

# Hospital Reconfiguration

**An ippr briefing**

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# Hospital Reconfiguration: an ippr briefing

## Introduction

The new Chief Executive of the NHS, David Nicholson, has signalled a wave of reconfigurations of hospital services. The ippr provides a question and answer briefing to explain this story.

Our hospitals need to change and ippr research suggests that around one in four general hospitals will be seriously affected. For too long, politicians and senior NHS managers have been unwilling to have this debate with the public.

This should not just be about short-term cost-cutting. Bringing our health service up to world-class standards will mean closing some hospital units such as A&E departments in order to provide safer, higher quality care in more specialist centres, and providing more routine care closer to people's homes.

Not everywhere in the country will be affected equally. London, the North East and North West of England are likely to require the biggest changes. But the fact is we have too many general hospitals right across the UK.

ippr's Future Hospital project assesses the current and expected pressures on future hospitals. Looking beyond technical issues, we will research communities' attitudes to hospitals and health care and explore how the public and staff feel about anticipated changes. We will investigate case studies of hospital reconfiguration to explore how economic, clinical, public, patient and political interests have developed. The project will suggest how changes in health care provision that improve health and reduce inequalities can build on the popularity of the local hospital to ensure the future hospital is economically and politically sustainable.

This is an interim paper in the Future Hospital project. Further papers will be published this autumn and winter. For further information please refer to the project website: [www.ippr.org/research/teams/project.asp?id=2142&tID=100&pID=2142](http://www.ippr.org/research/teams/project.asp?id=2142&tID=100&pID=2142)

## Is it true that up to 60 hospitals will have to close?

No – as David Nicholson explained, it is unlikely that general hospitals will close completely. However, there is a need for about one in four hospitals to be reconfigured to improve safety and provide more care closer to home.

It is true that there are currently too many general hospitals in England. Acute care, like accident and emergency (A&E) and specialist surgery, needs to be concentrated in fewer locations so that doctors with the right skills, experience and equipment are available to treat the sickest patients safely. More routine services could be provided locally outside general hospitals in community centres more accessible to people who need them.

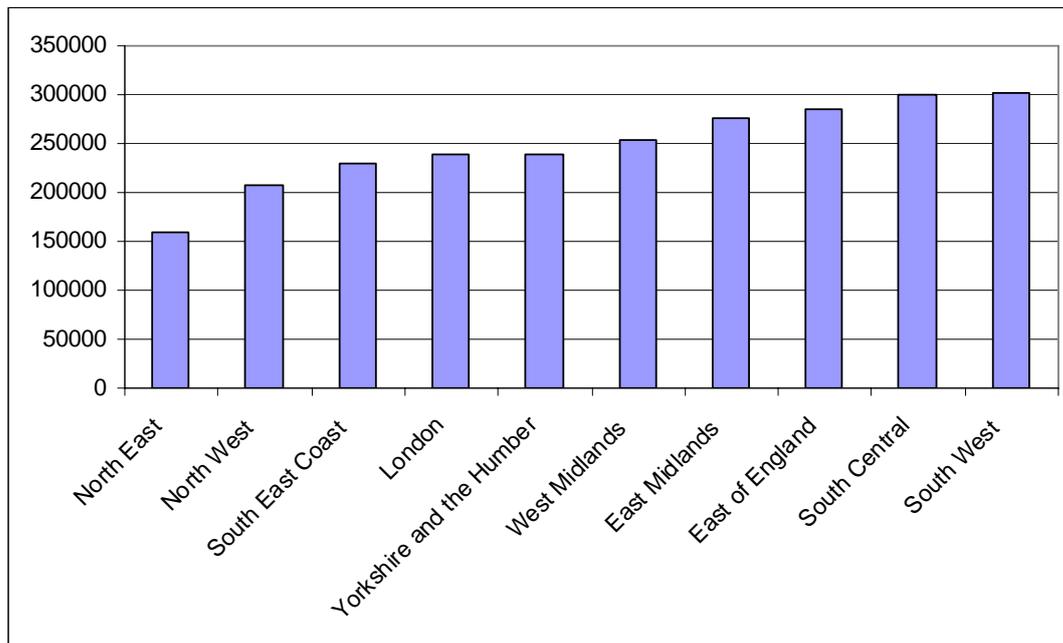
However, senior managers and Ministers have been unwilling in the past to argue publicly for hospital service closures. Local changes to health services can be very unpopular unless patients and staff are persuaded of the case for change and involved in the decision-making process. One reason why we have too many hospitals is that politicians like to open new buildings but are afraid of closing them in case they lose their seat.

## Where will these changes be?

Decisions about hospital reconfigurations can only be taken locally by managers and clinicians working closely with local people. Attempts in the past to plan service reconfigurations centrally were not sustainable or popular with patients.

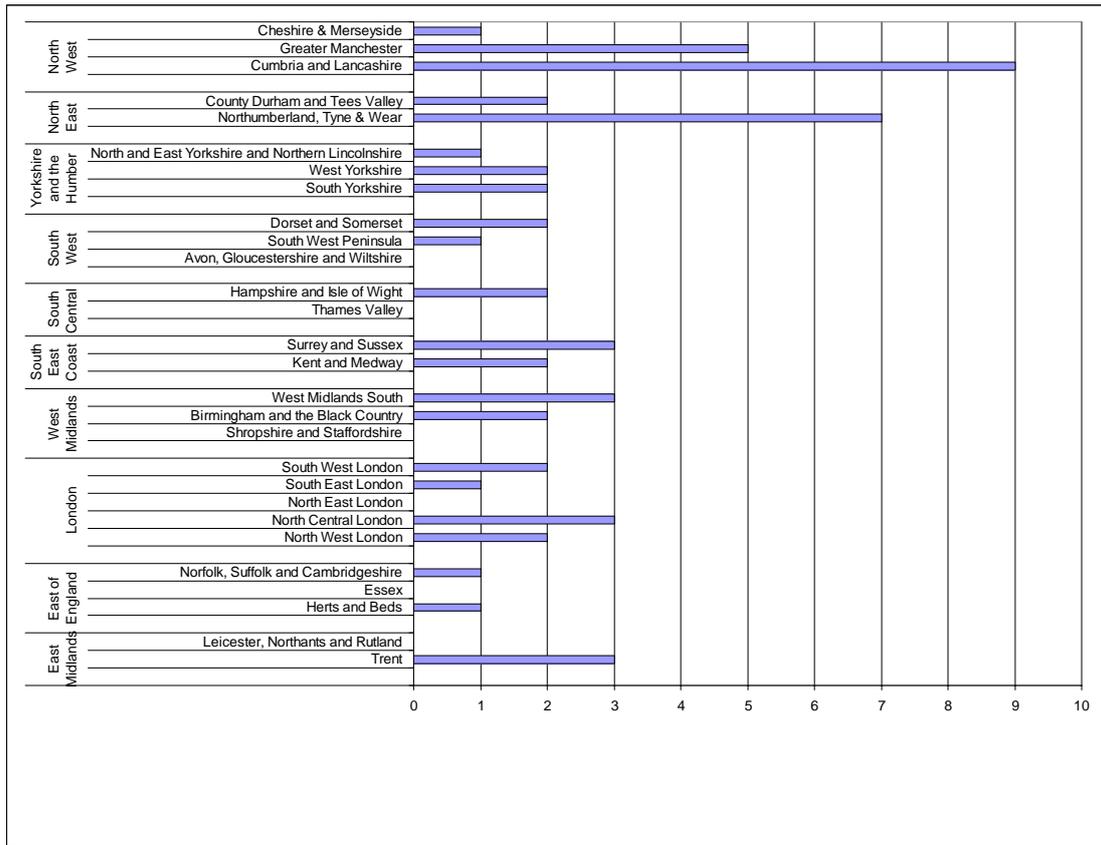
However, it is possible to predict the degree of change needed in different regions (NHS Strategic Health Authorities). ippr's research, based on advice from the top surgeons, suggests that the highest need for reconfiguration will be in London, the North East and North West where there are currently more hospitals per head of population.

### Population per general hospital



The Royal College of Surgeons of England recommends that hospitals providing emergency surgery, which is necessary to back up general A&E departments, should serve a minimum catchment population of 300,000 people. At present, eight out of ten NHS Strategic Health Authorities have too many hospitals according to this criterion. Breaking these down into smaller areas (former Strategic Health Authorities), about 57 hospitals would need to be merged in order for the NHS to provide a smaller number of A&E hospitals with safe surgical back-up, alongside more local services like minor injuries units and community hospitals.

**'Excess' general hospitals in each area (total = 57)**



**So should we have fewer, bigger hospitals?**

This paper does not argue for concentration of all hospital services onto fewer, larger sites. The primary objective for concentrating specialist services is to facilitate the safe performance of surgery. This is of course an important objective and one that has not been adequately communicated by political, management or clinical leaders. However, using hospital to population ratios is only one way of illustrating the problem, rather than a blueprint for reconfiguration.

The relationship between improved clinical outcomes and bigger hospitals with higher volumes of activity is a matter of some controversy amongst experts and we would not advocate a policy of centralisation of all services. For many procedures, services or conditions, the best quality research evidence of a direct relationship between volume and quality is debated, especially after controlling for other risk factors<sup>1</sup>. Government reconfiguration guidance emphasises that many procedures could be carried out locally rather than in major specialist centres<sup>2</sup>. For example, spreading good practice in neonatal intensive care treatments from larger to smaller hospitals eliminates differences in outcomes; pancreatic surgery can be performed safely in small hospitals; hip fracture and cataract surgery can be safely performed at lower volumes (from citations in the above sources). Advances in telemedicine, ambulatory care and collaboration between hospitals can also allow more services to be provided locally.

<sup>1</sup> Posnett, J. (2002) "Are bigger hospitals better?" in McKee, M. and Healy, J. (eds.) *Hospitals in a Changing Europe*, Buckingham: Open University Press.

<sup>2</sup> Department of Health (2003) *Keeping the NHS Local – a new direction of travel* London: DH; DH (2004) *The Configuring Hospitals Evidence File*, London: DH.

The implication of these findings suggest that much work currently conducted in general hospitals could either continue at that level, or be devolved further to local community hospitals and clinics. The White Paper, *Our Health, Our Care, Our Say*, sets out the Government's objective to move more services out of hospitals into treatment centres, and community facilities. This means we need more, smaller community hospitals to provide these more routine services closer to home, with a greater emphasis on keeping people healthy.

However, there is also evidence that points towards greater centralisation for certain specialties. In particular, there is strong evidence that major surgery such as cardiology, neurosurgery, liver transplantation, some cancer surgery and major vascular surgery is more safely provided in larger hospitals. These are reflected in guidance for hospitals, although in the White Paper and reconfiguration guidance these have been given less prominence. Where relationships between concentration and outcomes are evident, this is probably due to a combination of individual physician experience, the performance of surgical teams, and the availability of support services on site in bigger units. In order to provide a safe emergency service around the clock, the British Association of Emergency Medicine recommends that there needs to be immediate access to intensive care, anaesthetics, acute medicine, general surgery and orthopaedic trauma<sup>3</sup>. In turn, other hospital departments need A&E as a back-up in case surgery goes wrong. The interdependencies of services create pressures to concentrate in order to improve safety. Therefore in this paper we have taken the provision of A&E as an indicator of a general hospital that should be serving a population of at least 300,000 people.

In summary, these clinical volume/ outcome arguments suggest that some services could be further devolved to community levels to improve access, while for safety reasons other services should be concentrated to improve outcomes as a function of individual and team experience and support facilities. These pressures would be salient in a limitless healthcare budget.

However, the NHS (like all health systems) has practical resource constraints. These include financial resources but also, just as importantly, human resource constraints. There are limited numbers of doctors, nurses and therapists available, and it takes many years to train extra staff. There are also new regulations on the amount of time staff can work. Therefore it is important not only that we aim to improve outcomes by providing specialist surgery in centralised locations so that staff and teams have the requisite experience, skills and support to perform operations safely. We also need to ensure that we use scarce financial and human resources wisely. In some cases this may mean concentration of services in order to make the best use of expensive equipment; it also means that round-the-clock services cannot safely or practically be provided in some smaller hospitals where there is not enough money or qualified professionals to provide safe care to patients.

In some remote rural areas, smaller hospitals may need to be maintained to provide a minimum level of access. There will inevitably be difficult trade-offs in some areas and for some specialties between quality and distance. For example, local health communities may, in consultation with clinicians and the public, agree to maintain more specialist services at low volumes in smaller hospitals in order to provide services to more remote communities, even though the quality of services provided may be lower. In other, more populous areas, greater concentration may be desirable for more specialist services. Other reconfigurations may rationalise services across hospital sites without affecting A&E.

This analysis does not imply that the 'excess' hospitals should close. Only the specialist acute services, including emergency surgery and A&E, need to be concentrated in hospitals serving larger populations. Other services, including minor injuries units, outpatients, diagnostics and rehabilitation could remain on existing hospital sites or be provided more locally in community hospitals and clinics. The headline figure of 57 hospitals indicates the number of

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<sup>3</sup> British Association for Emergency Medicine/Faculty of Accident and Emergency Medicine (2005) *Way Ahead 2005* London: BAEM/FAEM

small A&E departments that would need to be merged with larger centres, along with other more specialist acute care.

## Why should hospitals change?

There are six positive reasons why hospitals should be reconfigured:

**1. Safety:** by concentrating acute care in fewer centres, hospitals would be able to ensure that surgeons were more experienced and that enough staff were available to look after any patient safely. Surgeons say that they can only provide care safely if they work in hospitals serving larger populations of over 300,000 people. Most hospitals serve smaller populations so surgeons may not be experienced or skilled enough. On average, one in four hospitals would have to be merged in order to achieve this size of population. The degree of over-capacity varies by region, as shown in the notes.

**2. Accessibility:** whilst specialist acute services like emergency surgery should be more concentrated, much more care could be provided outside acute hospitals in community hospitals and GP clinics. Most patients who currently attend A&E departments could be treated more locally in minor injuries units, or by ambulance service professionals at home.

**3. Efficiency:** more patients should stay for shorter periods at hospital after surgery, with appropriate support in community hospitals or at home. At present, there are big variations between hospitals in the length of time that patients stay in hospital.

**4. Prevention:** as society gets healthier and older, more people have long-term illness, requiring care at home, than acute conditions requiring hospital in-patient care. However, at present people with long-term conditions frequently end up in hospital because they do not get the preventive care they need. Long-term conditions affect more than 15 million people in England and account for 75 per cent of the time spent in a hospital bed. Dr Foster Intelligence<sup>4</sup> identified big variations across the country in keeping ill people healthier outside hospital, with some areas having 10,000 emergency admissions by 'high-impact users'<sup>5</sup> per year, compared to other areas with only 1,000 admissions. If more resources were available outside hospital to keep ill people healthier then there would be less need for hospital care. At least 50 per cent of people currently driven to accident and emergency departments by ambulance could be cared for at the scene by emergency care practitioners, in community clinics or minor injuries units<sup>6</sup>.

**5. Responsiveness:** Health care needs to be more flexible so that it can respond to changing health needs and patient demands. A hospital-focused health system, with lots of fixed costs and immovable buildings, is not able to adapt to changing needs easily. Smaller, more flexible providers closer to communities would be better able to meet changing needs and patient demands.

**6. Equity:** more and better primary and community services are important to ensure the NHS is a health service rather than just a rescue service for when people become acutely ill. There is an 11 year life expectancy gap between rich and poor in the UK, which has grown since the NHS was established. A preventive health system would need to be primary and community-care led, with a shift in resources from hospitals to community and primary care.

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<sup>4</sup> Dr Foster Intelligence (2006) *Keeping people out of hospital: The challenge of reducing emergency admissions* London: Dr Foster Intelligence.

<sup>5</sup> Defined as people who have had more than three emergency admissions in a year, many of whom have long term conditions that could be managed better outside hospital.

<sup>6</sup> Department of Health (2005) *Taking healthcare to the patient: transforming NHS ambulance services* London: DH

## Isn't this just about short-term financial cuts?

There are short-term pressures on hospitals that will force managers to think about the number of hospitals. These include:

**Doctors' working hours:** New rules about how long doctors are allowed to work mean that it is harder to provide safe services in smaller hospitals. Whereas ten years ago junior doctors often worked up to 100 hours per week, by 2008 the maximum working week will be 48 hours. The hours that doctors used to work meant that the risk of errors was increased. This would now be illegal.

**Choice and payment by results:** New ways of paying hospitals according to the numbers of patients they treat (in England) means that, if hospitals don't have enough patients to cover their costs, they will make a loss. Therefore hospitals may need to merge to ensure that they have enough patients to sustain their services, or close services where there is not enough need. One aim of these policies is to ensure that inefficient or unneeded services are not maintained.

**Financial deficits:** Many areas of the NHS were in deficit in 2005-06. The Secretary of State has asked all NHS organisations to break even by March 2007. This could mean that some areas reconfigure their services to make immediate savings. This maybe necessary in areas where the hospitals have been inefficient, for example where patients are kept in hospital for several days when they could go home with the right support. However, reconfiguration does not normally lead to short-term cash savings and may take time and money to ensure that local services are transformed.

## Aren't NHS hospitals closing because of privatisation?

There are good reasons set out above why hospitals should be reconfigured in order to improve safety and local access to community services. There are also long-term external factors including technology and changing health needs that mean our health services need to change. More immediate pressures like working time regulations affect all health services.

Competition from independent sector treatment centres (ISTCs) aims to create pressure on local NHS organisations to improve their efficiency. In some areas this could mean that local surgery departments have to close because there is not enough demand to sustain them, or they cannot run departments efficiently enough.

The Private Finance Initiative (PFI) may have encouraged local planners to build larger hospitals in order to attract private investment. This may have contributed in some areas to the problem of over-capacity in acute hospitals, which could reduce the flexibility of local services to adapt to changing health needs and patient demands.

It is important that reform policies, including the use of the private sector, are designed to encourage sustainable reconfigurations, improving care outside hospitals and ensuring that services meet the needs of patients in the future. However, reconfiguration is a challenge facing all developed countries. Wales, Scotland and Northern Ireland are also having to make difficult decisions about hospital reconfiguration, despite the different approaches to health reform in the devolved administrations.

## What happens next?

Some parts of the NHS have recently reconfigured their services, or are currently consulting on changes. Other areas have not yet begun to tackle these issues and this announcement should encourage managers to begin discussions with local stakeholders about redesigning health services.

It is not the role of the Chief Executive of the NHS to instruct hospitals to reconfigure their services. It is for local NHS organisations, led by Primary Care Trusts, to discuss with stakeholders including patients and staff what shape their future health service should take.

Achieving sustainable reconfigurations of hospitals is notoriously difficult. Aside from the more technical considerations explored in this paper, local staff, patients and politicians are very protective of local hospitals and are worried that these changes will lead to worse access to healthcare. Most famously, in the 2001 General Election, Labour Minister David Lock lost his seat to an independent anti-reconfiguration campaigner, Richard Taylor. ippr is currently examining the local politics of hospital reconfiguration and will be producing a series of papers in the autumn and winter.