconfiguration versus re-election: public expectations and health reform*, 24 June 2013

[55] NHS England, *Planning, assuring and delivering service change for patients*, November 2015, p25-33

The King's Fund study reviewed the evidence of the effect of access on patient outcomes, and found that:

- Some studies suggest greater distance to hospital is associated with an increased risk of mortality. A 2007 study found a 1% increase in mortality risk for every 10 kilometres travelled, with a higher risk for those with respiratory distress.
- Studies also detected a 'distance decay' effect, meaning patients tended to use services less the further away they were, particularly low-income, elderly and disabled patients.[56]

4.5 Technology

The King's Fund identified technology as a potential driver of reconfigurations, particularly in terms of remote monitoring and consultation. It argued that this could mitigate pressures to centralise services that arose from workforce constraints. The report also looked at evidence of telehealth and teleconsulting, which can allow community or more remote hospital services to access specialist consultant diagnosis and advice.[57]

Improvements in technology may help further drive the Government's agenda for more out-of-hospital care. This was set out in the NHS Five Year Forward View, although there was also caution about the scope of potential impact:

> Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.
>
> But we do have an arguably larger unexploited opportunity to combine different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.
>
> The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.
>
> Over the next five years we intend to change that.[58]

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[56] The King's Fund, *The reconfiguration of clinical services: What is the evidence?*, November 2014, p24
[57] The King's Fund, *The reconfiguration of clinical services: What is the evidence?*, November 2014
[58] NHS England, *Five Year Forward View*, October 2014, p34

5. Sustainability and Transformation Partnerships

Sustainability and Transformation Plans (STPs), announced in December 2015, saw NHS bodies and local authorities come together across 44 geographic areas in England, to deliver population-based health and care over the next five years, in line with the Five Year Forward View (see section 1.3).

Draft plans were produced by June 2016 and final plans were submitted later that year, which are now subject to a process of assessment and further development. Since the submission of the sustainability and transformation plans, STP now also stands for Sustainability and Transformation Partnerships, the bodies responsible for delivering the plans.

In a 2016 King's Fund report, the focus of many STPs on reconfiguration was highlighted as an issue that could cause local pressure:

> Leaders from all STP areas recognised the potential political problems that their plans might face once they became public, at both a local and a national level.
>
> At a local level, a number of NHS leaders were concerned about the potential reaction from the public and local politicians to the service changes being proposed in their STP. This was particularly true when STP footprints were considering reconfiguring acute hospital services – such as consolidating services currently provided on multiple sites, or downgrading accident and emergency (A&E) services. As one leader said, 'there is going to be noise' from local people and politicians when the plans are finalised and announced. The lack of extensive public engagement in the plans so far was seen to have added to this risk.[59]

More detailed information can be found in the Commons Library briefing paper, *Sustainability and transformation plans and partnerships*.

5.1 Involvement with patients, the public and the NHS workforce

Although CCGs and NHS bodies have a duty to involve the public in decisions related to service reconfiguration (see section 2.1), concerns have been raised around the involvement of the public in the development of STPs and the transparency of the process.

Some stakeholders felt that engagement with the NHS workforce, the voluntary sector and the public was limited in the initial development of the plans submitted in 2016. The King's Fund traced media coverage of STPs from December 2015 to September 2016 and found increasing concerns about lack of public involvement:

> The volume of regional media activity increased in April. References to STPs appeared in news items about the 'financial

[59] The King's Fund, *Sustainability and Transformation Plans in the NHS: How they are being developed in practice?,* November 2016, p41

> crisis' facing NHS services, alongside terms such as 'privatisation', 'radical restructuring' and 'fear'.
>
> The concept of winners and losers in STPs entered regional media reports in May. Some stories reported concerns that rural areas could 'lose out' as a result of the plans. Articles also reported that a range of stakeholders (including GPs and local authorities) felt 'shut out' of the STP process.
>
> […]
>
> September was the busiest month for regional media on STPs. Articles focused on what STPs might mean for particular services in different parts of the country, after some draft plans were 'leaked' into the public domain. These articles were typically concerned with NHS services and beds being 'axed', 'centralised' and 'closed'. Coverage also continued in national broadsheets – although their focus was less on service changes and more on the secrecy of the process. Some pieces linked STPs to the possible privatisation of the NHS.[60]

On 15 September 2016, NHS England published advice for local health and care leaders on how to engage local people in the STP process. NHS England's Medical Director Sir Bruce Keogh addressed issues of transparency directly in a November 2016 speech:

> I am sure there are things that could be learnt about the process. But when you are trying to improve care for patients across a whole system things are never going to be straightforward. It would be naïve to think otherwise. We need to keep our eye on the prize and that is better care for the people we serve.
>
> Claims of secrecy have been overtaken by the fact that we've asked that all STPs are now published over the next few weeks. And the extra time this has provided has given local hospitals, GPs and mental health service leaders the time they need to develop a starting-point for local conversations.[61]

Significant service changes through STPs are still subject to public involvement and local authority scrutiny duties, the four reconfiguration tests, and the new bed numbers test (see sections 1 & 2).[62]

Lack of involvement of the public and of local authorities has also been raised as a concern by the Public Accounts Committee, in its 2017 report on *Integrating health and social care*,[63] and by the House of Lords Committee on the Long-term Sustainability of the NHS in its 2017 report.[64]

5.2 STP reconfiguration plans

Sustainability and transformation plans for each of the 44 footprints are publicly available. The plans are wide ranging, encompassing not only

60 The King's Fund, *Sustainability and Transformation Plans in the NHS: How they are being developed in practice?*, November 2016, p14-15

61 'Common sense changes will prepare NHS for future, says NHS top doctor', *NHS England press release*, 14 November 2016

62 PQ 9711 [NHS: Reorganisation], 18 September 2017

63 Public Accounts Committee, *Integrating health and social care*, HC 959 2016-17, 27 April 2017, p6

64 House of Lords Select Committee on the Long-term Sustainability of the NHS, *Long-term Sustainability of the NHS and Adult Social Care*, HL 151 2016-17, 5 April 2017, p19

proposals to reconfigure hospital services and move more care closer to home, but also ways to improve efficiency, prevent ill-health and address wider pressures facing the health and care system, such as workforce shortages.

The King's Fund has argued that due to the short timescales for introducing STPs, many are short on detail as to how proposed improvements in finances and outcomes will be achieved:

> When draft STPs were produced, leaders in all areas commented that their plans were 'high level' and lacking in detail on how broad principles (such as strengthening primary and community services) would be put into practice. This was seen as an inevitable consequence of the timescales that had been given to develop the plan – as well as the need to keep key details of service changes (where they existed) out of the public domain. But it meant that leaders often only felt ownership of the broad vision or 'case for change' set out in the STP, rather than any specific service changes to be implemented.[65]

As explored in section 4, there is mixed evidence on the impact of reconfiguration on financial savings and improved outcomes. With regards to STPs, the Nuffield Trust has highlighted concerns with a number of proposed improvements, for example with regards to emergency care:

> Our analysis suggests that some STPs are targeting up to 30 per cent reductions in some areas of hospital activity, including outpatient care, A&E attendances and emergency inpatient care over the next four years. Yet this is being planned in the face of steady growth in all areas of hospital activity – for example a doubling of elective care over the last 30 years.[66]

In September 2017, NHS England updated its 2011 publication, *Leading Large Scale Change: A Practical Guide*, as a planning resource for STP leads.

[65] The King's Fund, *Sustainability and Transformation Plans in the NHS: How they are being developed in practice?,* November 2016, p47

[66] The Nuffield Trust, *Shifting the balance of care: Great expectations*, March 2017, p4

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BRIEFING PAPER
Number 8105
9 October 2017