A guide to hospital reconfiguration for doctors

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1. Introduction and background

This document was requested by BMA Welsh Council and builds directly on the Good Practice Guide produced in 2007 by the BMA's UK Consultants Committee (UKCC). The NHS in England is undergoing a process that appears radically and overtly fragmentary, which is not discussed further here. In Wales, as in Scotland and Northern Ireland, healthcare has become the responsibility of devolved government.

It is the stated intention of Welsh Government to maintain a national health service in Wales; to consider the health of the people of Wales as a priority of this system; and to work in partnership with Health Boards, the professions, other agencies, the voluntary ‘third’ sector and the people of Wales themselves to achieve the best value health per pound spent. What this means to the NHS in Wales, and how this is achieved, is the subject of the current service reviews being undertaken by each Welsh Local Health Board.

BMA Cymru Wales accepts the principle that service redesign is inevitable in the current climate of financial cut-backs – and challenges to training, staff recruitment and staff retention – that are being reported throughout Wales.

The process of service review (which has been the subject of a separate BMA Welsh Council position paper) is *not* synonymous with reconfiguration. Reconfiguration can take a range of forms: departmental re-organisations; mergers and closures of departments and hospitals; and the provision of new service units. Essentially, however, reconfiguration means that the way in which services are delivered will change, and usually results in some services being provided in more specialist centres, with others being provided closer to the patient’s home. In an ideal world one would balance the other, and everyone is then happy because care is provided that most meets patients’ needs. When it is done badly, however, it results in a worsening access to services for some patients (often those who are the most deprived or least able to access services in the first place) and risks perpetuating inefficient services elsewhere. For example, acute care – such as accident and emergency and specialist surgery – may be concentrated in fewer locations, whilst more routine services – such as diagnostics and rehabilitation – may simultaneously be provided locally in community hospitals and clinics. If this is not the result, this represents a service cut and should be clearly flagged up as such.
The situation in Wales is complicated as the same criteria for rationalisation cannot be applied uniformly because of the rural nature of and the geographical challenges that result away from the ‘M4 corridor’. There is a natural tension created, therefore, between evidence based on proxy data that do not directly relate to the current service(s) being provided; ethical considerations with respect to equity and health inequalities; and societal and political pressures – such as extra family and transport costs. The principles for considering these are given in the BMA Welsh Council position paper on service reviews.

Although Welsh Government will ultimately ratify radical changes to service provision, it has delegated the task at an operational level mostly – if not totally – to the seven Health Boards and two NHS Trusts. Hospital reconfigurations should be considered alongside other initiatives, such as the introduction of care closer to home and an intention to move more services out of hospitals into community settings. A more unified, co-operative approach has been promoted in Wales between healthcare providers than that seen in England, but the need for cross-border and highly specialised services needs to be taken into account in service design for Wales as a whole.

The original guidance was produced by the UKCC to highlight the key principles it believed should be fulfilled in order for service changes to be acceptable to the profession, and to assist consultants in their involvement in any such plans. This current document states the views of BMA Welsh Council, and is intended as a constructive attempt to assist the professions, healthcare providers, politicians and public in assessing the merits and consequences of any proposed reconfiguration changes.
2. Key principles

The health of every person in Wales is seen as equally important. Financial strain within the NHS has created a suspicion that service reconfiguration is being driven by short-term financial pressures, rather than on the basis of clinical need. Within the current budget allocation there is an horrendous cash shortfall in the NHS in Wales, and although Health Boards may deny the financial drivers, the fiscal implications of service changes must be considered in the light of all additional costs or savings.

Frontline clinicians must be involved from the outset to establish the case for change based on clinical evidence, and to allow them to engage with the public about the clinical desirability behind any changes proposed. There has been a notable lack of frontline clinical engagement in the process of reconfiguration reported by some BMA members to date, and this has inevitably caused both misunderstandings and unnecessary conflict.

Where there is good evidence of patient benefit, or where safety and standards can be preserved and enhanced, reconfiguration in some areas may be desirable. Reconfiguration of hospital services must stand up to scrutiny in terms of clinical gains.

Reconfiguration is acceptable to the profession where it:

- is evidence-based,
- is clinically-led in partnership with patients. ‘Clinically-led’ acknowledges the ideas and expertise of front-line staff caring directly for patients who often have a wider local knowledge of what works and what obstacles and barriers exist to more cost-effective care. It is neither ‘clinician-fronted’ rhetoric of a managerial imperative nor just the views of employed clinical directors,
- is demonstrably safe,
- maintains or enhances standards of care across a health economy, or produces an equivalent clinical service for less cost (particularly where this releases resources for reinvestment),
- protects those least able or most deprived from a change of service that would otherwise widen inequalities, worsen outcomes or increase user dissatisfaction,
• explores novel and different ways of providing services in an integrated and planned manner across the NHS, higher education institutions and Welsh Government.

These criteria are essential in securing the support of doctors for reconfiguration plans in their locality. Although decisions about hospital reconfigurations can only be taken locally, they require full clinical and patient engagement and consideration of the overall health of the public across the whole of Wales.
3. The case for change

It is recognised that reconfiguration of hospital services will be justified sometimes on clinical grounds. Clarity is required in defining what is meant by ‘best clinical outcomes’ and there must be transparency in the identification of non-clinical factors that may have affected outcomes historically, such as under-investment or differential and preferential staffing arrangements.

An under-utilised A&E centre that is not greatly benefiting its local population, for example, may be drawing resources away from one that desperately needs more capacity. Provided a good patient transport infrastructure is in place it may be justifiable to re-grade, or even in rare circumstances close, the unit under consideration. This must be determined carefully and there are cautionary tales from elsewhere in the UK. It is manifestly important that Wales looks at services as a whole, and not just within individual Health Boards that might have adjacent services close by but outside their area – including across the border in England.

Similarly, clinical problems may stem from the geographical dispersion of hospital sites, and these problems may provide legitimate reason for considering the viability of a hospital site or service. For example, research suggests that if heart attack services were centralised so that all heart attack patients could receive angioplasty, then fewer patients would die per year. This has happened with the siting of the cardiac catheter lab on the central Glan Clwyd site. In some cases, concentrating services may make the best use of expensive equipment and allow for the provision of round-the-clock services. This has also been seen with stroke services.

In remote areas, however, smaller hospitals may be needed to provide a minimum level of access. It is vital that appropriate transport links are considered in all reconfiguration discussions, if unnecessary tragedies are to be avoided. It is inappropriate to shift the burden of travelling extensive distances to large numbers of patients if this could be avoided by better planning of health services.

In other situations change might mean shifting care into the community, allowing patients to gain access to more services closer to their home, rather than by travelling to hospitals. Patients could stay in hospital for
shorter periods after surgery and, with appropriate support, could be treated for long-term conditions in community hospitals or at home. A failure to plan for this has created unnecessary strain on the NHS in Wales.
4. Review of proposals for service change

In a review of service change and reconfiguration proposals commissioned in 2006 by the Chief Executive of the NHS in England, Sir Ian Carruthers stated that:

‘Without exception the proposals are not about closure or simple downgrading. They are about the NHS adapting itself to new patterns of care, using leading edge technology and care pathways to treat people more quickly, more safely and in more convenient settings.

‘In order to deliver better outcomes for patients, some specialised services like trauma, should be centralised in specialist hospitals, in order that clinicians and frontline staff have access to the best equipment and experience, and patients receive the specialist care they need from specialist staff.’

A number of recommendations from this review focused on improving processes and ensuring early clinical engagement. Such recommendations included:

a a full business case setting out the clinical and patient benefits of service change… should be produced for all proposals, before clinical consultation begins,

b a senior clinical lead should be identified at the outset, and should have support to help them ensure that clinicians are involved in the proposals for change,

c before embarking on the process, it is important to have a clear, evidence-based communications and stakeholders engagement strategy, which is managed and effectively delivered throughout.

In Wales, it is unclear who provides an independent oversight of hospital reconfiguration. The terms of ‘stakeholder’ and ‘clinical engagement’ have been altered by the previous Health Minister in favour of Health Boards, and formal consultation with the public has been delegated to the Community Health Councils, which seem to be in the process of becoming more centrally-organised, appointed bodies. Since everyone who lives in Wales has a stake and thus a ‘vested interest’ in the Welsh NHS, it is easier to be pragmatic and to state that there is no such thing as an ‘independent’ view or report per se, therefore progressing debate on the basis of this understanding.
In taking decisions about service changes, the Scottish Government, for example, has indicated that it would approve proposals where:

- There is evidence of improved clinical outcomes.
- There are resource or workforce constraints and it can be demonstrated that:
  - the services are highly specialised and a clinical benefit will result; or
  - the services included 24-hour receiving of seriously ill patients; or
  - the services involved care for medically unstable patients through the night; and
  - service redesign will not achieve a sustainable outcome.

In Wales, the National Clinical Forum has been established by the Welsh Government to provide a sounding block for Health Boards to present their service reconfiguration plans, but there are doubts about whether this represents a process of robust independent scrutiny and whether it carries enough expertise to understand the complex health, social and local political issues that many try to simplify inappropriately. There is wide clinical representation, but the BMA is not represented on this group. In Scotland, when taking final decisions, the Cabinet Secretary was guided to operate a policy presumption against centralisation, but the policy position in Wales is less explicit.

BMA Cymru Wales shares BMA Scotland’s position in supporting the principle that care should be as local as possible but as specialised as necessary, and that the key factor in any decision is a well-staffed service that is high in quality and safe for patients. NHS plans based on political expediency in response to local pressures will most likely not improve patient care. Local views therefore have to be balanced with clinical considerations; sustainability; safety; and value for money. Both BMA Cymru Wales and BMA Scotland support public engagement and consultation at an early stage in any proposed major reconfiguration, before any decision on the preferred option has been taken. Clinical engagement must not be a window-dressing exercise for clinically-fronted, management-driven changes to service.
Services should be provided on the basis of patient need and a demonstration of best outcomes. Welsh Council advises against making assumptions that larger hospitals are automatically ‘better’ than smaller hospitals. Although there are economies of scale, clinical networks may offer the same benefits over a wider geographical area and there is evidence that hospitals above a certain size can have worse outcomes because they cannot pay appropriate attention to individual patients than those more able to focus on personal health needs.

If services are poorer in one location than another, due credence should be given to maintaining the higher quality service. This means avoiding parochial protection where evidence shows another service to have better outcomes; the pain of reconfiguration should fall on every aspect of health and social care in Wales, and it should be driven by quality, safety and performance – and not by reputation. Indeed, there is much to be learned about reducing waste and variation in NHS Wales by supporting high performing teams and learning from them, wherever they are in Wales. Where data support it, disinvestment from the centre into higher-performing localities is a possibility. Such data, where they exist, should be analysed and discussed openly, objectively and with the public.
5. Getting involved – questions you need to ask

Clinical involvement is essential, and doctors should seek to be involved in reconfiguration engagements and consultations wherever possible. As many Health Boards and NHS Trusts appear to have very poor communication with and between professional groups, secondary care doctors should discuss changes readily and extensively with each other and with colleagues in other services and hospitals. Furthermore, discussion is also essential with community and primary care colleagues – still a challenge within existing NHS structures, but one that the integration into Health Boards was designed to avoid. If your department or hospital is likely to be affected by reconfiguration and centralisation, you should consider whether any – and not necessarily all – of the following justifications for reconfiguration are being cited:

- increasing specialisation and complexity of skills (e.g. angioplasty, vascular surgery),
- fairer distribution of services,
- provision of treatment closer to the patient’s home, and the benefit to patients who have long-term conditions,
- enhanced delivery of a service (e.g. by combining two small adjacent maternity units).

Where it is claimed that a reconfiguration is based on a clinical problem, consultants should already be aware of the problem and have perhaps been involved in bringing it to light.

If the four points above are not demonstrably present, or if local consultants appear not to have been involved in the plans, you might like to consider raising the questions listed in Section 6 of this document with your hospital’s senior management team, either as an individual or as a group.
Your local BMA Division can assist you in addressing your concerns. In Wales, the ability of GPs, SAS doctors, juniors and consultants to communicate rapidly within their divisions and across branches of practice has been key to effective professional engagement. The Local Negotiating Committees, Local Medical Committees and BMA Cymru Wales office in Cardiff can give you protection from undue employer pressure and other outside interests. BMA Cymru Wales will support members in fulfilling their duty to patients, as outlined in the GMC’s ‘Good Medical Practice’.

**The duties of a doctor registered with the General Medical Council**

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- make the care of your patient your first concern,
- protect and promote the health of patients and the public.

It is important that the profession stands up for patients and that it questions decisions that do not make clinical (or even common) sense, even if there is a superficial belief that it is too late to alter them. Conversely, we believe that doctors should not oppose a clinically-justified reconfiguration because of their own interests. This is a difficult area, because it is easier to make decisions about patients and staff that don’t directly affect your own working practice and more difficult to see the bigger picture for Wales and for the most vulnerable in our society. The interdependencies at play in modernising the NHS in Wales may mean some personal and professional sacrifices and changes to the ways all of us work.

To avoid changes that may subsequently turn out to be catastrophic for the NHS and the population in Wales, BMA Cymru Wales will challenge, where appropriate, the assertion that the collapse of services is inevitable or irreversible in all circumstances. It will achieve this by utilising the expertise of the medical profession in considering radical alternatives that could be explored by Health Boards, politicians and other organisations – such as the Universities and Welsh Deanery. The ‘Francis Report’ manifestly states that we have a duty to highlight potential mistakes and dangers that would lead to poorer outcomes, reduced quality of care and increased patient
dissatisfaction, in our case, extrapolated to the NHS in Wales. For contact details of your local BMA Division, please contact support@bma.org.uk. A number of BMA Divisions are already taking an active role in cases where the motives for reconfiguration have been questioned.

BMA Cymru Wales is keen to receive feedback and case examples of where reconfiguration has been carried out, either successfully or unsuccessfully. If you have specific concerns, but would like them to remain as confidential as possible, these can be e-mailed to: jthomson@bma.org.uk. We will find a way of linking you with local and national support.

You might also consider writing to your local Member of Parliament (http://findyourmp.parliament.uk/) or Welsh Assembly Member (http://www.assemblywales.org/memhome.htm).
6. Key questions

To what degree is the reconfiguration based on financial pressure?

- Are services being cut without detailing the investment in the services that will replace the scaled-down services, or demonstrating a genuine reduction in the need for such services? Are services being lost in totality, entirely to save costs?

- Does the proposed reconfiguration not only offer a solution to short-term deficits, but also be part of a programme of service improvement sustained by financial stability?

- Where there are moves to improve timely discharge of patients, which is both clinically appropriate and financially desirable, will there be adequate follow-up healthcare and social support closer to patients’ homes?

- Are there any financial or operational dependencies that will change as a consequence of a reconfiguration and weaken other NHS services, potentially destabilising them? Pathology services perhaps?

To what extent will reconfiguration be clinically-led and evidence-based?

BMA Cymru Wales emphasises the need to distinguish between service change after consultation and agreement with front-line staff, and ‘clinically-led’ changes that represent managerially-motivated clinician-fronted reconfiguration, because the priorities may not be aligned. The best interests of patients and the service can mean different things to different groups, depending on context.

- Have you been properly consulted on the reconfiguration? Clinicians – of all Branches of Practice – should be engaged early on in the process.

- Can you be confident of the clinical reasons for the reconfiguration? For instance, were the choices for reconfiguration driven by party political considerations, perhaps to retain a popular but clinically less preferable site?
• How will the clinical benefits of the reconfiguration be measured (e.g. against national standards of care)? This is somewhat difficult for the devolved nations as several UK ‘national standards’ are based on UK large urban populations, or within 30 miles of these, and they may not always be applicable to the more rural situations in Wales. Furthermore, these consensus standards may be based on poor quality evidence and constitute opinions of ‘experts’ who have no first-hand experience or understanding of rural issues and constraints, but they are then quoted and applied by managers and politicians inappropriately.

• Have the potential ‘whole system’ effects of any transfer of services been assessed and mitigated in advance e.g. transport implications?

• Have the responsibilities for clinical delivery and competency been defined in advance of any transfer of services? Is there clinical involvement and leadership in the proposal? This is important because clinical staff have different experiences and it cannot be presumed that this level of expertise will occur naturally somewhere else.

• Where an Emergency Department or other emergency service, such as general surgery, is moved away from a hospital, does adequate emergency support remain for the rest of the hospital to function in a suitably-integrated manner?

To what extent will there be public consultation?
• How will the public (including patients and carers) be engaged in developing the proposals for change? How will their views be followed-up and weighted in any recommendations? The public need to understand the case for change, how it will impact on them and what the benefits will be.

• Have communications aimed at the public been considered to ensure relevant and clear information is easily accessible to them? Information needs to be provided in a way that is easily understood and not misleading.
How will the reconfiguration affect other aspects of the service?

- Where services are reconfigured, there are often knock-on effects for other areas of the health service. Does reconfiguration destabilise other departments to their detriment? For example, will a hospital remain clinically viable when a key part of one specialty is moved to another site? *This was the case, for instance, against moving emergency general surgery in north Wales. This is a complicating factor that argues against one service taking unilateral decisions without considering, and allowing for, unintended consequences. This is particularly so when considering teaching and training across Wales as a whole – a hospital with no surgical trainees is unlikely to be recognised for general medicine training, for example.*

Have education and training needs been taken into account?

- Will the reconfiguration result in a reduction in training opportunities for trainees?

- Will the reconfiguration result in a drop in the number of trainees’ posts?

- How will research and teaching be delivered if reconfiguration takes place? *This will need serious consideration as undergraduate education takes place in almost all clinical environments in Wales.*

- To what extent have providers of medical education been consulted? *(Undergraduate and postgraduate training will be subject to an additional BMA Welsh Council position paper.)*
7. Where reconfiguration directly affects you (individual and collective rights)

Depending on the nature of the reconfiguration you may be asked to change your job plan (including a potential drop in Programmed Activities), be asked to relocate, or, in extreme circumstances, you may be subject to a redundancy process. There have already been examples of consultants being threatened with redundancy notices in England, and where BMA representation has averted redundancies. It is important that you are clear what protection you have if you are being asked to travel large distances as part of your new job plan or being asked to change your on-call arrangements – either to cover a site that may be 30-40 miles from your home or base hospital, or to be resident on-call. The amended Welsh Consultant Contract is specific about this, but the Local Negotiating Committee and BMA Cymru Wales need to know when there is pressure being applied to members to accept local variations to terms and conditions of service. This should be discussed with your Assistant Secretary via the BMA’s first-point-of-contact number – 0300 123 1233. Your LNC Chair will help.

Therefore, regardless of the broader arguments surrounding reconfiguration, you should consider how reconfiguration might affect you personally and how you need to respond to protect your own personal interests.

If you suspect that your personal employment situation will be affected you should immediately call the first-point-of-contact number on 0300 123 1233 to access the BMA’s employment relations’ services. First-point-of-contact advisers will initially discuss your situation and tailor BMA support to your individual circumstances, as appropriate.