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Service Reconfiguration

Position Statement -
RCEM Service Design and Configuration Committee

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There are currently a number of ongoing plans and discussions regarding service reconfiguration in the UK and Ireland. In many cases these are legitimate debates informed by the triple aim of improved health and wellbeing of the population, improving quality of care and reducing cost of NHS care, as initially described in the NHS Five Year Forward View (2015) and more recently the 10-year NHS Long Term Plan (2019).

Within England these processes are often led by the infrastructure charged with delivery of the Sustainability and Transformation Partnerships (STPs), and their successors, the Integrated Care Systems (ICSs)[1,2]. In Scotland, Wales and Northern Ireland the mechanisms charged with the attempted delivery of service reconfiguration are different, but the perceived objectives are broadly similar.

Different systems will have different drivers at different times. For example, a discussion about closure or "downgrading" of an Emergency Department (ED) may be initiated by an inability (or perceived inability) to staff the department appropriately, to resource that appropriate staffing level, or an inability to provide the essential services that must exist alongside an ED to ensure that the service is able to deliver safe patient care.

In April 2017 RCEM published guidance on ED reconfiguration[2]. This remains current and available on the RCEM website and we would encourage healthcare leaders to consult this guidance in full. Key components include:

- Reconfiguration of services **must** have the safety and quality of patient care at its core. Perceived savings to the overall health and care system will usually be false once travel costs (for patients, staff and relatives) are taken into account.

- Centralisation of some specialised capacity (e.g. stroke services, emergency cardiac services and major trauma) is appropriate, but the benefit of this has already been realised in most systems. For the vast

majority of patients presenting acutely, care delivered closer to home delivers good outcomes and represents better patient experience.

- Relocation of emergency patients to neighbouring emergency systems has the danger of overwhelming that system/ED in a situation where it is unlikely that capacity to absorb that demand exists.

Removal or reconfiguration of essential services that support an ED (e.g. Critical Care, Paediatrics, General and Specialist Surgical services) can lead to a "house of cards" effect in which all other services become untenable because of the complex inter-dependencies that exist in systems that assess undifferentiated emergency presentations. Any such reconfiguration should be avoided wherever possible but, where considered, must have robust governance arrangements in place to ensure that the safety of all patients is maintained.

Although there is no absolute "one size fits all" for emergency services in all systems, a clear focus on safety and quality and care will inform decision making as to how to configure services[3]. An Invited Service Review, commissioned from RCEM, can assist local decision makers in cases where there is pressure on services and/or uncertainly regarding re-configuration decisions.

RCEM intends to publish guidance on staffing and service configuration for smaller UK EDs (typically around or less than 60,000 attendances per annum) in 2019. This will provide further support and guidance for those systems that are most challenged by reconfiguration pressure and debate.

References

1. https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/
2. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
3. https://www.rcem.ac.uk/docs/Policy/Reconfiguration%20guidance%20April%202017.pdf
4. https://www.cqc.org.uk/sites/default/files/20171124_sharing_best_practice_emergency.departments.pdf