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Questions addressed

1. How have patients across England responded to hospital specialisation elsewhere in the NHS? – what benefits and drawbacks have they identified?
2. Have clinicians identified any benefits or drawbacks with hospital specialisation?
3. Are there other important lessons to learn from hospital specialisations done elsewhere?

Patient responses (1). General comments

- Studies have found resistance to change processes is greater when reconfiguration is perceived to include hospital downgrading
- Opposition is most likely in relation to 'money', 'transport' and 'emergency care' (Independent Reconfiguration Panel 2010)
- Communities themselves are not unitary or homogeneous, and may be characterised by disagreement about the desirability or otherwise of service change proposals
- Protests and campaigns give an impression of uniform opposition but this can be misleading

Patient responses (2). Reasons for centralization

- Underlying logic of centralization is often accepted, e.g. relating to:
  - infrastructure
  - changing/reduced health need
  - service duplication
- But other grounds are contested, e.g.:
  - service quality
  - Efficiencies and opportunity cost
  - Central policy

Patient responses (3). Trust

Most justifiable reasons for moving or taking away services	**Least justifiable reasons for moving or taking away services**	**Reasons why services are actually moved or taken away in practice**
If there are changes in patient/service user need	To make financial savings	To make financial savings
If a service is not being used very much	Political pressures at the local level	Decision makers (e.g. commissioners) are in favour
If other similar services are available)	To meet the interests of organisations (e.g. hospitals) or individuals (e.g. professionals	Political pressures at the local level

Williams, I. et al. (2017). Decommissioning health care: identifying best practice through primary and secondary research–a prospective mixed-methods study.

'So often the NHS doesn't want to talk about the financial element of these decisions, but the public knows full well (especially in the current context) that finances are a major driver in reconfiguration. The service has got to be able to have a more sensible conversation with the public about finances, acknowledging that they are a driver for change, but also pledging to the public that any changes made will always either maintain or improve standards of care. The trouble, of course, is that the public often doesn't trust decision-makers and so any conversation of this kind gets derailed quickly because the public suspects hidden agendas and personal motives.' (patient participant in Williams et al. 2017*)*

Patient responses (4). Access

- Travel time and convenience are consistently shown to be important to patients (Victoor et al. 2012)
- This includes access for families/carers as well as patients
- Wider dimensions of 'accessibility' – e.g. community vs acute (Davidson et al. 2019)
- Continuity of care and access are interwoven

Travel times, patient behaviour and health inequalities

- Relationship between distance/travel times and health outcomes unclear
- But evidence synthesis suggests positive association 'cannot be ruled out and should be considered within the healthcare services location debate' (Kelly et al. 2016)
- Access barriers are related to age and other socio-economic factors

Patient responses (5). Other issues

- Wider community significance and benefits of local hospital provision relate to employment, sense of local place and ownership, viability, of small towns and villages and so on (Davidson et al. 2019)
- Rural vs urban differences: many health policies are shaped by the 'urban lens'

Clinician responses

- Clinical opinion is often split – champions and detractors
- These debates are usually conducted in relation to proposed new 'clinical model' and the evidence supporting (or not) this
- Responses often draw on knowledge of the local patient population group's unique or under appreciated characteristics

Other considerations

- Underlying logic of centralisation is not always supported by the evidence and this is compounded by complexities of scale, context, intervention, workforce etc
- Responses are often as much about the process of implementation and consultation as they are about the proposed change

Key messages

- Patient and stakeholder responses to centralisation are varied and sometimes unpredictable
- Rejection of budgetary and political drivers can put patients and communities at odds with service planners
- Important issues include trust, access and the wider attachment to local health care services