

# Changing care, improving quality

Reframing the debate on reconfiguration





# The partners

**The NHS Confederation**  
[www.nhsconfed.org](http://www.nhsconfed.org)

**The Academy of Medical Royal Colleges**  
[www.aomrc.org.uk](http://www.aomrc.org.uk)

**National Voices**  
[www.nationalvoices.org.uk](http://www.nationalvoices.org.uk)

# Contents

Foreword	2
Executive summary	4
Introduction	7
The case for change	8
Meeting patients' changing needs	9
Improving quality, safety and outcomes	12
Achieving better value	15
Challenges of reconfiguration	17
Getting access right	18
Getting resources right	21
Getting the system right	25
Getting leadership right	29
Getting communication right	32
Getting collaboration right	35
Conclusion	38
Participants	39

# Foreword

Change is rarely easy. This is particularly true when dealing with an institution as complicated and cherished as the NHS. The health service is constantly under pressure from rising demand and limited resources, and must keep evolving to adapt to patients' changing needs and innovation in treatments. Challenges will always emerge from this process, but we are concerned that the debate on change has become polarised and is excluding those looking to engage in a more meaningful way.

Reconfiguration, the term often used to describe large-scale changes in healthcare, has increasingly become associated with making cuts and downgrading services. It is also more commonly associated with changes to health services that have been triggered and driven by a financial or clinical crisis. As such, the act of transforming how we deliver care is regarded by many as a threat to the services people rely on.

That is why we came together to produce this report. As national bodies, we seek to convene patient groups, clinicians and managers from across the UK to move the debate on, understand what is driving change in our health service and consider how we can ensure it always works in the best interest of patients. Nobody understands the NHS better than its

'Healthcare should never be allowed to stand still. It should never be permitted to accept that care is not as good as it could be'

patients, clinicians and managers. Every day, they witness at first hand the incredible achievements of a healthcare system that is recognised around the world. But they also observe that historical patterns of provision mean care is often not in the right place or at the right time to achieve the outcomes patients want, and there are sometimes disastrous failures to maintain standards.

Healthcare should never be allowed to stand still. It should never be permitted to accept that care is not as good as it could be. If there is good evidence from clinical research and patient experience for changing healthcare, to improve it and deliver it in a more consistent and sustainable way, we must be at the forefront of the discussions of how to do so. We know there will be concerns about the challenge and we do not pretend that we will always agree on how health services should change. Cooperation requires all of us to face up to difficult questions about the demands we place on the system. We all bring our own concerns and worries to that discussion, but these anxieties are better considered collectively, rather than in isolation.

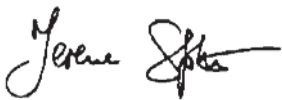
This report aims to highlight the value of collaboration and use our stakeholder conversations to support those engaged locally in making a decision on whether to redesign services and, if so, how to make change happen. It provides an authoritative, expert view on a case for change that focuses on how to meet the needs of patients, improve the quality of care and achieve better value for society. This type of change demands co-production and a whole-system approach to developing new models of care that treat patients in the right

place at the right time. It is not recommending change for the sake of change or for services to be redesigned without proper patient and public engagement.

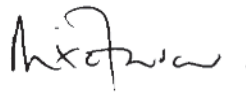
The views have arisen from focused, structured interviews and a facilitated seminar with experts in this area. Although many of our recommendations are aimed at leaders in England, our message on change is relevant for healthcare across the UK. We do not

prescribe how change should be delivered at a local level and nor should we. Nevertheless, we hope that the reasoned debate presented in this report will support people to have the courage to engage with their local health services and help reframe the narrative in changing them.

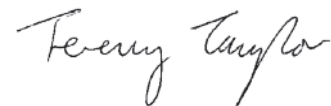
Please take the time to read our report and consider it as part of a more constructive debate on one of the biggest issues facing the NHS.



**Prof Terence Stephenson**  
Chair, Academy of Medical  
Royal Colleges



**Mike Farrar**  
Chief Executive,  
NHS Confederation



**Jeremy Taylor**  
Chief Executive,  
National Voices

# Executive summary

One of the greatest challenges facing the health service today is the need to redesign services to meet the needs of patients, improve the quality of care and achieve better value for society. There is growing support among patient groups, clinicians and managers for the potential benefits of 'reconfiguration' in health services, which focuses on making large-scale changes to provide care in the right place at the right time.

The Academy of Medical Royal Colleges, the NHS Confederation and National Voices have come together to examine the case for radical, far-reaching change across the NHS. This partnership brings together important views from those who know the healthcare system best, gathering evidence from over 50 face-to-face interviews and a series of workshops and meetings.<sup>1</sup>

This report outlines what we learned from these crucial conversations and aims to support those engaged locally in making a decision on whether to reconfigure services and, if so, how to make change happen. We have identified six key principles to consider as a foundation for most reconfiguration plans:

## **1. Healthcare is constantly changing**

Health services cannot be allowed to stand still and now, more than ever, they will need to adapt to an ageing population and the proliferation of innovative treatments.

## **2. There are significant benefits to delivering new models of care**

Clear evidence on better experience and outcomes for patients highlights that there is more to be gained than lost in changing many services.

## **3. 'Reconfiguration' is a catch-all term**

Reconfiguration is a general term for a collection of different types of change, the drivers of which need to be understood to consider their potential benefits.

## **4. Patients can co-produce better services**

Patients and their organisations need to be engaged as equals to critique current provision and redesign it to meet their needs and preferences, a practice known as 'co-production'.

## **5. A 'whole-system' approach is essential**

One service cannot be changed in isolation from the rest of the system. New models of care will require the health service to go beyond traditional borders in healthcare to deliver the most public value.

## **6. Change requires consistency of leadership**

Strong leadership is needed to develop change with the local community. This collaboration relies on strong relationships to be formed between leaders, built on trust and experience.

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1. A full list of the participants can be found at the end of this report.

It is clear, however, that some people are suspicious of changes they perceive to be aimed at cutting services and downgrading the care they receive. This is because many attempts at change have failed up to now and have established a toxicity to the debate on reconfiguration. This is reflected in a narrative that tends to focus on the closure or downgrading of hospitals, not the significant benefits that might be gained from developing new models of care.

The current debate on service reconfiguration needs to be reframed, but to do so we will need to learn from where change has failed in the past. This report offers an authoritative, expert view on the causes of these past failures. From that, there are ten recommendations to consider. Some of these are about how local organisations can manage their plans for redesigning services and what they can do to better understand and respond to public concerns. There is also a role for government and national leaders to support local communities to redesign services in the interest of patients.

## **Our recommendations for local leaders**

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### **1. Co-produce any change with patients – don't rely on formal consultation**

Where patients and their organisations are engaged from the start as equals in shaping the case for redesigning services, it is much more likely that reconfiguration will meet their needs and preferences and succeed in delivering better experience and outcomes.

### **2. Create a clinically-driven case for change, to motivate clinical leaders**

Clinical leaders bring credibility to decisions about health services and are motivated by a desire to improve them so they can cope with future challenges. Clinicians who are engaged from the start in shaping the clinical basis in service redesign are more likely to take on leadership roles.

### **3. Make the case for value**

Financial risks and benefits need to be openly discussed, along with the benefits to patients and the public. The focus should be on delivering 'public value' in the form of better experience and outcomes for patients and more appropriate use of resources, rather than solely on financial savings.

### **4. Provide a forum to consider access**

Access concerns cannot be ignored. Patients, staff and the public need the opportunity to highlight any issues they have with the impact of changes, many of which can be solved by working with local authorities and transport groups.

### **5. Develop plans openly with staff**

Staff will understandably have concerns about how changing services will affect their jobs. Rumours have a tendency to spread quickly through organisations. Staff need to be regularly updated with plans and offered the opportunity to input into proposals that are developed openly.

## Our recommendations for national leaders

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### 1. Provide more slack for change

A number of structural barriers are hindering change at the local level. As part of their review of the payment system, Monitor and NHS England should prioritise incentivising new models of care and allowing commissioners the flexibility to create investment in change.

### 2. Communicate a national vision on community services

Community care can often be unseen, causing concerns about how it can support hospitals. National leaders need to promote coordinated, person-centred services close to home to deliver better outcomes for people with many long-term conditions and better value for limited resources.

### 3. Be clear about the rules of engagement for crisis-driven change

Reconfigurations may be driven through the failure regime, which offers less time than is often needed. There needs to be a clearer sign from Monitor that change should not be pushed through in a crisis and that meaningful public and other stakeholder engagement needs to be retained.

### 4. Let change be driven locally and regionally

Further reorganisations of the NHS or major policy shifts will hinder the ability of local leaders to work together and build relationships. Continuity in leadership is a key factor to facilitate complex changes.

### 5. Establish a political consensus on clinically-driven change

Politicians need to join with patient groups, clinicians and managers to highlight the potential benefits of change, where the evidence is strong, and promote the realised impact it has on care.



# Introduction

Service reconfiguration faces many hurdles, of which semantics and language are fundamental issues. With a myriad of different meanings and connotations, 'reconfiguration' is understood differently by different people. This is reflected in a narrative focused primarily on the closure or downgrade of hospitals, rather than on the significant benefits of developing new models of care. As a result, reconfiguration is seen by many as a threat to the services people rely on, and an attempt to rob patients, staff and the public of something important. Such perceptions are counterproductive, and many will need to be convinced of the merits of reconfiguration so it can deliver potential benefits.

As the voices of clinicians, managers and patients, the Academy of Medical Royal Colleges, the NHS Confederation and National Voices have come together to reframe the current debate on service reconfiguration, bringing together important views from those that know the healthcare system best. This report is the result of over 50 face-to-face interviews with patient groups, clinicians, managers, academics, statutory bodies and

politicians conducted across the UK, and a series of workshops and meetings to collectively discuss healthcare. It summarises these discussions and presents a collective voice on why health services should change and the concerns about how to make change a reality.

The three lead organisations for the project are:

- **Academy of Medical Royal Colleges:** the independent body comprised of presidents of 20 medical royal colleges and faculties that promotes, facilitates and, where appropriate, coordinates their work.
- **NHS Confederation:** the independent membership body for all organisations that commission and provide NHS services; the only body that brings together and speaks on behalf of the whole of the NHS.
- **National Voices:** the national coalition of health and social care charities in England, which works to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

## What is reconfiguration?

Reconfiguration is a general term for a collection of different types of change, often used to describe large-scale changes in healthcare. Three types of change featured prominently in our discussions with patient groups, clinicians, managers, academics, statutory bodies and politicians, and are explained in more detail throughout this report:

- moving care out of hospitals into 'wrap-around' primary and community care
- centralising specialist services to concentrate quality
- reacting to hospital trusts that are unsustainable (the failure regime).

We use the term 'reconfiguration' fully aware that it symbolises an unnecessarily technical language that has, up to now, alienated many people. We have tried, where possible, to speak directly. If a more constructive debate is to be had, we will need to consider our language carefully, so that everyone who should be part of the discussion is motivated to do so.

We are more specific about the types of change when discussing the main drivers in the first half of the report, but use the term reconfiguration more generally as it develops to consider why some have failed. The principles outlined in the conclusion are offered for all changes and should be applied to reconfiguration as a whole.

# The case for change

There is nothing unusual about change in the NHS. Current public spending on healthcare is £118 billion, which is more than ten times bigger than the original NHS budget in 1948.<sup>2</sup> This growth in resources has funded a transformation in how services are delivered, often in response to the challenge of growing demand and the development of new technologies and methods of treatment.

Health services have therefore evolved and changed since the inception of the NHS, as has healthcare in other developed nations. This doesn't mean change occurs naturally in the interest of patients. In fact, it requires a deliberate decision by those in the system to direct it towards that purpose. Reconfiguration is this deliberate decision to do things differently and to find alternative ways to deliver healthcare.<sup>3</sup> Mental health services, for example,

are unrecognisable now from those delivered before large-scale changes moved more care into the community and out of large institutions, which were generally deemed to be inappropriate places for many patients to be treated in.

It has been suggested that the impetus for change in health services should come from outside of the system, but to deliver real improvements to patient care, change must be driven and encouraged from within.<sup>4</sup> We have to recognise how to work together to devise new solutions. This report discusses the drivers for doing this in more detail. It highlights what patient groups, clinicians and managers have told us about why health services need to change now and how large-scale redesign can be used to develop new models of care that allow the right care to be delivered in the right place.

## The three drivers which were identified and will be considered in more detail:

**1. Meeting patients' changing needs – page 9**

**2. Improving quality, safety and outcomes – page 12**

**3. Achieving better value – page 15**

2. Office for National Statistics (2011) *Expenditure on healthcare in the UK: 2011*.

3. National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (2001) *Organisational change*.

4. Clayton M. Christensen (2009) *The Innovator's Prescription: A Disruptive Solution for Healthcare*.

## 1. Meeting patients' changing needs

"Patients don't want to go to hospital. Reconfiguration should be about making the health system more convenient for them."

**Patient group**

"There is certainly a percentage of patients in emergency departments that could be seen in other settings. The size can be argued, the existence cannot."

**Clinician**

"We are bound by history of where hospitals are built. The system is not designed to work for patients, everywhere there is a barrier."

**Manager**

Patients need to be at the heart of everything the health service does and should not fall through gaps in the system. People are living longer today and the health service has to adapt to caring for the needs of an older population, who tend to have more complex long-term conditions with multiple needs for clinical treatment, care and support.

Care is too often not joined up and people are treated by teams who do not work across disciplines. This can work well for patients with conditions that are relatively easy to diagnose and treat, but is more difficult for those with longer term conditions. Services for the latter

'Reconfiguration will need to focus on developing new models of care that are able to provide packages of care closer to home'

can be difficult to navigate, as they need to manage their health over time and require a wider range of services.

We were told that many patients find themselves being shunted around the system, and that it would be better if more services were designed and organised around their needs. Reconfiguration will need to focus on developing new models of care that are able to provide packages of care closer to home. The current tendency can be to push patients into hospitals by default, whereas they need access to the right treatment in the appropriate setting for their condition. This is not to suggest that older people are not safe in hospitals, but instead that some conditions could be treated outside with more convenience and dignity – and potentially with better outcomes.

Urgent and emergency care is the point where the pressure to deliver appropriate care is most intensely felt. The NHS has experienced a phenomenal growth in unscheduled care over the past decade. This is raising serious questions about the capacity to maintain quality standards.<sup>5</sup> We heard that some people were being treated in the emergency departments of hospitals with conditions that might be treated effectively in the community. The percentage of people attending emergency departments with these conditions will vary based on a number of factors, but research indicates that between 10 and 30 per cent of emergency department cases could be classified as primary care cases, i.e. types that are regularly seen in general practice.<sup>6</sup>

5. Appleby, John (2013) "Are accident and emergency attendances increasing?" on King's Fund blog (29/04/13).

6. Primary Care Foundation (2010) *Primary Care and Emergency Departments*.

The emergency front door is not the only pressure point though. We were also told about the need to consider how patients in hospitals could be discharged more promptly, with support from recovery and continuing care closer to home.

Care pathways therefore need to be developed to establish a bigger role for services outside of the hospital, so they can deliver more care in the community and bridge gaps between care settings. Primary care can deliver many of these services, but it is also under pressure because of increasing demand. Community services are also usually better located, but will need more investment to develop their role. More investment will also be needed to better integrate social care services, particularly given the impact that unmet social care needs have on physical health. The capability of primary, community and social care needs to be developed to provide a 'wrap-around', coordinated service. This will be part of reducing the numbers of people who are in hospitals unnecessarily. There is also an opportunity for hospitals to deliver more of their services directly in the community

and have physicians working beyond the hospital walls with colleagues in primary and social care.

Better coordination of care along these lines could create a framework to enable more person-centred care, although it wouldn't necessarily guarantee it. Providers across the system will need to come together to show they can deliver a continuum of care for patients, who could also be supported to manage their conditions as successfully as possible. Properly coordinated, person-centred services offer an opportunity to deliver better care for the health and wellbeing of people, rather than simply dealing with the sickness of patients when they arrive at a hospital. The system-wide commitment by the National Collaboration for Integrated Care and Support highlights this common purpose and is an example of co-production between patients, service users, their organisations and system leaders.<sup>7</sup>

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7. National Collaboration for Integrated Care and Support (2013) *Integrated Care and Support: Our Shared Commitment*.

## Case studies: Wrap-around care

In **County Durham**, a primary care trust and a trust have funded a rapid access, one-stop diagnostic clinic to assess patients with suspected heart failure and breathlessness. The clinic is run from the hospital with GP referrals, by a GP with a special interest in cardiology, supported by heart failure specialist nurses, with a consultant cardiologist available for advice. Outcomes include reduced hospital admissions and high uptake of evidence-based heart failure therapies.<sup>8</sup>

**Shropshire Community Health NHS Trust** is working on a new system for treating frail and complex patients that aims to work together with other providers to deliver an integrated care model for them. It has assembled a team that focuses on frail and complex patients identified as having a potential length of stay of less than 72 hours. The team helps patients to avoid being admitted into the emergency department of the local hospital where possible, or else assists in having them discharged early from the acute medical unit where appropriate. Early results show reductions in admissions and a good percentage of patients being redirected back to their homes or to local community services.

**Birmingham Community Healthcare NHS Trust** has developed a model of care that enables rapid, 24-hour access to community services in an attempt to reduce emergency hospital admissions. It is available to all patients over the age of 17 in need of immediate assessment and

at high risk of hospital admission. A 24/7 single point of access for urgent and non-urgent referrals signposts patients to the appropriate care for their condition. For urgent care, a rapid response and advanced assessment at home is delivered within two hours. For non-urgent care, multi-disciplined teams respond within 48 hours.

The trust is now meeting its target of 100 per cent of referrals having a nurse respond within two hours. The single point of access team is now taking over 500 calls a week, signposting all to appropriate services and putting responsive packages of care into 200 of those calls directly avoiding A&E attendance and acute hospital admissions. This is over 10,000 avoided admissions a year through that service. In addition to this, their integrated multi-disciplinary teams are receiving over 200 calls per day that are responded to within 48 hours, i.e. 1,000 referrals a week.<sup>9</sup>

*"We have to stop looking at the system through the eyes of the acute sector and look at what is being done outside of the hospital. Our rapid response service is there to get the right care in the right place. The consequence will be less demand on overstretched hospitals, but we don't do it simply for that reason; we do it because we deliver flexible, person-centred care. This shift will not happen overnight; we have to encourage changes in behaviour to ensure the system works better together."*

**Tracy Taylor,**  
**Birmingham Community Healthcare NHS Trust**

8. Royal College of Physicians, Royal College of General Practitioners and Royal College of Paediatrics and Child Health (2008) *Teams without Walls*.

9. NHS Confederation (2013) *Transforming local care: community healthcare rises to the challenge*.

## 2. Improving quality, safety and outcomes

“Too many people are seeing too few people, like the super-specialists that look at just one organ.”

**Clinician**

“There needs to be more openness with the public about how erratic their services are. Many people don't know how much variation there is during the week and assume all is fine.”

**Manager**

“The case for concentrating specialist services has been over-claimed, the data is not as clear cut, which makes it harder to get on board.”

**Paul Burstow MP**

The development of healthcare treatments over the last few decades has been remarkable. Medicine and nursing have both become more specialised and disease and organ-based specialities have grown rapidly. Treatments are now more effective and play a big part in the increase in survival rates for single conditions. The clinicians we spoke to highlighted that highly-specialised care does, however, present challenges. Fewer units are able to deliver treatments as they become more specialised. This is because there is a smaller pool of adequately-trained staff available and the technology they need is often more high-tech and expensive.

A succession of royal college reports have highlighted strong consensus and compelling evidence for the need to concentrate various specialist services into fewer centres (see box on page 14). These central settings would allow multi-disciplined teams to be assembled to

provide adequate medical cover and a better environment to develop clinical skills and experience. Managers told us that these workforce concerns were a significant reason why they considered reconfiguration essential, indicating that they did not have the scale and scope of practice or the workforce pattern to deliver safe services over and over again.

Managers also highlighted that it is difficult to deliver specialist services consistently throughout the whole week, primarily because current practices and workforce rotas do not allow for it. Both clinicians and managers suggested that a concentration of specialist services would provide them with the opportunity to be more flexible with rotas and increase the scope to deliver seven-day care with consultants always available. Considerable feedback highlighted that the variation in service quality from one day to the next was not yet fully recognised by the public and that greater awareness would likely intensify the need for change.

It is important for patients that these recommendations are explored and considered. Evidence from national clinical audits and registries supports clinicians in making the case for establishing larger centres of excellence to improve outcomes for many specialist services.<sup>10</sup>

The evidence, however, is not clear for services in all parts of the UK, and international analysis also suggests that the relationship between volume and outcome might not be as strong for all specialist services.<sup>11</sup> Our

10. Royal College of Surgeons (2013) *Reshaping surgical services*.

11. Harrison, Anthony (2012) “Assessing the relationship between volume and outcome in hospital services: implications for service centralization” in *Health Services Management Research* (Volume 25, Number 1)

conversations indicated that it was sometimes difficult to translate the evidence for centralising services on a national level to local services and circumstances. This can make reconfiguration more complicated. If the evidence is clear, it is difficult for anyone to oppose it. But if it is based on a 'leap of faith', it will be harder to obtain agreement on what that judgement is based on. This was a major concern for many people, particularly those reliant on experts to agree on how services should change.

We generally accept that judgement plays an important part in the delivery of healthcare and so it should do when it comes to considering how to deliver services. The fact that the

evidence for some reconfigurations is based on interpretation should not necessarily undermine the case for change, so long as those judgements are formed by people who know the services best. They can examine the risks and consider how they balance against the risks of no change.

Those who know the services best include the patients who use them and patient organisations with accumulated experience and expertise. Where patients and patient groups have been able to see clear evidence of the need to improve quality and safety through service change, they have supported the rationalisation of specialist services – as in the London Stroke Strategy (see case study below).

### Case study: Improving quality, safety and outcomes in stroke care

**The London Stroke Strategy** replaced 32 stroke units across the capital with eight hyper-acute stroke units (HASUs) as the first destination for anyone who has a stroke in the capital. After an initial 72 hours of specialist care, patients are transferred to their local hospital specialist stroke unit. Quality criteria apply to all of the stroke units in London, with the HASUs having to meet specific quality standards associated with delivering 24-hour emergency stroke care.

The model did require extra investment, but that investment has resulted in a reduction in overall costs across London as the average length of time patients stay in hospital has decreased. Early findings show impressive improvements in stroke care across the city,

with an increase in the use of thrombolysis to a rate higher than any other major centre in the world and an overall fall in mortality rates across the capital.<sup>12</sup>

*“Before 2010, stroke care in London was very variable, with some of the best stroke treatment in the world available from central London hospitals, and relatively poor care in many parts of outer London. There was initially some resistance to the London stroke model, but clinicians and patient organisations were united in believing that reconfiguration was needed. It is clear that it is delivering high-quality stroke care to all Londoners; the clinical case has really been proved.”*

**Joe Korner, Stroke Association**

.12. Royal College of Physicians (2010) *National Sentinel Stroke Audit 2010*.

## Royal college reports

"The College is adamant that the obstetric delivery suite needs fully qualified specialists available at all times, 24 hours a day, 7 days a week – more than half of all births, after all, take place 'out of hours'. That requires the employment of more specialists, which raises the issue of affordability. This, in turn, may well mean fewer acute obstetric units, so that for the more specialised obstetric care, women may have to travel further as the service applies the logic that care should be 'localised where possible, centralised where necessary'."

**Royal College of Obstetricians and Gynaecologists<sup>13</sup>**

"Transforming the care that patients receive can only be achieved by challenging existing practice. Organisations involved in health and social care, including governments, employers and medical royal colleges, must be prepared to make difficult decisions and implement radical change where this will improve care."

**Royal College of Physicians London<sup>14</sup>**

"Whilst full adoption of the standards [on seven day consultant present care] may deliver some savings over time, it is not anticipated that they will be self-funding. Other interventions, such as changes in work patterns and service reconfiguration onto fewer sites, will be needed."

**Academy of Medical Royal Colleges<sup>15</sup>**

"The demands placed upon the NHS in terms of changing patient needs and expectations, increased specialisation, the availability of new treatments and technologies, and the challenging financial environment, mean that in many cases maintaining the 'status quo' will not be an option. The NHS must demonstrate that it can deliver safe and effective care to patients, while ensuring the efficient use of taxpayers' money."

**Royal College of Surgeons of England<sup>16</sup>**

"The College will work further to encourage units to provide better consultant (or equivalent) coverage when they are at their busiest. It is essential that paediatrics is a 24 hours a day, seven days a week specialty, and consequently the service should be organised around the child's needs."

**Royal College of Paediatrics and Child Health<sup>17</sup>**

13. Royal College of Obstetricians and Gynaecologists (2012) *Tomorrow's Specialist*.

14. Royal College of Physicians (2012) *Hospitals on the edge?*

15. Academy of Medical Royal Colleges (2012) *Seven Day Consultant Present Care*.

16. Royal College of Surgeons of England (2013) *Reshaping surgical services*.

17. Royal College of Paediatrics and Child Health (2013) *Back to Facing the Future*.



### 3. Achieving better value

“The economic ability to fund current models of care has been great, but the changing economic environment has questioned this. Reconfiguration was difficult before the pressures hit, but now there is no alternative.”

**Manager**

“It is difficult for us to think this way but, within a limited budget, profligacy in the treatment of one patient comes at the expense of treating another.”

**Clinician**

“The NHS seems to have focused more on cuts before reinvestment.”

**Patient group**

The health system operates with finite resources and funding is directed to it from taxpayers. It is important therefore that the value from the money spent is maximised to deliver the greatest benefit to society. The need to spend money well has never been more important than in the present financial environment. If services need to change, it can no longer be done on the basis of annual budget increases.<sup>18</sup> The NHS in England is going through its tightest financial squeeze for 50 years and economists believe it is highly unlikely there will be increases in line with the historic average. This could mean that a gap of up to £54 billion will need to be filled by 2022.<sup>19</sup> If health funding is unlikely to

increase, alternative ways will need to be found to pay for the shortfall. This will focus mainly on making the most of resources that are currently in the system and ensuring they are spent in a way that delivers the most possible public value.

‘Public value’ means not just value for money but the overall sum of benefits, which includes better experience for service users, better outcomes, and the most appropriate use of resources. Resources are more than just money. Staff, estates, technology, patients and their carers are all resources the health system regularly draws upon, and it should be looking to capture the greatest possible value from all of them.

This means considering the value that patients and service users themselves can bring, for example by using their experience to help co-design more successful and appropriate services, and by successfully managing their conditions, with the right support. Evidence from hundreds of research studies shows that patients who are more involved in their health and healthcare are likely to report a better experience and better outcomes. They are also more likely to make the most appropriate use of services, for example by taking up preventive services and by opting for less interventionist treatment.<sup>20</sup>

It also means looking at where we currently put many of our resources and deciding whether they might be better spent elsewhere. If resources are being spent to maintain the current models of care, but there is more to

18. NHS Confederation (2013) *Tough Times, Tough Choices*.

19. Nuffield Trust (2012) *A decade of austerity?*

20. Coulter, A and Ellins, J (2006) *The effectiveness of patient-focused interventions*.

be gained than lost in spending them on developing new models, it is in the interest of patients and the public that resources are shifted. A good example of this is shown by the changes to pathology services, which were driven by a report by Lord Carter that highlighted that there were too many laboratories duplicating each other's repertoire.<sup>21</sup>

Person-centred care could offer a greater benefit to society than delivering care concentrated around the hospital because people are more likely to get the right care in the right place. As highlighted earlier, this new model of care will need investment in the primary, community and social services that are better placed to deliver it. In a no-growth health funding scenario, this investment will be difficult and would probably only be possible by taking resources from one part of the system – hospitals – and using them to invest into others, i.e. primary, community and social services.

Similarly, if clinical evidence and patient experience highlight the need to deliver specialist services on fewer sites with multi-disciplined teams, then resources will also need to be shifted. This probably means moving the staff, technology and money being spent in multiple sites into concentrated larger ones. It is not feasible to deliver both in the long term.

'Person-centred care could offer a greater benefit to society than delivering care concentrated around the hospital'

Reconfiguration in most cases can be an attempt to do both of these things. Changes to secondary care in isolation will not be effective, just as attempts to deliver person-centred care will not be successful without considering the current model of care that puts patients in hospitals. Value cannot be understood in isolation and needs to be looked at from a whole-system perspective, which considers the benefit of all providers working together to deliver the right care in the right place.

Shifting resources will not be easy. If resources are taken away from hospitals, but the demand remains with them, those providers will be destabilised. Furthermore, if specialist services are centralised and some patients need to travel further for treatment, they may have their access impeded. The transition therefore in moving resources from one model of care to invest in another over time will need to be managed carefully, but with the value to the whole system as its main focus.

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21. Lord Carter of Coles (2006) *Report of the Review of NHS Pathology Services in England*.

# Challenges of reconfiguration

This project aims to reframe the current debate on service reconfiguration so it can focus more on how to meet patients' needs, improve the quality of care and achieve better value. Patient groups, clinicians and managers are clear that new models of care need to be considered. But this is not a new conversation. Models of care that treat patients outside of the hospital have been developing, but are progressing slowly and activity continues to be directed through the hospital. The prevailing focus has been on trying to make hospitals as efficient as possible by decreasing average length of stay and hospital bed numbers.<sup>22</sup>

Reconfiguration, however, should be about making larger scale changes across the system

to deliver more appropriate care for patients. There have been many attempts at this, but the success has been mixed. We cannot avoid the fact that despite good drivers for change, many attempts have failed up to now to deliver the potential benefits. We discussed with experts the reasons why many changes had failed and six factors emerged as crucial to success.

For each, three primary concerns were highlighted, which will need to be addressed to progress the reconfiguration debate. We also offer case studies and tips that might support those engaged locally and nationally in dealing with these concerns and will help to share learning about what has and has not worked elsewhere.

## Six factors crucial to success

**1. Access** – page 18

**2. Resources** – page 21

**3. The system** – page 25

**4. Leadership** – page 29

**5. Communication** – page 32

**6. Collaboration** – page 35

22. Appleby, John (2013) "Feature: The hospital bed: on its way out?" in *British Medical Journal* (12/03/03).

## Getting access right

“Patients will travel to the ends of the world for the best treatment, but will be annoyed if they have to travel far for routine checks.”

**Patient group**

“Patients need to know that distance is not always a major factor. It needs to be explained that current services can mean that it actually takes longer to be treated because you need to be referred on again.”

**Clinician**

“We need to work out how to offer a vision for community care. At present, we haven't been able to articulate effectively what community care is, other than presenting it as the opposite to hospitals.”

**Clinician**

If specialist services are concentrated into fewer central sites, some people will need to travel further for treatment. A YouGov survey with the Welsh NHS Confederation highlights that more than three-quarters of respondents would be willing to travel further for treatment to see a doctor who is a specialist in their field.<sup>23</sup> This would suggest that people could be convinced to support services being moved further away if it meant they could receive better quality treatments. Patient groups told us that: “Patients are likely to measure access more broadly than simply time and distance to their local hospital.” Instead, “good access for them will relate to

‘If clinical risks are better understood, people will see that they are often minimal when compared to the potential benefits of the change’

the right care for their condition, regardless of where it is delivered.”

This is not to say that time and distance are never important factors. A study into severe trauma suggests that there may be a 1 per cent absolute increase in mortality for life-threatening conditions with each extra ten kilometres in straight-line distance.<sup>24</sup> Clinicians told us that the impact of distance on outcomes should never be disregarded, but this didn't mean that the distance between the hospital and the patient could never be increased safely. If clinical risks are better understood, people will see that they are often minimal when compared to the potential benefits of the change. This means communicating exactly how the most serious conditions will be handled, for example by showcasing an assortment of 'what if' scenarios to highlight how quickly different patients will be able to access services.

Clearly, there is a difference between access issues in urban and rural communities, with concerns about access for urban services tending to centre on timescales and distances that are much smaller. We were told that urban communities were often concerned by the

23. YouGov (2011) YouGov /Welsh NHS Confederation Survey Results.

24. Nicholl, Jon et al (2007) “The relationship between distance to hospital and patient mortality in emergencies: an observational study” in *Emergency Medicine Journal* (22/05/07).

impact of traffic on access, while for many rural communities the main issue was the availability of public transport and adequate travel routes. This highlights the importance of having a good understanding of the specific local needs and concerns with regards to access.

There is no universal resolution to the issue of access in reconfiguration. Local communities need to be engaged in a discussion about the difficulties in moving services, and people need the opportunity to feed back their concerns and help to resolve them. We were told that many solutions to individual access concerns could be identified by working with local authorities and transport groups, rather than changing plans themselves. A dedicated access forum therefore

offers a good way of understanding issues that local people might have and allows them to be explored in more depth with local partners.

Some concerns about access relate to the feeling that community services do not have the capacity to deliver the care currently delivered in hospitals. One clinician told us that people go where the lights are on, and it is understandable that they would see hospitals as the best place for treatment because that is where many resources are spent. If awareness of community services is low, people are likely to be less enthusiastic about a new model of care that moves care to them. More is needed to emphasise the care that can be provided in the community and highlight how it can deliver the

### Case study: A dedicated transport group to consider access

**Better Healthcare in Bucks** was a public consultation that sought to relocate acute services and integrate community services across Buckinghamshire. Discussions with patients showed support for a model of care delivered closer to home and an understanding that consolidation of acute specialties might increase travel times for those admitted to hospital. A recurrent theme for patients and the public was transport. Parts of Buckinghamshire are poorly served by public transport and this added to natural concerns about getting to and moving between sites.

In response to this, a transport group was established made up of council, hospital and ambulance service representatives, which looked at the issues in more depth and even held its own engagement sessions. Outcomes

from this group were improved and free travel on local bus networks, and the establishment of a county-wide community transport hub to provide a central information point for community and voluntary transport.<sup>25</sup>

*“We understood from the start that we would never be able to provide a door-to-door service to everyone, but in reality the local community didn't expect us to do so. What they wanted us to do were the obvious things. By working with local partners, in a total place way, we were able to arrange for free travel for staff, patients and their extended family between our hospital sites. Our community transport hub also brings together a network of volunteer providers and helps to support them in delivering an important transport service to patients.”*

**Ian Garlington, Buckinghamshire Healthcare NHS trust**

25. For more information, see NHS Confederation (2013) *Service redesign case study: Better Healthcare in Bucks*.

same – if not better – outcomes for many conditions compared to the hospital. We were told that community services were often unseen and that a distinct vision was needed to communicate what they can offer patients in practice. Experience of the services will be important to do this, but where there is less familiarity, it could be useful to publish a collection of local patient stories that draw attention to the experiences of those that have used them.

This vision could also establish a bigger role for technology and explore the value it might offer

as part of new models of care. Some people told us that telehealth could offer many benefits to patients, allowing them to be treated in their own home and to be empowered to take control over their own condition. It is clear, however, that the evidence for telehealth still needs to develop and that it cannot be presented as an easy solution to issues of access. If technology is integrated into new models of care, it should be able to provide an important part of the continuum of care and help to improve the communication between services that are working together around the needs of patients.

## Primary concerns about access

### **People may find it harder to access care when services are concentrated onto fewer sites**

Some people will need to travel further for specialist care, but the treatments they receive should be better quality. Patients should also benefit from having good access to more convenient care delivered by a blend of local services. Where there are access concerns, a specific group that explores concerns in detail with local partners, such as the local authority and transport groups, can resolve issues that are raised by staff, patients and the public.

### **The public are concerned that bigger distances to hospitals will have a negative impact on clinical outcomes**

Longer access times can pose clinical risks that are often small when compared to the benefits from moving services. Many risks sit with the most serious conditions, but these are less frequent and can be reduced by good contingency planning. It is important that clinicians are engaged from the start to help make this judgement. It is important to develop a plan that considers how the most serious conditions will be handled and to use this when highlighting to patients and the public that changes will not compromise clinical outcomes.

### **Many people are not certain that community care can replace the services currently delivered in hospitals**

The public are more likely to support moving care out of hospitals if they are aware of the benefits of community care. Local leaders need to offer a vision for community services that highlights how they can deliver the same, if not better, outcomes for many conditions compared to the hospital. This message could be delivered locally through patient stories that showcase what community care can offer. To support a local vision for community care, national leaders need to offer a unified message on the value of care delivered as locally as possible.

## Getting resources right

“There should be a fifth Lansley principle, a hurdle test which requires advocates for acute reconfigurations to set out costed plans for developing primary and out-of-hospital care. Without such plans, the public is being invited to take a leap in the dark.”

**Paul Burstow MP**

“The timescales and resources on hand for reconfiguration can make you feel like you're knitting fog.”

**Manager**

“There is an obstacle of time. Hit squads solving the problem in minimal time will not help, they will just present plans as a *fait accompli*.”

**Clinician**

There is no blank sheet of paper on which health services can be designed. Current models of care are treating patients now and it is difficult to shift resources to invest in new models without potentially impacting on the services patients currently need. Changing services can therefore be like fixing an engine while the motor is still running. If the disinvestment in services is more visible than the money going back into developing new models of care, people will perceive it simply as a cost-cutting exercise.

Our conversations highlighted that many attempts to shift resources had hitherto fallen short in making clear the reinvestment into new models of care. Ideally, this perception could be countered by establishing a period of time where current services continue to be funded

‘Changing services can therefore be like fixing an engine while the motor is still running’

in parallel with the investment into new models of care. This phase of double-running helps patients to migrate gradually from one service to the other, or else carefully manages the disinvestment in current services. We were told that this would soften many transition risks and could help people to recognise over time the benefits of investing in community care. The obvious problem is the costs associated with funding multiple services simultaneously, which for many local health economies will be an unmanageable challenge. This is compounded by the fact that the process itself is resource-intensive anyway.

It is apparent therefore that new models of care are limited by the resources that are available to deliver them, which in a no-growth health funding scenario will be especially scarce. One of the main challenges is often not how services should be changed, but how the whole process will be funded. We were told that the hopes for savings being made early in the process to fund investment were often unrealised, which made it necessary for funds to be available up front. However, we did hear that it was sometimes possible to save costs in the short term, but that it depended greatly on the services being changed.

Reconfiguration should be based on a judgement that care will improve over time, but it can often be triggered by a concern about the sustainability of current services. Finance and quality are intrinsically linked and the ability to disinvest from services that need to change will be limited, without impacting on the quality of

services in the transition. Aside from external investment, there doesn't appear yet to be an easy solution to this challenge. It is important though that new models of care are delivered on the basis of realistic objectives for financial investment, both in the short and long term, so that it is clear from the outset how much it will likely cost. It will also need to be realistic and clear about how the clinical benefits will be measured, using transparent data that can be set out in advance and tracked through implementation.

If resources are limited in general, they are especially restricted when a change is being driven by crisis and has been brought about by financial instability. It is becoming increasingly apparent that many trusts are being pushed closer to a financial cliff edge, which will raise serious questions about the way services are delivered. The new NHS failure regime in England gives a trust special administrator (TSA) 150 days to secure the continued provision of NHS services for trusts that are no longer a going concern. From our conversations, it was clear that this small window would offer little opportunity to develop plans with the local community, particularly considering that existing forms of engagement are explicitly cut off with the dissolution of the trust's board and the removal of governors. Monitor's guidance to TSAs highlights the difficulty in gaining support from commissioners and other local providers for any changes that raises public concerns, but its recommendations for engaging with patients, staff and the public focuses too much on needing to reassure and inform them.<sup>26</sup> Financial failure

cannot justify the exclusion of the local community from shaping health services.

Monitor's current guidance to TSAs states that they must consult with NHS England and all commissioners when drafting their report, but that they should use their judgement on whether to engage staff and the public. This needs to be urgently reviewed. It should be made clear that it would be exceptional for staff and the public not to be engaged, at least informally, in the drafting of proposals by the TSA and that, where they deem this unnecessary, the reasons why should be made clear. Excluding the public from coproducing change in the failure regime guarantees that it will be set up to dissatisfy the local community, and will likely deliver a change that they cannot be sure will be in the interests of patients.

The failure regime is a new concept for the NHS, but it is inevitable that health services will be changed through it in the future. These changes will be reactive to immediate financial concerns and we cannot ignore the difference between this and the type of proactive change this report is primarily looking to encourage. This is not least because the former will be restricted both by time and resources, while the latter will have greater scope and capacity to deliver change. The commissioning system has an increasingly urgent challenge to get ahead of this curve, planning proactive change, so as to avert crisis-driven change being imposed later.

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26. Monitor (2013) *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*.



## Case study: Crisis-driven change

Last year, **South London Healthcare** became the first NHS trust to enter administration and be subject to a new failure regime. The trust had consistently struggled to provide services within budget and there was no approved plan to fix its problems in the long term. A trust special administrator (TSA) was appointed by the Secretary of State, and his final report outlined recommendations for securing sustainable services for the local community.<sup>27</sup>

The report made a number of recommendations as to how services should change, including a proposal to replace the full admitting accident and emergency department at University Hospital Lewisham, which was not part of the trust, with a non-admitting urgent care centre. In the report, the TSA said: "This recommendation is not about 'closing' an A&E department but rather making changes to it. If you can get yourself to the hospital in a car or on public transport then University Hospital

Lewisham's Urgent Care Centre would be able to give you the care you need".<sup>28</sup>

A campaign was formed to oppose the changes to University Hospital Lewisham, and thousands of people took part in a series of protest marches both during and after the consultation period. A particular criticism by the campaign was the decision to include a hospital in the changes that was not part of the trust in administration. Ultimately, the Secretary of State approved the proposals, but decided that University Hospital Lewisham should instead retain a smaller A&E service with 24/7 senior emergency medical cover.<sup>29</sup>

*"South London was intended to be the process that would set a precedent for reconfiguration and pave the way for future attempts. It turns out to be the exact opposite, as it has set a precedent for preventing future attempts."*

**Manager**

27. "South London Healthcare NHS Trust put into administration", BBC News (12/07/12).

28. Office of the Trust Special Administrator (2013) *Securing sustainable NHS services*.

29. "Protest against plans to scrap Lewisham Hospital's A&E", *Daily Telegraph* (26/01/13).

## Primary concerns about resources

### **The public see the money coming out of services, but are not always aware of the money going back in**

People will not be enthusiastic about services being changed if they cannot see the investment into new models of care and the services that are needed to deliver them. Reconfiguration needs to sell the benefits rather than the cuts. The best way to show investment is often to run services alongside one another and gradually migrate patients from one model to another. However, this can make the process even more expensive and will require extra investment to be available from the start. Local leaders need to ensure that they are clear about the level of investment needed and to identify where it will come from. National leaders need also to consider whether there is capacity to deliver large-scale change across the healthcare system.

### **Changes don't seem to save money and often appear to cost more**

The need for change is focused on improving quality and ensuring sustainability in the long term and so it cannot be expected to save money immediately. Better quality services should save money over time or else they will capture greater public value from the resources available. Local leaders should make sure they have realistic plans on costs and that they set achievable targets that help to maintain momentum during implementation.

### **The NHS failure regime offers too small a window for engagement with the local community**

Financial failure will drive more change through the NHS failure regime, which regulates a set timetable to develop plans. This timetable provides a small window for co-production, but it shouldn't be used to justify the exclusion of the local community from shaping health services. The role of the local community needs to be clearer during the failure regime. Monitor should recommend more strongly to the trust special administrator that they engage with staff, public and patients as they develop their report. Monitor also needs to observe how the failure regime is proceeding and look to review its flexibility and capacity.

## Getting the system right

“Society can often be averse to changing the status quo, but we need to convince everyone in the system when the status quo needs fixing and why.”

**Clinician**

“There is a price disincentive to keep services in the acute sector. If moved, variable costs will fall but they have fixed costs that need to be utilised. The result is that patients are sucked into their services.”

**Patient group**

“Pricing won't help you find win-wins. Tariff doesn't usually allow change and cannot facilitate benefit sharing. There doesn't seem to be any slack for reconfiguration at the moment.”

**Manager**

The NHS payment system in England relies to a large degree on reimbursing hospital care on the basis of activity, which can incentivise hospital providers to deliver more treatments to cover costs that are often fixed. Primary and community care on the other hand tend to be reimbursed in blocks that can create incentives to deliver less to minimise costs. If new models of care are to develop that utilise services outside of hospitals, financial incentives will need to be aligned towards this objective. Otherwise, change will be more difficult and less sustainable for some providers. Flexibility in the reimbursement of services is important to allow

‘Flexibility in the reimbursement of services is important to allow the risks and benefits from moving care to be shared fairly among providers at the local level’

the risks and benefits from moving care to be shared fairly among providers at the local level.

Monitor and NHS England recently outlined their current reasoning for the objectives of the NHS payment system, which they will govern together from 2014. They made it clear that services need to be redesigned to offer improved patient outcomes at lower costs and that the design of the NHS payment system should support both commissioners and providers in making the change that NHS care needs. This would support what we heard from patient groups, clinicians and managers, and it is important for this to remain as one of the primary objectives for the payment system.<sup>30</sup>

Our discussions also identified questions about the impact of competition in healthcare. If the number of hospitals is reduced this could unfairly restrict patient choice, and could raise concerns with regulators looking to prevent any substantial lessening of competition.<sup>31</sup> Competition and integration shouldn't be mutually exclusive, but commissioners will

30. Monitor and NHS England (2013) *How can the NHS payment system do more for patients?*

31. Competition Commission (2013) “CC to investigate hospitals merger” (08/01/13).

need to ensure that collaboration is not hindered by providers needing to compete for services. Monitor will advise the Office of Fair Trading about the patient benefits of any proposed mergers involving NHS foundation trusts.<sup>32</sup> In doing so, it will need to ensure that competition can be used to drive up quality, but that it fulfils its obligation to enable integrated care and encourage providers to work together.

We were also told about several other legal and regulatory requirements that need to be considered, including an obligation to consult with the local health overview and scrutiny committee (HOSC) on proposals for substantial changes in local health services.<sup>33</sup> Managers told us that there was generally good available guidance for many of these obligations, but that strong project management was important to keep on top of them all.<sup>34</sup> They also stressed the value of developing strong relationships with relevant bodies throughout the process to help deal with uncertainties. One of the main risks presented to us was the potential loss of momentum, if changes are stalled at a later stage by legal review.

NHS England is currently reviewing the role of local HOSCs in scrutinising changes to services and it will need to do this with consideration of the new role of local health and wellbeing boards (HWBs). We were told that these

boards could offer an opportunity to provide good strategic direction for local services and a degree of democratic accountability that can often be lacking. The guidance which will follow that review should be clear about these roles in service change and be reflective of the need both to ensure proper scrutiny and to maintain the momentum built up through engagement and consultation.

NHS England's review will also need to support local leaders in understanding the shifting influence within local communities, following recent reforms. Clearly, newly-formed clinical commissioning groups (CCGs) will have significant responsibility for driving new models of care and it is important that they have the support and guidance to help them to do that. NHS England is developing the role of new NHS commissioning support units (CSUs), so they can support CCGs in their transformational commissioning functions, such as service redesign.<sup>35</sup> Similarly, clinical senates, which will span professions and include representatives of patients, volunteers and other groups, are being developed to have a proactive role in promoting and overseeing major service change, for example advising on the complex and challenging issues that may arise within their areas.<sup>36</sup> Local area teams of NHS England will play a role on HWBs and will directly commission primary care locally.

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32. Monitor (2013) *The respective roles of Monitor, the Office of Fair Trading and the Competition Commission in relation to mergers involving NHS trusts and NHS foundation trusts*.

33. Mason, David (2012) "Public involvement and consultation" in *Capsticks CCG Handbook*.

34. Useful resources can be found on the NHS Confederation website: [www.nhsconfed.org/reconfiguration](http://www.nhsconfed.org/reconfiguration)

35. NHS England (2012) *Commissioning support: Key facts*.

36. NHS England (2013) *The Way Forward: Clinical Senates*.

Added to these new structures is the need to encourage an open culture that allows relationships in the community to develop. Our discussions highlighted that consistency was crucial to allow leaders to work together and that this would be less likely if the system continued to reorganise and changed leaders regularly. Even at a lower level, there was emphasis on the importance of maintaining staff who have experience of joint working and service change. The system needs to have an open culture that supports innovation. We heard of few incentives for leaders to be bold and take risks. Instead, many often fear that such actions will be punished or else go unnoticed. Many people suggested that this had

'Many people suggested that this had drained the enthusiasm in the system and that change fatigue was apparent, which made it harder to work together and maintain momentum for change'

drained the enthusiasm in the system and that change fatigue was apparent, which made it harder to work together and maintain momentum for change.

## Primary concerns about the system

### **The current pricing system is creating a disincentive to develop new models of care**

Financial incentives that encourage activity in hospitals will not support new models of care that look to deliver more care in the community. Local leaders need to explore what flexibilities there are in the current payment system to try to support reconfiguration. NHS England and Monitor should design the NHS payment system to support both commissioners and providers in aligning incentives towards the objective of delivering more appropriate care.

### **Legal and regulatory hurdles can stall change and make it lose momentum**

There needs to be good local scrutiny for changes to health services. Local leaders need to ensure that they are prepared for the hurdles currently in the system and to develop strong relations with the relevant bodies. NHS England needs to use its review of reconfiguration to clarify roles and responsibilities in the system and offer support to commissioners in driving change. In doing so, it will need to be reflective of the need both to ensure proper scrutiny and to maintain the momentum built up through engagement and consultation.

### **Risk-aversion and change fatigue is apparent**

The culture in the NHS needs to be open to local leaders taking risks to challenge the status quo in healthcare. All local leaders will have a role in trying to establish this culture and to build up the enthusiasm for change. However, national leaders will need to recognise the need for a period of stability and be alert to the dangers of reorganising the system further.

## Getting leadership right

“We need to find a way to make clinicians more visible to win the trust of the local community.”

**Patient group**

“There will be disputes between clinicians, but this can be good if it is evidence-based.”

**Clinician**

“Change needs a consistent and persistent vision in the long-term. We need to do more to retain corporate memory because without consistency you forget what works. This cannot be achieved if you keep changing – it is not surprising that clinicians are disillusioned with managers.”

**Manager**

Good leaders are willing to make bold decisions that challenge the status quo because they believe it will improve patient care. This leadership is more likely to emerge in an environment that allows expertise to mature and the trust between leaders and the local community to develop. Leaders are important in helping to engage the local community in the delivery of health services and to overcome the obstacles to change. They can help set the strategic direction and offer a single point of reference and responsibility.

Few people doubt the expertise that clinicians can bring when considering how to change health services. Their leadership can draw on the trust they have built with the local community they serve and underline the credibility of the plans. This doesn't mean it is easy for clinicians to become leaders. In fact, it can often be difficult for them to direct changes

‘Leaders are important in helping to engage the local community in the delivery of health services and to overcome the obstacles to change’

to services they have worked for many years to develop. Reconfiguration can therefore create tensions between clinicians, although when constructive this tension can help test the basis for change.

Understanding why some clinicians choose to lead is important in encouraging others to lead in the future. The clinical leaders that we spoke to said the main motivation was the desire to improve services so that they could cope with future challenges. This underlines the importance of having a vision for change that is positive and based on clinical judgements of how the quality of care can improve. This can be developed through tools such as clinical summits and clinician-to-clinician workshops.

The introduction of clinical commissioning now provides the opportunity for more change to be led by clinicians and to establish a stronger clinical basis for designing health services. We heard optimism for the potential of CCGs to drive change and to use their role on local health and wellbeing boards to develop relationships across the system. However, to do this they will need the support and guidance that allows them to improve services while managing their day-to-day duties.

Leadership should not, however, begin and end only with clinicians. Managers can have a good systemic view of health services and are often well placed to understand the wider impact of

changing health services. They will be needed to engage with staff and to develop channels of communication with them as plans are developed and implemented. There has been good investment in the development of leaders in the NHS and we heard that this seemed to be making some progress.<sup>37</sup> However, we were told of concerns about the relatively high turnover of NHS managers, which makes it difficult for experience to develop. The managers we spoke to highlighted that leading reconfiguration could often be a thankless task. They told us it was particularly difficult to give full attention to the complex aspects of change while also managing day-to-day services. It is crucial therefore to have clear governance within the management team, so pressures can be shared and daily challenges are not overlooked. Relationships between managers of different organisations can also provide the impetus for future collaborative working around new models of care across the system.

What is often ignored by statutory services is the potential for patients to be leaders. Patients and their carers have intimate

knowledge of health services and will know better than most the impact that changes will have. We heard that many patients found it hard to become leaders because they didn't feel confident that their voice would be heard equally with those of clinicians and managers. Encouraging patients into these roles will necessitate that their voice is actually heard; that they have the support to understand the system and its business language; and that planning and decision-making processes are adapted for their full participation. The pressure on their time and resources has to be appreciated as many patients and carers have demanding roles managing their conditions and/or caring for others.<sup>38</sup>

Co-production should allow a relationship between leaders to develop and for all local leaders, whether they be patients, clinicians or managers, to feel like equal partners in decision-making about local services. Each leader will clearly bring their own expertise to that process, but so long as their role is well defined they can support the benefits of change to be communicated and facilitate strong engagement with the local community.

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37. A good example is the NHS Leadership Academy's Elizabeth Garrett Anderson programme that offers those from both a clinical and non-clinical background to develop skills to drive and sustain real change – building a culture of patient-focused care at a wider departmental or functional level. More information can be found at: [www.leadershipacademy.nhs.uk](http://www.leadershipacademy.nhs.uk)

38. "The quiet revolutionaries: patient leaders", *Health Service Journal* (19/02/13).



## Primary concerns about leadership

### **It can be difficult for clinicians to lead changes to health services**

Clinicians can be hesitant about changing services they may have worked for many years to develop. Clinical leaders should, however, be motivated by a desire to improve services and so it is important that that change is driven by quality and that clinical engagement has been strong from the start. Clinicians also have a responsibility to ensure that they engage with the process and to be confident in taking a leading role in reconfiguration.

### **Managers are not supported enough in reconfiguration**

Reconfiguration is a thankless task for many managers and they will need more support as they lead change and build relationships across the system. Relationships between managers of different organisations are important, however, because they can provide the impetus for future collaborative working around new models of care across the system. A clear governance structure will be important to help define management roles in change and distinguish it from the day-to-day responsibilities of running health services.

### **Patient leadership is often ignored and under-utilised**

Patients have the potential to be strong leaders and offer their essential knowledge of health services. Local leaders need to demonstrate that change is being co-produced and should make good use of local patient groups to identify potential champions. They will also need to recognise the pressures on the time and resources of patients to ensure that they are supported to lead.

## Getting communication right

“Money is obviously a factor, but there is a sense of dishonesty about how change is spun and the motives are often misconstrued.”

**Patient group**

“Politicians can provide the political cover that is needed for reconfiguration but the willingness is simply not there. Good politics should be about honesty.”

**Phillip Lee MP**

“You need to understand the different ways that people get information about healthcare and adapt your message to each of these.”

**Manager**

The way that change is communicated influences how it is heard and understood by the local community. From what we were told, NHS organisations are beginning to recognise the importance of communication and more resources are being committed to presenting a positive public value case to the local community. The concern that we heard was that this message could be drowned out by a narrative that focuses on what might be lost by change, rather than the benefits.

All clinical and financial risks and benefits need to be clear and in the public domain, so that people are better placed to understand why change is needed. It was suggested to us that some people may take advantage of this honesty to use in their arguments against change, but often this information becomes known regardless. It seems better therefore to be open from the start and work to develop trust with the

‘All clinical and financial risks and benefits need to be clear and in the public domain, so that people are better placed to understand why change is needed’

local community through honest conversations. These discussions shouldn't prevent a positive vision from being communicated, which highlights how new models of care can deliver better quality for patients and that, while some services will be changed, greater value will be achieved across the system.

Communicating this message will rely on the ability to encourage the local community to be engaged in the conversation about why health services should change. This will involve an extensive communications strategy that tries to allow a mature public discussion to take place. Many people told us that this was possible and that the receptiveness of the public can often be underestimated. The public might not necessarily be aware that health services need to change, but they are willing to listen and discuss why.

Good communication needs to focus on how to present information in a way that people can easily access and understand, tailoring the message to different groups. We heard of extensive engagement programmes that took a lot of time to understand how communities accessed information and went to great lengths to ensure they were given the right information in the right way. This could include using websites, social media, printed materials, radio, churches and local associations, among numerous tools.

One important tool is local, and sometimes national, media. We were told that it can be hard to get positive messages communicated through the media, but that it was possible to show them, if the message was clear, why the public would be keen to read about it. Good relationships with journalists will probably already be in place for most local leaders, but these will need to be strengthened when engaging in reconfiguration. Regular meetings and briefings can help to ensure that they are constantly informed and to prevent any misunderstandings. Social media can add to this by enabling conversations between stakeholders that are continuous and responsive, and an increasing number of healthcare leaders are opening up this dialogue, for example through Twitter and LinkedIn.

Politicians, both at a local and national level, have an obligation to represent the views of their constituents and this often means they will want to engage to address concerns voiced by constituents. A number of the people that we spoke to suggested that politicians were often difficult to engage and many would be upfront about the fact that they would suffer politically from supporting change in health services, even though they might understand the reason for it. The issue of political support in reconfiguration seemed to be a thorny subject with the people we spoke to, and many felt it was doubtful that

they could alter the political reality. It was suggested that the best way to get political support would be to concentrate on building up local support, or at least responding to and addressing concerns that have been raised, to help take the sting out of the public debate. This, however, would be less probable as important elections approached and political realities were more likely to take precedence. Getting the relevant service user groups involved in designing the changes will make it harder for politicians to oppose.

Local leaders will need to accept that opposition will be inevitable and focus on how to consider the concerns that are raised. Politicians are familiar with debates that have different opinions and it is important that the case for change is strong enough so that it can overcome any case against. Where there is a strong case for change, which is supported by a significant part of the local community, political support should, however, be more apparent. Certainly, there needs to be a clearer indication from national politicians of support for clinically-driven change in the best interests of patients. Politicians of all colours need to put themselves at the front of the honest conversation with the public about the pressures that the NHS currently faces and how the money we have can be spent in the future to deliver the best quality of care for patients.

## Primary concerns about communication

### **There is a tendency not to talk about the finances**

Change should be driven by a desire to improve quality, but finances will be a factor when changing many health services. Local leaders need to be honest about the financial risks and benefits to allow people to understand the desire to achieve greater public value. Some might take advantage of this openness, but the local community should appreciate an honest discussion and carefully consider the information presented.

### **Local communities are often unaware of change and the information they get is usually negative**

Communication needs to be an extensive process that gives the local community the information they need to engage. This means consulting clearly with all groups in the local community and ensuring that the message is tailored to different people. Numerous tools can be employed as part of a robust communication strategy and they should look to understand who has influence in the local community and how people usually obtain information about their health services.

### **Politicians are unwilling to engage, but will often oppose any change**

The only obvious way to develop a more constructive relationship with politicians is to build local support and highlight the depth of the debate to encourage, at the very least, an open mind. Getting the relevant service user groups involved and designing the changes should make it harder for politicians to oppose. A stronger political consensus is needed at a national level to support change when there is strong support amongst patients, managers and clinicians.

## Getting collaboration right

**“The local community needs to feel that they invented reconfiguration.”**

**Patient group**

**“The closure of any department can have a big effect on staff. It is a big deal – some people will have worked hard on their service and are devoted to them. Staff need to be actively recruited as part of the solution, not flushed away as part of the problem”**

**Clinician**

**“A routine flaw of reconfiguration is that they don’t engage early enough with the public and community leaders, and when they do, it is usually a box-ticking exercise. Most of those with a stake in reconfiguration don’t feel part of the process and are not involved effectively.”**

**Paul Burstow MP**

Healthcare should engage the intelligence and imagination of the whole system and bring together patients, clinician and managers to discuss how health services need to be delivered. Co-production is essential to redesign services and can enable people to feel part of their local health services. Collaborative relationships across the local community will be valuable for the future, if new models of care are to be developed that deliver a continuum of care for patients.

An open and mature dialogue across the system allows perspectives to be brought together and individual concerns to be raised and addressed collectively. If every voice is heard with sufficient interest, this dialogue offers an opportunity to create a closer association between the local community and their health services. Collaboration does of course take place in most

local communities, but we heard that more was needed to understand the variety of mechanisms that convened people. It is often difficult to assess whether discussions on health services in one forum complement or overlap those being discussed in others.

Certainly, many people identified the creation of local health and wellbeing boards as a possible opportunity to get a better understanding of where strategic dialogue about the needs of the whole system could take place, although it was uncertain what influence providers could have with such boards. What was clear was that redesigning services could benefit from being governed by an individual framework to identify how co-production was being facilitated.

Staff engagement needs to be considered as part of this conversation and we were told that their role and influence in the local community can often get forgotten. Staff will understandably have concerns about their jobs, and rumours about change have a tendency to spread quickly through organisations. Resources should be committed from an early stage to engage staff specifically, and they will need a direct opportunity to shape proposals. Openness is important and we were told that open board meetings allow staff the opportunity to input into proposals and witness them being developed and to highlight that they were being given all the information.

Collaboration of any kind will need to include a central voice for patients. Co-production must allow a strong role for patients because health services cannot be understood unless they are considered through their lives. They know the services and will be able to offer strategic advice on how care can be delivered around their needs. They can also offer a non-institutional perspective that can test proposals and see if they really are more convenient and better for

patients, and not for services themselves. Quality is about patient experience, as well as outcomes, and if we are looking to change services to deliver more quality, the views of patients will be needed to understand how this can be achieved. Recent investigations of co-production by Nesta have shown not only a series of benefits to patient care, but also the potential to save over £4 billion from the NHS budget.<sup>39</sup>

We were told that reconfigurations could sometimes fail to achieve meaningful patient engagement, relying on formal consultations that were both too late and unhelpful for many people. There is a legal requirement to engage with the public on substantial changes to health services, although what is important is the role of patients in helping to produce changes in the first place. In particular, and as highlighted earlier, requirements for engaging with patients so they can produce changes

through the failure regime do not seem to be particularly strong.

If the patient voice is a whisper at the table, it will be difficult to convince the local community that change is in the interests of patients. We heard that clear and noticeable involvement of patients allows the local community to have more belief that change is being driven by and for them. Feedback supported the strengths of establishing central patient and public engagement programmes from the start and close working with local patient groups. The use of 'you said, we did' tools can also highlight the power of the patient voice throughout the process. It will need to be remembered though that, like with many groups, the opinion of patients can be divided. Emotional attachments to local services sometimes will override rational considerations of risks and benefits, and an open and honest partnership with patients should allow such divisions to be better understood.

## An example of working with patients

**The Patient and Client Council** provides a powerful, independent voice for people in Northern Ireland. In 2012, it began a review of people's views on health and social care, especially in light of the Transforming Your Care proposals to change services, put forward by the Northern Ireland Department of Health, Social Services and Public Safety. The council's work considered the views of more than 13,000 people, which were analysed and feed into the Transforming Your Care programme. It highlighted that there was much common ground between the priorities of both and confirmed many of the key messages and highlighted common concerns.

*"We gathered the opinions of patients and the community through a wide variety of interviews, street consultations, surveys and small group discussions. Some key messages emerged from this, such as the importance of service user involvement, good communication between and within the services and with the patient, timely and accessible information, continuity of care, support for vulnerable groups, support for carers and equal access to services. But, what was evident from this work is that people recognise that the way in which services are delivered in Northern Ireland has to change."*

**Maeve Hully, Patient and Client Council**

39. Nesta (2013) *The business case for people powered health*.

## An example of collaborative working

**Marie Curie** led a national programme, currently consisting of 18 projects, to develop services for palliative patients to be cared for and die in their place of choice. Each project aimed from the outset to understand the needs of local patients and carers, by completing a comprehensive review of existing services. Seven workstreams were set up to do this and they look at key areas of improvements including information-sharing, coordination, communication, professional development and the provision of high-quality care whenever it is needed.

The programme is built on collaboration and it focuses on how it can work in partnership

with local providers and commissioners to develop 24-hour services to meet local needs. The relationships between each organisation is defined in a memorandum of understanding that offers a clear governance structure.

*"We got everyone to sit at the table and discuss making changes to redesign services around end of life for patients. There was a clear governance structure that brought together every part of the system around a common goal of improving end-of-life care."*

**Karen Burfitt, Marie Curie Cancer Care**

## Primary concerns about collaboration

### Staff are not being engaged in reconfiguration plans

Staff engagement needs to be considered as a standalone part of collaboration and their perspective on health services will be vital as part of co-production. An open channel of communication should be established to allow staff to engage from the start and feed in concerns to be considered and addressed. Communication about any plans to change services will need to be regular, and open meetings should be encouraged to give staff the information they need to engage.

### The patient voice is often ignored and consigned to a box-ticking exercise

Patients and their organisations need to be engaged as equals to critique current provision and redesign it to meet their needs and preferences – a practice known as co-production. Patients offer a unique perspective to help change deliver its objectives of improving patient care, and local leaders need to ensure there is a strong patient and public engagement programme from the start.

### Collaboration across the system is difficult to facilitate

Local leaders need to come together to help deliver health services in the interests of patients. There are numerous ways for this collaboration to currently take place, although it is difficult at times to see how these complement each other. Local health and wellbeing boards offer an opportunity to provide good strategic direction for health services, and clarity in their role, as well as their relationship with providers, will be useful. In many cases, a separate board to oversee reconfiguration specifically can help to be clear on governance and to define each person's role.

# Conclusion

This is not the beginning nor will it be the end of the debate on reconfiguration. This report has attempted to reframe how it is discussed and has brought together those people that know the system the best to consider how it can be supported. The discussions have highlighted a number of interesting views that should be shared across the system and raised some important concerns that need to be addressed.

Above all, six fundamental truths came through in the discussions. These might serve as a foundation for most reconfiguration plans. They could be seen as complementary to the rules outlined by the former Secretary of State, Andrew Lansley, which make clear that any changes to health services should demonstrate support from commissioners, public and patient engagement, a clinical evidence base and promote patient choice. Although as with those they are likely to be too broad to solve the complicated issues in local reconfigurations. Nonetheless, we present them as guiding principles to be considered by all.

Six reconfiguration principles:

## 1. Healthcare is constantly changing

Health services cannot be allowed to stand still and now, more than ever, they will need to adapt to an ageing population and the proliferation of innovative treatments.

## 2. There are significant benefits to delivering new models of care

Clear evidence on better experience and outcomes for patients highlights that there is more to be gained than lost in changing many services.

## 3. 'Reconfiguration' is a catch-all term

Reconfiguration is a general term for a collection of different types of changes, the drivers of which need to be each understood to consider their potential benefits.

## 4. Patients can co-produce better services

Patients and their organisations need to be engaged as equals to critique current provision and redesign it to meet their needs and preferences – a practice known as co-production.

## 5. A 'whole system' approach is essential

One service cannot be changed in isolation from the rest of the system. New models of care will require us to go beyond traditional borders in healthcare to deliver the most public value.

## 6. Change requires consistency of leadership

Strong leadership is needed to develop change with the local community. This collaboration relies on strong relationships to be formed between leaders built on trust and experience.

These are principles for patients, clinicians and managers to consider. There is no uniform prescription for how reconfiguration should be undertaken. Local circumstances will dominate the needs of the process and it is up to those in the local community to work together and consider how those needs should be met. At the national level, however, we will continue to work together to present a more constructive voice that encourages patients, clinicians and managers to work together and share learning from across the system.

We hope that local leaders can take away the messages from this paper and use them as encouragement for engaging in the debate. It won't be easy, but it could help to improve the services that we all care about and ensure that they are able to cope with the challenges of the future. It might also help to persuade local leaders that health services are better considered together and that a whole system approach is the best way to deliver change to meet the needs of patients, improve the quality of care and achieve better value for society.



# Participants

We are grateful to all the people who participated in this project. Below is a list of those individuals and organisations that agreed to be interviewed and/or took part in the subsequent meetings and workshops.

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Sarah Baker, Warrington CCG

Dr Jane Barrett, Royal College of Radiologists

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Karen Burfitt, Marie Curie Cancer Care

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# Changing care, improving quality

One of the greatest challenges facing the health service today is the need to redesign services to meet the needs of patients, improve the quality of care and achieve better value for society. There is growing support among patient groups, clinicians and managers for the potential benefits of 'reconfiguration' in health services.

The Academy of Medical Royal Colleges, the NHS Confederation and National Voices have come together to examine the case for radical, far-reaching change across the NHS. This report identifies six principles to consider as a foundation for most reconfiguration plans, and aims to support those engaged locally in making a decision on whether to reconfigure services and, if so, how to make change happen.

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