



Implementing changes to hospital services: Factors influencing the process and ‘results’ of reconfiguration

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ABSTRACT

Objectives: Acute hospital reconfiguration is often presented as a problem to be solved by calculations of optimal design, a rational process amenable to influence by open and responsive consultation. We aimed to analyse factors in the process and ‘results’ of hospital reconfiguration in three case study sites in the English NHS.

Methods: In-depth semi-structured interviews were conducted with internal and external stakeholders at each site. Analysis within each case was complemented by cross-case analysis focusing on the relationships between the features of the origins and process of reconfiguration and progress in the implementation of plans.

Findings: We identified a number of inter-related factors operating in the process of implementation which influenced the ‘results’: the drivers for change, the reconfiguration, its content (particularly the extent to which services are withdrawn or made less accessible), the influence of stakeholders, such as local politicians, financial pressures, and the role of the management team.

Conclusions: We argue that the differences in reconfiguration implementation between the three cases reflected the nature of the proposed changes and local politics, rather than the strength of the ‘evidence’ for change. National policy has tended to over-emphasise the importance of consultation using ‘evidence’ and underplays these influencing factors.

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1. Introduction

Many health systems are concerned with the issue of how best to configure their hospital-based services. In addition to their other roles, hospitals appear to have a particularly important symbolic role with the public in terms of representing a strong welfare state [1]. It has also been argued that hospitals in the UK have a role in maintaining and improving trust in the NHS [2]. Proposed changes to hospital services therefore often create high profile, con-

tentious debates locally, and sometimes nationally (see e.g. [3]).

The term ‘reconfiguration’ has been used in the context of health policy in the UK to describe changes to hospital services. Earlier changes, for example in the 1980s, were referred to as ‘rationalisation’ or ‘retrenchment’ [4]. These terms may be seen by stakeholders, such as the media and the public, as euphemisms for ‘cutback management’, changes driven by financial concerns. A Department of Health (DH) report describes reconfiguration as ‘synonymous with major service change, service improvement and delivering value for money for the taxpayer’ [5]. There is no one, agreed definition for the purposes of the study on which this paper is based; therefore, we have developed this one:

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“A deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in locality, region or health care administrative area” [6].

Although it may be associated with mergers, or the formation of structured networks, reconfiguration is that measure of change which directly addresses operational rather than structural change: hospitals may merge, form networks, or change their divisional or governance structures, without reconfiguring services.

The driving forces for these changes to hospital services are related to upward pressure on costs, as a consequence of new technologies and rising public expectations, in parallel with downward pressure from previous periods of economic recession and political unwillingness to increase taxes [7]. The most frequent response to these pressures is to seek ways of limiting costs. As hospitals account for 40–60% of health expenditure in OECD countries, it is not surprising that the focus has been on acute hospitals and the way in which they are organised [7]. These drivers are common across countries in Europe [7], and other developed countries [8]. Drivers have also included improved clinical safety and outcomes, using arguments relating to improvements in quality predicted through higher volumes of activity, better medical training, and easier recruitment and retention of staff [9]. Evidence shows that higher volumes are associated with improved clinical outcomes for some conditions and procedures, but gains are exhausted at relatively low thresholds [10], and the mechanism for the relationship, if it is causal, is contested [11]. Downward pressure on doctors' working hours, particularly in the UK where hours were traditionally long from, among other sources [12], the European Working Time Directive (EWT) has also provided arguments for centralisation and reconfiguration [13].

There is, in general, a paucity of empirical studies on the reconfiguration process in the acute sector, particularly on the way the process affected the implementation of changes. There is a substantial literature on the experience of closing long stay psychiatric hospitals (e.g. [14,15]), and there were some studies of 'rationalisation' of acute hospitals in the 1980s [4]. More recently, there are some examples of studies based on particular local struggles over closure proposals such as in Kidderminster [3,16–18]. There are also a number of normative and prescriptive papers which develop modelling tools to help decision-making (e.g. [19–24]). There is a literature on mergers of hospitals, although these have not always resulted in service reconfigurations (e.g. [25,26]), and studies on other types of relationships between hospitals, such as networks (see e.g. [27]).

The term 'reconfiguration' has tended to be used in the UK policy context in a way which suggests a problem to be solved by calculations of optimal design. The DH and local health policy makers have often presented it as a technical matter of optimising bed to population ratios, or co-locating services that require close connections, and achieving "rational" resource allocation (e.g. [21]). However, the evidence base for these optimal ratios is slender,

and much of it relies largely on rules of thumb endorsed by established professional clinical institutes, rather than on careful evaluations. In England, government documents and policies have increasingly emphasised the role of 'evidence' and consultation with the public (e.g. [5]) based on the assumption that if only the public are involved 'enough' and are presented with the 'right evidence' they will be convinced of the need to change.

This paper analyses a number of factors important in the process and 'results' of implementation at a local level from a study of three cases of reconfiguration in the English NHS. Findings are presented indicating the following inter-related factors: the content and drivers of the proposed changes, responses of stakeholders, and financial pressures, thereby illustrating the complexity of the process. The paper thereby also provides an analysis of the extent to which representation of reconfiguration as a rational process amenable to influence by open and responsive consultation is a helpful one.

2. Methods

We used a comparative case study design to enhance both internal and external validity [28,29]. Yin [30] suggests that case studies are particularly suited to the complex nature of health service systems and are a powerful way of gathering detailed, in-depth data on organisational processes and the impact of policy changes [31].

2.1. Case studies and interviewees

Three case study hospital trusts (National Health Service organisations providing hospital care and often including more than one hospital site) where reconfiguration was in progress were selected by England's Department of Health (DH) as they were part of a pilot programme receiving some DH funding to support the process.

We identified a list of core key informants to be interviewed in each trust (Table 1). To this core group we added further clinicians, managers, and stakeholders from outside

Table 1
stakeholders interviewed in all three case studies.

Internal stakeholders	External stakeholders
Chair of Board	Strategic Health Authorities ^a
Chief Executive Officer	Primary Care Trusts ^b
Director of Nursing	Social Services
Medical Director	Overview and Scrutiny Committees ^c
Project Manager	Member of Parliament (MP)
Financial Director	Local Media
Director of Modernization/Service Re-design	

^a A type of English NHS organisation, created in 2002, responsible for strategic planning and maintaining quality in NHS services across several Primary Care Trusts.

^b A type of English NHS organisation, created in 2002, which commissions services, sometimes provides community services, and co-ordinates general practitioner services).

^c Local government committees responsible for reviewing decisions, performance and policy of local NHS organisations on behalf of the community, intended to give the NHS some democratic accountability through an elected body.

Table 3
Characteristics of trust, reconfiguration, and 'results'.

	City Trust	Rural Trust North	Rural Trust South
Sites included in study	Big Hospital – large teaching hospital and Small Hospital – small district general hospital (DGH). The two merged shortly before the start of the study	Medium DGH and Little DGH merged before reconfiguration. Merger with Large DGH – was an element of reconfiguration	General Hospital – large DGH, and Community Hospital – community hospital
Socio-demographic issues Drivers of change	Sites close together in metropolitan community Sustain emergency care given workforce pressures including European Working Time Directive and training requirements	Hospitals are in small towns surrounded by dispersed community Sustain surgical services at Little DGH compatible with training requirements Sustain some obstetrics, gynaecology and child health services at Little DGH given training and safety issues	In towns twenty miles apart in isolated dispersed community in tourist area Maintain services in Community Hospital serving small isolated town while maintaining clinical standards given workforce constraints
Consultation	Consulted on new building but not service redesign	Consultations separately on surgery and obstetrics/gynaecology/child health	Several public consultations by Trust and PCT met with public opposition. A consultation led by new PCT resulted in review which secured most threatened services at end of study period
Changes implemented	Service changes internal to trust fully implemented, including new building and model of care Positive expected outcomes reported	Almost complete implementation of reconfiguration plan	No agreed plan
Changes not implemented	Some elements involving delivery of care in community not implemented because of – PCT had deficit and could not deliver some of its part of the reconfiguration Low surgical activity in diagnostic and treatment centre	Integration of surgical services across three sites not working as designed, jeopardising sustainability of Little DGH's elective surgical unit	No reconfiguration achieved

different way and isn't this exciting?" And they bought into that'. Internal stakeholder, Round 1

There was no public consultation specifically over this service change, and no public concern was raised about its introduction. At the first round of interviews the operation of redesigned services had begun. By the second, interviewees reported that elements within Small Hospital were operating as planned:

'... they basically created a whole model. It's working and now we're putting it up in front and saying, "Look, you said this couldn't be done. We've done it here. If we can do it there, why can't we do it here?"' External stakeholder, Round 1

However some community-based and general practice elements were not implemented because of a PCT deficit, including a GP-run minor injuries unit in a community hospital, and GP-led minor injuries in the hospital.

The redesign of services in this trust was reported to be viewed by government as a model which other small hospitals could follow.

Events outside the trust made the survival of the new services questionable. The PCT deficit, and loss of its planned elements to the redesign meant that part of the unique patient journey was lost. The trust itself went into deficit during the study period, with the redesigned acute admission process and the diagnostic and treatment centre at Small Hospital identified as contributing significantly to losses, because of low levels of activity. PbR conflicted with an earlier government policy for shifting treatment to community services [38] which underpinned Small Hospital's redesign, by giving incentives for hospitalisation. Some

interviewees also perceived PbR as putting it at a disadvantage with the private sector by fixing NHS service prices while private hospitals were free to vary prices in response to the market, and cross-subsidise.

3.2. Rural Trust North

Rural Trust North had three main hospitals in a rural area dotted with formerly industrial towns. Each was a separate hospital trust in the recent past. A need to create services with sufficient volume for modern training standards while still accessible to a dispersed and deprived community drove merger between Medium DGH, a moderately sized DGH, and Little DGH, a smaller hospital 15 miles away. A later merger with Large DGH was an element in the reconfiguration under study. Our study focused on the relocations of obstetric and emergency surgery services, two elements of a larger reconfiguration. Little DGH's emergency surgery and consultant-led obstetrics moved to Medium DGH, while stroke services, elective surgery and haematology moved to Little DGH.

Interviewees reported that the main driver for reconfiguration was the delivery of safe services in Little DGH, compatible with workforce and training requirements of regulatory bodies. Consultants in Medium DGH initiated the plan, and an external expert, appointed to resolve concerns of a PCT, introduced new elements including the merger with Large DGH. The expert intended this merger to introduce higher volumes of elective surgery to Little DGH's new theatres built with PFI funding.

Internal interviewees reported that the reconfiguration was implemented to time and on budget, in accordance with a well developed plan.

'The biggest strength ... is the project management and I would say that that was strong both internally, but also strong performance management by the then health authority to ensure that the changes were implemented'. Internal non-clinical stakeholder, Round 2

Their public consultations met with and overcame opposition and they reported introducing some elements of the plan, including Little DGH's midwifery-led unit, as a result of consultation.

However, some internal clinical interviewees at Little DGH felt vulnerable, arguing that management saw the site as a first choice for cuts. They, and interviewees at Medium DGH, reported that senior clinicians at Large DGH were reluctant partners to the merger, and perceived the development of Little DGH as being at the expense of a necessary expansion of capacity on their own site. Some respondents at other sites believed that providing services at Little DGH conflicted with Large DGH consultants' private work. They had not referred to the Little DGH surgical unit to the level hoped for:

'... a huge reluctance of people to change the way they work and perhaps an element of reluctance of management to, you know "Come on guys, we want you to go and do your operative, your elective operative stuff at Little DGH"'. Internal clinical stakeholder, Round 2

Rural Trust North was the only case study of the three not to experience financial problems. The NHS organisations in the area including its PCTs were financially sound. Powerful members of government represented local constituencies, and they and local government supported the trust management.

By the second round of interviews, interviewees were still satisfied at the progress of the reconfiguration, although they reported continued lack of commitment to the merged trust from Large DGH clinicians. Several directorates had merged across the trust. Most single-hospital directorates were in Large DGH. Little DGH clinical interviewees' concerns about their site's viability remained.

The long-term sustainability of the services at Little DGH was poor. Under PbR the elective theatres and midwifery-led unit looked uneconomic because of low activity levels. The trust was still committed to PFI payments for the building.

3.3. Rural Trust South

Rural Trust South is in a rural, tourist area. General Hospital is a large DGH in a central town, and Community Hospital, a small hospital in a town 25 miles away. The trust must accommodate peaks in demand at holiday times and make services accessible to a dispersed community. The PCT and trust developed reconfiguration plans to bring more serious urgent cases from Community Hospital to General Hospital over nearly a decade.

Consultants at General Hospital became anxious about safe provision of services at Community Hospital, particularly emergency medical and surgical admissions and anaesthetic cover, given workforce constraints. The trust and PCT were concerned to maintain a viable unit on the

site because of the strength of community attachment to local provision.

'I would never ever recommend the service to be withdrawn if it was a great service that was utterly sensible, but was expensive. It's just that this service is not sensible, it's not safe and it's costing a fortune and all of those three put together the reason that that is happening is because the, the local politicians and health groups [in the area of Community Hospital] are holding this hospital to ransom, and threatening both individuals and the organisation with all sorts if anybody touches our hospital and tries to downgrade it any further'. Internal clinical stakeholder, Round 2

We observed several attempts to agree a reconfiguration, rather than a reconfiguration process. Consultation on each plan, and on a leaked tentative proposal, sparked vehement protest including street demonstrations. Twice a Minister of Health intervened to promise that existing services would be maintained, overruling trust and PCT proposals.

A joint body with community involvement, with a chair trusted by the community from outside the area, and advice from an outside expert, made one attempt at resolution. The resulting plan, initially acceptable to both sides, proved technically impractical to the trust and gave insufficient security to campaigners. The trust made a new proposal for increased elective, low risk and outpatient activity at Community Hospital, while services deemed risky were moved to General Hospital. The community campaign was suspicious of all moves of services away from Community Hospital, which it attributed to attempts to cut costs. A trust deficit emerging during study period supported these entrenched views. The campaign was strengthened by funding and political support from local councils and members of parliament opposed to the party of government who perceived NHS problems as government failings.

As data collection ended a new county-wide PCT replaced the previous smaller ones, and initiated a service review. The review had a deliberately conciliatory approach to the community campaign, and made early commitments to maintaining some threatened services at Community Hospital.

Resolution of Rural Trust South's clinical concerns would mean restoring the community campaign's confidence in NHS organisations, or reducing its impact. The new PCT's conciliatory approach seemed to be productive, and a local government reorganisation has removed the tier of government which funded the campaign. Community Hospital was economically unviable under PbR. The financial viability of Community Hospital may prove more intractable.

3.4. Cross-case analysis

At City Trust and Rural Trust North case study sites, substantial changes were made in accordance with a reconfiguration plan, while at Rural Trust South, a plan was yet to be agreed. At City Trust, progress seemed to have stalled by the end of data collection, because of financial problems, and the future of all three trusts was jeopardised by finan-

Table 4
Factors influencing 'results'.

	City Trust	Rural Trust North	Rural Trust South
Characteristics of reconfiguration with impact on local population	Involved no removal of services; modern building replaced a dilapidated one, designed around the patient journey	Removal of services from isolated community, and some enhancement of existing services. Depended on integrated operation of 3 geographically distant units	No model of care presented which met internal objective to remove clinically 'unsafe' service while addressing community concerns about access
Response to reconfiguration and consultation	No concerns expressed about redesign by external stakeholders	Concerns expressed some of which resulted in change to reconfiguration plan e.g. introducing a midwifery-led unit	Community campaign organised large demonstrations, supported by other external stakeholders, and rejected all plans put forward by trust
National politics	Government saw small hospital as a model for sustaining other Small Hospitals	Powerful members of government represented the area in parliament and local councils were supportive of trust	MPs and all local authorities were from political parties opposed to the party of government and partly blamed government policy for problems with health services. Two government ministers had visited the area at the time of protests and supported the local community position against the trust
Local events with financial impact	PCT deficit leading to loss of PCT provision of community services integral to redesign Trust deficit changed trust's priorities	Rural Trust North is the only study trust not have to deal with deficits of its own or in its health economy	Trust deficit emerged, and grew, over study period
National policy with financial impact	Payment by results (PbR) penalised the model which shifted much traditionally acute care to community, and contributed to low surgical activity by making diagnostic and treatment centre less competitive Private Finance Initiative (PFI) payments at Small Hospital contributed to costs at this site	Financial sustainability was jeopardised by PbR with impact on sustainability and competitiveness PFI payments for Little DGH added to overheads	PbR threatened the sustainability of services at Community Hospital

cial problems in the pipeline, made more apparent by PbR. Table 4 summarises factors influencing 'results'.

3.4.1. Drivers for and content of change

All three reconfigurations were driven by attempts to provide accessible services in small units, but that superficial resemblance concealed differences. At City Trust, management anticipated an economic threat to the small unit, and devised a solution (which involved no loss of services), by seeking a niche in the wider health economy without any evidence of community concern, while in Rural Trust North and Rural Trust South, with more dispersed communities, the attempt to preserve small units was in response to community concerns. Clinicians and managers sought to ensure a configuration of services at these units which was safe and viable, removing services to other sites which they believed were more safely or economically delivered at higher volume.

3.4.2. Influence of stakeholders

Community concerns also influenced the progress of reconfiguration, at Rural Trust South obstructing the agreement of a plan, and at Rural Trust North being apparently managed and overcome, while no significant community opposition was reported at City Trust. Other stakeholders – local and national politicians – also influenced the progress of reconfiguration. At Rural Trust North particularly, political support seemed to protect the trust management's efforts, while at Rural Trust South, political support and

financial contributions from local government strengthened community opposition to reconfiguration plans.

3.4.3. Financial pressures

The financial state of the health economy changed the course of City Trust's reconfiguration when the PCT's financial problems meant that PCT elements were not implemented. The trust's own deficit led to close examination of the viability of reconfigured services. At Rural Trust South, the trust's deficit deepened community mistrust in reconfiguration attempts. At Rural Trust North, a robust health economy seems to have facilitated implementation of plans.

3.4.4. Senior management approach

The cohesiveness of the senior management team seemed to be related to the progress of reconfiguration at City Trust and Rural Trust North. At City Trust, the reconfiguration was initiated when Small Hospital was an independent trust reported as having a dynamic and innovative culture, and initially the board of City Trust was dominated by Small Hospital Trust board members. Over the course of the study, these members were replaced by outsiders who looked more critically at the reconfiguration in the light of the trust's deficit and those elsewhere in the health economy. Rural Trust North's board was reported to be cohesive and to share a project management approach. Membership did not change over the period of

data collection, unlike that of Rural Trust South which had considerable turnover.

4. Discussion and conclusions

Our study of hospital reconfiguration illustrates a range of 'results': in one case (City Trust), reconfiguration plans were implemented fully; in the second they were partially implemented (Rural Trust North); and in the third they were not implemented at all (Rural Trust South). We identify a number of important, inter-related, factors in the process of implementation which influenced these 'results' i.e. what was implemented, confirming what other studies of local implementation of national policies have found (e.g. [4,26,39,40]) i.e. a mix of responding to other national policies which conflict with this one and local contexts and processes. The content of reconfiguration (particularly the extent to which services are withdrawn or made less accessible) and the related strength of local opposition emerged as influential in the outcome of reconfiguration. Where reconfiguration was perceived as a 'downgrading' of service provision, there was more active internal (professional) and external stakeholder involvement as illustrated in Rural Trust North and Rural Trust South, whereas in cases where changes were not perceived as 'downgrading' because services were not being moved from one site to another or closing, as in City Trust, there was less conflict.

Local party politics and their relationship to national party politics played an important role in strengthening the local opposition or creating a secure environment for the trust's management. This was evident in Rural Trust North and Rural Trust South where in the former, local politicians were influential in the party of national government facilitating a more secure environment for change; while in Rural Trust South, local politicians from opposing parties joined forces with public opposition to change. However, in each case, there was a complex web of political and other relationships that need to be taken into account.

The financial context was important in all three cases in terms of the national context of the change in funding arrangements (PbR) and in City Trust and Rural Trust South in terms of specific local difficulties. Rural Trust North, which had nationally influential MPs, seemed to be cushioned from these effects compared with the other two. PbR affected all three trusts' reconfiguration plans contributing to threatening the sustainability of these organisations by imposing a fixed payment which did not cover high overheads of a small unit and making this shortfall transparent [41]. In two trusts, the legacy of PFI buildings compounded this. Others have noted the inflexibility of PFI arrangements to adapt to new circumstances [42].

The role of the senior management team was important in both the process and outcome of reconfiguration, although perhaps mediated by other factors. The turbulent context for Rural Trust South was mirrored by a high turnover in senior management, whereas City Trust and Rural Trust North had highly committed and cohesive senior management teams which designed and initiated implementation.

These factors provided context for the consultation processes (or lack thereof) in all three cases. The differences

between the three cases reflected the nature of the proposed changes and local politics rather than the strength of the 'evidence' for change. National policy has tended to over-emphasise the importance of consultation using 'evidence' and underplay these contextual factors (see e.g. [5]).

We may be entering a new period of rationalisation and reconfiguration in the NHS in England. The NHS is charged with saving £20bn by 2015, and the current proposed reforms including 'any willing provider', whereby private companies will be allowed to compete with the NHS for patients, may add to the pressure on the viability of individual units and whole hospitals. On the other hand, in May 2010 the newly elected coalition government announced an end to 'top-down forced closures' and the need for NHS trusts to pass several tests to allow a closure: support from payers, better public and patient engagement, and clear clinical evidence to justify the change [43] – underlining the previous government's belief in a rational, technical process.

This paper highlights the importance of using multiple, longitudinal cases in this study of hospital reconfiguration as it has been able to uncover these contextual factors and how they inter-relate [44]. Although the three case studies provide examples of different types of reconfiguration, as well as contrasting in the socio-economic characteristics of their populations, and their national and local political context, the fact that they had been in receipt of some funds to support the reconfiguration process, may mean they differ in some important ways from other reconfigurations. However, differences between the cases in terms of context and content enable us to be confident that relations among these factors constitute a robust analysis of the process and 'results' of reconfiguration.

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