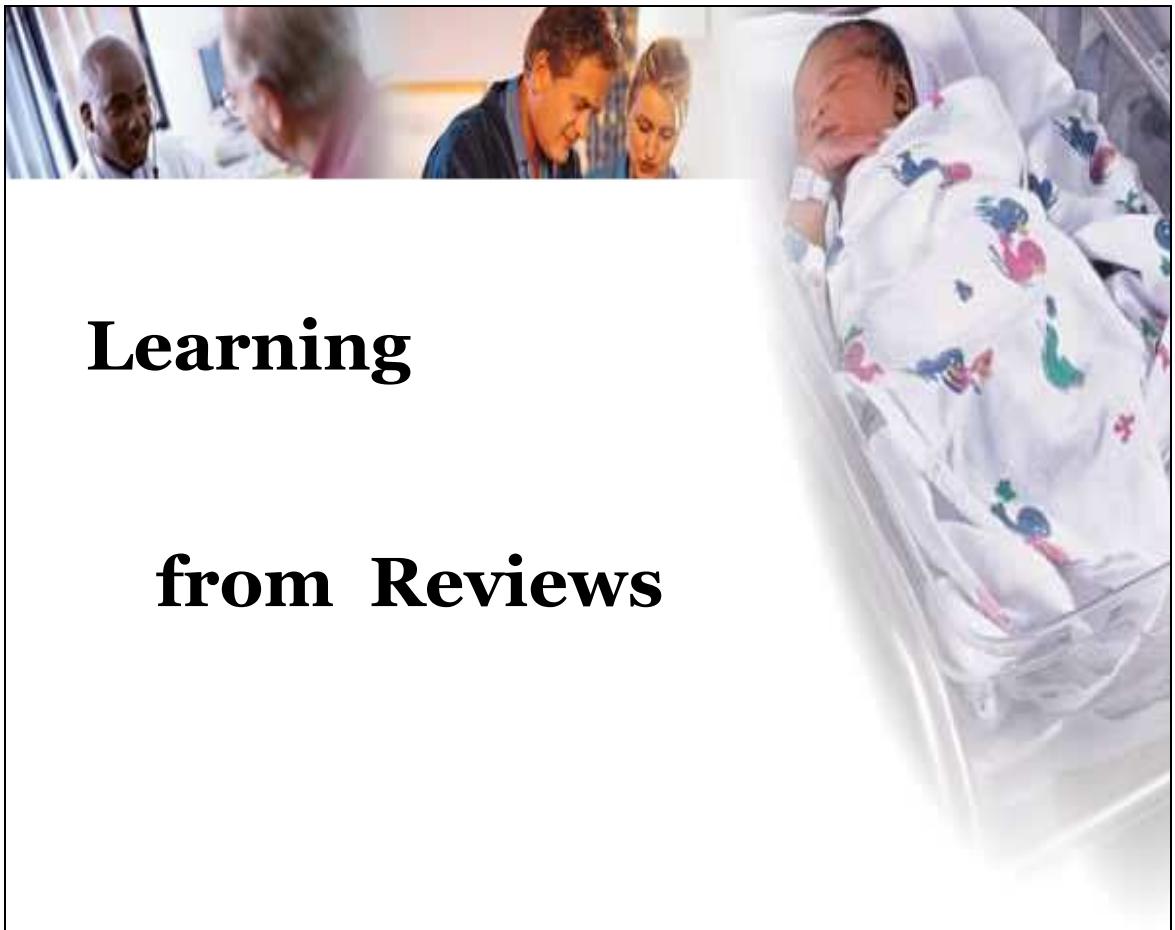
IRP

INDEPENDENT RECONFIGURATION PANEL



Learning from Reviews

AN OVERVIEW

November 2008

FOREWORD

We are all touched at some stage in our lives by the NHS and care deeply about what happens to our local services. It is not surprising therefore that the often thorny subject of NHS reconfiguration raises passions in us when changes are proposed to what we know and trust. I strongly believe that there is a need for an independent non-political body to review such NHS proposals when the local community and NHS cannot agree a way forward. With that in mind, I was delighted to take up the chairmanship of the IRP in 2003.

It is the IRP's role to provide advice to the Secretary of State for Health about contentious reconfigurations. The IRP, made up of a mixture of lay, clinical and managerial members, operates in a wholly independent way. When reviewing a contested reconfiguration proposal we actively seek local and national views, listen to and record all sides of the debate, read mountains of written evidence, and visit the relevant sites. Our focus is always on the needs of patients and the highest possible quality of care as we seek to put any proposal through the filters of safety, sustainability and accessibility, eventually arriving at what we as a group consider the best advice for the local circumstances. In the spirit of independence and transparency, we publish our advice on our website. This advice, if accepted by the Secretary of State, can help to draw a line under previous conflict and allow the local population and NHS to move forward in a constructive way to improve services.

We have now completed fourteen full reviews and it seemed appropriate at this stage to step back and see what themes had emerged from our work that would be of use to both the NHS and local communities. A number of themes do indeed arise which NHS organisations might care to consider prior to embarking on the path of service change. Hopefully, this will help to reduce the number of contested reconfigurations. However, I believe that there will always be some instances where genuine local disagreement remains no matter how good the process. It is for these particular circumstances that the IRP exists as an independent body.

I attach a health warning to our review of reviews. The NHS operates in an environment of rapidly changing medical treatments and demography. We are always 'at a point in a journey'. Our findings should not be used as a fixed blueprint for action nationally but as a guide to planning for successful change that can be locally applied. As local circumstances

change then so may our advice. Putting patients and the highest possible quality of care at the centre of proposals for reconfiguration will remain the key to success in the future.

Dr Peter Barrett CBE
Chair
Independent Reconfiguration Panel

INTRODUCTION

Since it started work in 2003, the IRP has published 14 reports giving formal advice to the Secretary of State for Health on contested proposals for reconfiguring local health services.

These reviews have been about services in many parts of the country, for both urban and rural communities and about various aspects of healthcare. Six have dealt with maternity or children's services (or both) and another six with emergency treatment and care - Accident & Emergency (A&E) services, inpatient emergency trauma (treatment of serious injuries), surgery and medical care. The other two covered general care for older people and services for older people with mental health problems.

This paper sets out some themes - clinical, managerial and procedural - which we have identified from the reviews. They emerged in response to two questions:

- Are there common factors in cases where proposals for change have been referred to the Secretary of State?
- Are there particular problems in healthcare delivery which have been common to these referrals?

In addressing these questions, we have drawn on our published reports, on a range of NHS guidance material, and on interviews with 28 stakeholders who contributed to reviews as NHS leaders, local councillors or community representatives.

We hope that what we have learned may interest and help all those considering how best to change and improve their local healthcare services.

Quotations, ***in italics***, are taken from IRP reports.

The critical list

The IRP's verdict on why reconfiguration proposals have been referred:

- **inadequate community and stakeholder engagement, before options are published in a formal consultation**
- **important content missing from reconfiguration plans - local communities want to know what services will be provided, where and how they will access them**
- **mixed messages about clinical issues – if doctors in an area publicly disagree, their patients are entitled to be sceptical about proposed changes**
- **proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services**
- **health agencies caught on the back foot about the three issues most likely to excite local opinion – emergency care, transport and money**

BACKGROUND

The Role of the IRP

The IRP was set up as an independent body to advise the Secretary of State for Health on contested NHS reconfigurations in England and specifically to give advice about proposals formally referred to him for decision.

Its establishment was part of a package of changes to the arrangements for patient and community engagement in healthcare services set out in the NHS Plan in 2000 and introduced by the Health and Social Care Act 2001. Community Health Councils were disbanded and replaced by Patient and Public Involvement Forums and the Patient Advice and Liaison Service and, for community representation, by local authority **health overview and scrutiny committees (HOSC)**. HOSCs have a general monitoring role but also must be consulted by local NHS bodies about proposals for substantial developments or variations in services provided. A HOSC has the right, now enshrined in the NHS Act 2006, to refer proposals to the Secretary of State if it is not satisfied:

- with the content of the consultation or
- with the time that has been allowed or
- that the proposals are in the interests of the health service in its area.

In addition to providing formal advice to the Secretary of State on referred proposals, the IRP from 2004 also took on a role in providing informal advice to health bodies, HOSCs and other stakeholders where reconfigurations were being planned or debated. It has now contributed in this way on more than 50 occasions.

The organisation and working methods of the IRP are summarised in Appendix A.

Most reconfiguration proposals referred to the IRP have come about when acute hospital trusts, that are responsible for more than one hospital serving different communities, have put forward plans to alter the range of services on the various sites. In these circumstances, one or another community may be - or may perceive itself to be - the ‘loser’ of healthcare which should be provided locally.

As might be expected where it has not been possible to resolve disagreement and the Secretary of State is asked to make a decision, there are often strong arguments on both sides. The IRP reviews each case on its merits taking into account the evidence - usually extensive - which it receives from stakeholders. Our brief is to consider whether proposals are in the best interests of patients and will improve services and health outcomes, within the context of safety, sustainability and accessibility.

The NHS environment

In the years since the IRP was set up there have been a number of developments in the NHS particularly relevant to its work. These include:

- the reorganisation of primary care trusts (PCT) and strategic health authorities (SHA) in 2006 - this affected the leadership of consultation and of service design in some cases
- the wide range of guidance published in the last three years by the Department of Health, the Royal Colleges, the Healthcare Commission the Kings Fund and others
- financial uncertainty - in 2005/06 for example, 190 NHS bodies reported deficits so it is not surprising that some trusts and PCTs were in deficit or financial recovery at the time their reconfiguration proposals went for public consultation.

PCTs, provider trusts and SHAs are now developing their plans to improve services in the light of the new strategic framework set out in ***High Quality Healthcare for All*** (June 2008). HOSCs and the public should be playing an increasingly important part in shaping their local health services as this work proceeds.

Anticipating the need to improve the way the NHS approaches reconfiguration, the Department of Health published new guidance, ***Next Stage Review: Leading Local Change*** in May 2008. This suggests a framework in which change should be:

- in the best interests of patients, benefiting them by improving health outcomes and/or aspects of the quality of the service
- clinically driven, but based on sound clinical evidence
- part of a continuing dialogue with local communities and health service stakeholders
- locally led and identifying the best local solutions
- managed so that new services are put in place before old ones are withdrawn.

THEMES FROM IRP REVIEWS

Why do proposals get referred?

The most common objections to reconfiguration proposals provide the background to referrals to the Secretary of State and make a potentially useful checklist of issues to which others embarking on a reconfiguration may have to respond. The most common objections are:

- the proposed future **location of hospital inpatient services** means a worse or lost service for a particular community - this may be argued even though there is agreement about the general need for and principles of changes
- people will be compelled to make long and/or expensive **journeys** that may deter patients from attending and reduce the opportunities for visiting
- a particular town or locality is big enough to need/justify having its **own full-service district general hospital (DGH)** - this may be seen as a 'right'
- **emergency services will be too far away** and very sick people will be put at risk by the time it will take to transport them - people may die as a result
- even if distance is not an absolute barrier, the **ambulance service** will not be able to cope with the extra demand and/or cannot be sure of journey times because of road congestion and/or will not have sufficient paramedics to cover all calls
- the case has been argued on clinical grounds but **not all the consultants and/or GPs support the proposals -** why then should other stakeholders accept it?
- the **plans are not sufficiently detailed –** there is not enough information about how services will work and what the plans will mean for individual patients, the full costs are not clear and it is not known whether there is sufficient capacity to implement the changes
- the **forecasts are wrong** - for example, of the number of patients who will in future have to travel further, or be taken by ambulance for treatment (and also of those who will want to visit them) or of population growth in the area, with the impact this will have on future demand
- the plans say that **local services will be expanded** (for example, more outpatient clinics/day surgery/diagnostic equipment/specialised treatments or that there will be more community services, such as physiotherapy and chiropody and improved social

service support) but people are sceptical that they will actually be provided – new services should be put in place before any changes are made that take away existing services

- The proposals are **not consistent with Government policies** about providing services nearer to patients - they will be much further away.

> ***"From the evidence submitted to us it is clear that many residents do not fully understand what would be provided at the locality hospital."***

Did the consultation process help or hinder?

None of the reconfigurations reviewed by the IRP were referred to the Secretary of State because the HOSC itself had not been properly consulted as required by law. Many HOSCs were positive about the way they had been involved and noted that both continuing formal meetings and informal negotiations had been held, often over a long period, to seek to resolve differences. However, most of the referrals also included some adverse comments about the wider consultation process, most often that it did not reach enough people or that it was too difficult to understand.

> ***"The Panel heard from a number of sources that, although compliant, the consultation perhaps did not reach all communities and stakeholders and that there did not appear to be any evidence of..... a proactive engagement strategy."***

This reflects the fact that the formal requirement to consult HOSCs is only one aspect of effective engagement with stakeholders in healthcare and in this broader context the IRP has seen a wide range of quality, from innovative, through very good 'best practice', to very poor. Even the best management of community and staff participation does not guarantee an agreed way forward. Change will often have drawbacks as well as advantages and may require difficult judgements about trade-offs - for example, the potential benefits for patients of being treated by more specialised clinical teams against greater travel times and distances as these teams operate from fewer centres. In a number of cases reviewed by the IRP, a joint HOSC

drawn from two or more local authorities supported reconfiguration proposals but one of the participating HOSCs subsequently rejected them and referred the decision to the Secretary of State, reflecting concern about the impact on its own part of the wider community.

The IRP's reviews highlight a number of problems which may generate or allow mistrust and cynicism to develop and make an impasse more likely.

Limited stakeholder engagement in the early stages of planning change. Formal consultation on reconfiguration options published to a largely unprepared community can provoke a hostile reaction. As well as community groups and patients, staff groups (including GPs) and the HOSC have not always been involved or kept informed before a consultation is launched. As a result, proposals have not taken sufficient account of how the public sees the priorities for healthcare services.

In some cases, consultation took place in the context of a long history of previous proposals for change which did not lead to a clear decision, or of decisions which were not then carried through. The process used to develop and consult on new proposals was particularly sensitive for these.

A badly written consultation document and associated literature. Some have been technically poor in structure and language. Others have not explained the purpose of the proposals effectively for a general audience - for example, how changes will result in better treatment - or have lacked sufficient detail about how and where future services will be provided and the clinical staff patients will be seen by in different circumstances.

> ***"There was a feeling that the consultation document was not as clear as it should have been regarding what is being provided and the key messages delivered."***

Inadequate attention given to the responses during and after the consultation. This compounded problems where early stakeholder engagement was limited. It can in any case

be difficult to provide a full analysis of further options suggested by stakeholders during a consultation - at that stage time is short and all the pressure is to move ahead with a decision.

> ***"....alternative options which could have maintained services at* [the] *hospital were too easily dismissed..... There was not time to do this properly at the end of the process and, by this time, mistrust had developed."***

Failure to anticipate critical community concerns. Almost all the proposals reviewed by the IRP were criticised locally for bring driven by the need for *cost savings*. This was foreseeable since it is part of mainstream political rhetoric about the NHS. In addition, many of the provider trusts and PCTs had recently had financial difficulties, so that the issue of funding was current in the local communities. In practice, most proposals were not developed to save money and many included plans for increased spending. Some provider trusts and PCTs nevertheless seem to have been inadequately prepared for questioning about resources, allowing the impression to remain that there was an underlying need to reduce services to save money. *Transport* has been a similarly recurrent theme, both for patients and family visitors, to get to new and possibly more distant places for treatment and for the ambulance service in an emergency, impeded by slow rural roads or heavy urban congestion. Some plans were little more than vague promises of improvements. In some instances, ambulance trusts had not been consulted early enough to ensure that they had robust proposals for handling extra emergency calls.

> ***"When we were shown the plans for the re-use of accommodation it became clear that* [local] *concerns were unjustified.....detailed plans made available to the general public would have helped local confidence in the proposals."***

Consultation on detail without sufficient link to the broader development of healthcare services. Reconfiguration should normally be led by PCTs which are charged with planning and commissioning a full range of services. In several cases reviewed by the IRP, smaller PCTs were in the process of merging at the critical time. Uncertainty about leadership and

ownership of proposals meant that they were driven by provider trusts, which have a narrower focus and which may themselves have been under challenge about their performance and/or finances. This affected public and stakeholder engagement and reduced the links to important parallel developments, such as plans for expanding community services.

> ***"It is clear from the views expressed to us that the process of public engagement and consultation did not entirely fulfil its purpose. Many members of the public felt that their comments had not been taken into account and there was a sense of unfairness...about some of the decisions taken. But equally it is true to say that NHS representatives felt a sense of frustration that sections of the local population appeared unwilling to recognise the need for service modernisation and planning for long-term sustainability of services."***

What was the contribution of the HOSCs?

The involvement of local councillors in overseeing and scrutinising health services is still relatively new and it is understandable that they have been exploring methods and procedures over the period of these IRP reviews. This has been made more complicated because many health reconfigurations affect the residents of more than one local authority, so that the formation of a joint HOSC is required. Nevertheless, it is clear that health scrutiny has developed in a positive way for all parties.

HOSC referrals to the Secretary of State have been supported in widely different ways. In some cases, they have said little more than that they do not consider reconfiguration proposals to be in the interest of the local community. At the other end of the spectrum, extensive dossiers have been compiled with a closely argued critique of the proposals supported by extensive references to guidance documents.

> ***"The Joint HOSC is also to be applauded for the very thorough way in which it has conducted its analysis of the proposals and for the quality of its response to the formal consultation."***

In most cases, once an a provider trust or PCT had reached a decision following formal public consultation and the HOSC disagreed with the conclusion, further efforts were made to find a way forward which both could support. HOSCs have referred proposals to the Secretary of State with some reluctance and as many have sought informal advice from the IRP as have referred to the Secretary of State.

Several HOSCs have recognised in their referral letters, and in giving evidence to the IRP, that the assessment of local reconfiguration proposals was finely balanced. Most have accepted the IRP's recommendations in a positive spirit.

> ***"The job of scrutinising such a large project was....no easy task and the Joint Health Scrutiny Committee deserves praise for examining the issue in such a measured and balanced way."***

How effective was the clinical case for change?

In most cases reviewed by the IRP, the principal argument for change has centred on developments in clinical practice driven by one or more of:

- increasing specialisation, especially in relation to complex treatments and in handling emergencies
- new medical manpower arrangements to meet the requirements of the European Working Time Directive 2003, which has already reduced the working hours of junior doctors and will further limit them in 2009
- advances in technology and clinical techniques which enable more diagnosis, surgery and other treatments to take place without being admitted to a large district general hospital.

> ***"What constitutes a safe practice is a constantly evolving concept – what was considered to be safe 20 years ago may no longer be considered safe by modern standards."***

Proposals address these trends by concentrating inpatient services on fewer sites, where there can be a 'critical mass' of clinical staff to provide 24-hour consultant cover, provide the most expert diagnosis and care for each patient, and make full use of often expensive equipment and facilities. In addition, as clinicians become more specialised, they draw patients from a bigger area to see those who need their particular expertise; and they need to do this to see enough cases to maintain and develop their expertise. Junior doctors too need to spend time in hospitals where they will see a range of patients with more complex problems.

For some communities, these changes mean services - for which they have always relied on their local hospital - in future being available only in another town or city, perhaps many miles away. This causes the strongest reaction when immediate treatment is needed, especially for complications in childbirth, where a heart attack or stroke is suspected, or when someone is seriously injured in an accident. Many of those giving evidence to the IRP - clinicians as well as community representatives - have suggested that possible risks from greater delay in getting to see a doctor weigh more heavily with them than the clinical benefits of more specialist attention in facilities which cannot be reached as quickly.

> ***"It appears to the IRP that where it is considered important enough to retain a local service, ways to do this are found."***

The way in which the clinical case is presented, and the evidence used to support it, has been important in the places where the IRP has undertaken reviews.

Greater emphasis has been given to staffing problems than to the benefits to patients of changing clinical practice. The message tends to describe what the NHS cannot do, not what it should and will do. Anticipated improvements in health outcomes are either simply

assumed or presented in very general terms. This is readily interpreted as financially driven 'cuts', even though most reconfigurations have cost more.

The clinical case has not been convincingly described or promoted. Detail may be lacking. Many proposals have been supported by senior clinicians but on the frontline colleagues continue to identify with their own site and GPs with services in their immediate locality. In some places, this may have been because the case for change was not canvassed sufficiently widely among the whole clinical community. Although external clinical support is increasingly sought, especially from the *National Clinical Advisory Team (NCAT)*, this has sometimes been late in the day - after proposals have already run into opposition.

Imaginative local solutions have been rare. National guidance has become more extensive and more coherent and is likely to become more widely cited in reconfiguration plans. But while this can confirm general principles, it does not necessarily provide a practical local template. Every community is different - its population, wealth and age distribution; the number of health facilities and distances between them; transport infrastructure; proximity of specialist services in other towns and cities in the region and so on. One reason for a limited perspective has often been the absence of clinical networks between organisations providing care to the same population.

> ***"The IRP was left with the sense that* [the] *Hospital remains a problem to be solved rather than a development opportunity."***

Clinical integration within multi-site acute trusts and a broader vision of integration into the whole health community has been weak. This has limited flexibility and encouraged site-based solutions rather than a broader vision of creating an excellent service for a whole community. The integration of acute services with primary healthcare and social care has also been weak.

Maternity, obstetrics and paediatrics - a service perspective

Six of the 14 full IRP reviews have been about the reconfiguration of maternity, obstetric and/or paediatric services. In all but one area*, the proposals would have concentrated consultant-led obstetric and paediatric care in fewer hospitals while developing more extensive community midwifery services and opening midwife-led birth units (MLU) for low risk mothers at hospitals from which consultant-led services were to be withdrawn.

* The other referral concerned closing three small midwife-led units and replacing them with a single MLU at the district general hospital.

Altering these services can prompt a particularly strong reaction from local communities because:

- The implications for individual women are foreseeable – pregnancy has a long and predictable progression which many service users will have experienced already
- Locality can have a particular resonance at birth – some people want their children to be born in their home town
- Mothers have a range of expectations and concerns – some, above all, want minimum risk (and perhaps minimum pain), others place a high premium on facilities and support for natural birth.

The problems described in this review about communications and consultation, and with the coherence of the clinical case for change, have variously been a feature of the maternity referrals. There have also been issues specific to these services.

Too much emphasis on clinical staffing requirements, driven by the European Working Time Directive and the management of medical training. The IRP has twice recommended the Secretary of State reject proposals because it concluded that these "drivers" had been given precedence over patient access and choice when innovative solutions to staffing needs should have been explored.

Too little detailed planning and explanation of a proposed development in community midwifery. The anticipation of travel problems and loss of continuity of care (seeing the same midwife throughout pregnancy and following the birth) are common objections to proposed changes. A community-based service should mean less travel and the same midwife except perhaps for the birth itself, but this needs to be explained thoroughly and persuasively.

> ***"Much concern was expressed to us that the proposals will deprive the most disadvantaged and needy of access to services. Yet the expansion of community midwifery services, if successful, would do exactly the opposite"***

Lack of clarity about stand-alone midwife-led units. Where these are operating already, they are likely to be highly appreciated. Where they are a new development, they may be portrayed by critics as second best to a consultant-led unit and perhaps as less safe. Where existing stand-alone MLUs develop and adhere strictly to protocols about the suitability of cases and transfer during care, they seem to be operating safely and are popular.

Inadequate assessment of the wider implications of moving paediatric services from a hospital, where this may make other acute services more difficult to maintain. Some proposals have envisaged locating obstetric and paediatric services on different sites. Maternity services cannot operate in a safe and sustainable way without consideration of services for newborns and reconfiguration proposals for either in isolation should not be pursued.

What was the IRP's advice?

Given the issues involved and processes leading to a referral, IRP reviews have rarely identified a simple outcome for the parties involved. Nevertheless, they always seek to unravel and reappraise the issues in dispute and then to suggest a framework for moving forward. An IRP review typically results in about 11 recommendations.

In general terms, three of the 14 reviews have supported the proposals, four have not supported them and seven have supported them in principle but placed conditions on their implementation. Once, proposals for new services were also suggested and on another occasion the advice was to develop a new proposal altogether.

The most frequent condition placed on implementation has been that alternative services should be up and running before changes are made to current services. Other conditions have included further public engagement and the agreement of detailed clinical service design.

Over half of the recommendations have been about the management of service change, addressing both weaknesses that have emerged in the reviews and areas that need more attention as next steps are taken.

Renewed engagement of stakeholders, particularly the public, and making real progress on travel and transport feature heavily. Perhaps more surprisingly, the need to strengthen clinical networks and make clinical service integration and design a practical reality are common recommendations. On occasions, the advice has also noted the need for a service strategy without which specific proposals for service change have no context or underpinning.

Finally, many reviews have advised strengthening the local NHS's framework for supervising service change, often suggesting more explicit quality and procedural assurance from the relevant SHA.

AFTER AN IRP REVIEW

The stakeholders we interviewed had been involved with the first 10 of the 14 Reviews carried out by the IRP. We asked for their assessment of what had happened since the IRP report was published and the Secretary of State's decision announced. (We did not follow up the four most recent IRP Reviews because these have been published too recently for much practical action to have taken place.)

Almost everyone was positive about post-review action. The strongest theme in their comments was that the review process had helped to draw a line, leading to a decision by the Secretary of State which enabled changes and developments to go ahead. This was particularly welcomed where there was a long history of dispute about services. Even most of those who disagreed with the IRP conclusions recognised the need to move on.

Most IRP reports include recommendations about the leadership, management and processes of next steps. Stakeholders welcomed this and had used the recommendations as a framework for their subsequent work. In different places this has meant, for example:

- PCTs taking over leadership of public engagement from provider trusts
- the creation of a new multi-stakeholder planning forum to start from the beginning again to review community needs and priorities
- rapid progress with commissioning new facilities, including in some cases major buildings
- more liaison about public transport services
- increased publicity given to the opening of new services
- expanded ambulance services working to newly agreed protocols for getting all patients to the right destination first time
- increased transparency generally about local debates and developments.

In two places where the IRP supported proposals to centralise consultant-led obstetric services, midwife-led units have recently opened on the sites from which the consultant presence was withdrawn. Both have had positive local publicity and are attracting up to twice the number of mothers anticipated when they were first planned.

However, in a few places the IRP's report and Secretary of State's decision has not brought an end to a reconfiguration dispute. One 'save our hospital' campaign group has been restarted and others have continued their campaigns, one taking advantage of the long time scales required for a complex reconfiguration to raise public pressure for a further rethink. One stakeholder wistfully commented: *"We haven't yet found a way of dealing with the politicisation of healthcare service planning"*.

Planning a reconfiguration?

Part of the IRP's remit is to provide advice about service change to trusts, HOSCs and other stakeholders in health care services. This analysis describes a range of clinical, managerial and procedural issues which have been significant in referrals that have been subject to formal review. But geography, population profile, resources, building and history mean that those planning service changes are always faced with unusual, even unique, circumstances.

If you think a well-informed, independent opinion about a change process in your area would be helpful, please get in touch for free informal advice or visit our website.

Tel: 020 7389 8047
Email: info@irpanel.org.uk
Website: www. irpanel.org.uk

APPENDIX A

IRP Reviews

The Panel

The IRP is an advisory non-departmental public body (NDPB). The Chair and 15 Panel members have wide-ranging expertise in clinical healthcare, NHS management, public and patient involvement and in handling and delivering successful health service change. Their details are on the IRP website. Panel members are public appointments who act collectively and contribute their time, knowledge and experience to individual reviews as required. They are supported by the Chief Executive and the Secretary to the Panel.

Initial assessments

When a HOSC refers proposals for change to health services to the Secretary of State, he may seek advice from the IRP. We will then undertake an initial assessment of the referral and review its suitability for full IRP consideration**.** We tell the Secretary of State our conclusions; if we conclude that a full review is not appropriate we set out our reasons, where possible providing advice on further action to be taken locally. These initial assessments are published on our website.

Where a referral is considered suitable for full IRP consideration, and the Secretary of State decides to request our advice, specific terms of reference and a timetable for reporting will be agreed. The focus of all reviews is the interests of patients and the highest possible quality of care in the context of safe, sustainable and accessible services for local people.

Formal reviews

The Panel seeks to develop a thorough understanding of the proposals, how they have been developed and consulted on, and the views of all interested parties. We will request written evidence, undertake site visits and hold meetings and interviews with interested parties. We consider all forms of relevant information and will listen to people from all sides of the debate.

At the start of a review, the IRP Chair will write to editors of local newspapers to advise them of the Panel's involvement and to invite people who have new evidence to offer, or who feel that their views have not been previously heard, to contact the Panel.

Where appropriate, a sub-group of Panel members may be formed to lead a review. However, as many members as possible will take part in visits, meetings and interviews. Different members may be involved on different days but all information is shared and the Panel as a whole will discuss evidence and exchange views in coming to a consensus on our recommendations.

Typically, reviews have involved between eight and 12 days of site visits and hearing evidence. All the people we meet are listed in the final report along with all the documents we have been given. In any one review, we have seen between about 60 and 150 people, received between about 60 and 150 documents, and received up to a thousand or more items of correspondence.

Final report

Following the review, a report containing the IRP's recommendations (agreed by the whole Panel) will be submitted to the Secretary of State for consideration and will then be published approximately one month later.

Where appropriate we have supported the NHS proposals but also generally made recommendations about improving the services, community engagement or planning and implementation procedures - sometimes all three. When we have concluded that proposals are not in the interests of patients and do not improve services we have advised the Secretary of State of this as part of our recommendations.

The IRP offers advice only. The Secretary of State makes the final decision on any disputed proposal.